The end of the Second World War saw the beginning of the National Health Service as we used to know it. The National Health Service Act was published in 1946 as the Government of the day sought to honour the commitment by the wartime coalition Government, in response to the Beveridge Report of 1944, that health care would be provided free at the point of delivery for the people of the United Kingdom. The Act came into effect in 1948 and virtually overnight the National Health Service became the largest employer of doctors in the country.

It was a period of optimism. Research fellowships were created, not only by the medical schools, but also by the NHS to encourage young doctors to become involved in research. In addition, special provision was made for those doctors from the Armed Forces who were returning to civilian practice, and a series of supernumerary registrar posts was made available. Many of these posts had a research component built into their terms and conditions of service.

From a purely parochial aspect, the specialty of anaesthesia was one of the first beneficiaries of the new health service. Despite some opposition, mainly from surgeons, consultant appointments in anaesthesia were created on the same terms as those in the main specialties of medicine, obstetrics and gynaecology, and surgery. In effect, the service emancipated anaesthetists, who no longer needed to depend on the goodwill of surgeons for their income, and departments of anaesthetics began to be formed throughout the country.

In 1952 the Faculty of Anaesthetists, which had been established in the Royal College of Surgeons of England some 4 years earlier, requested the surgeons to set up a research department of anaesthetics within the College. To the credit of the surgeons, they responded positively and the new department under the direction of Dr Ronald Woolmer was opened in 1957, supported by grants from industry and, more importantly, by covenants generously provided by anaesthetists both in the United Kingdom and overseas. At approximately the same time and possibly stimulated by the discussions on the Council of the Royal College of Surgeons, Professor Ian Aird, Professor of Surgery at the Postgraduate Medical School, was sponsoring the development of clinical research in anaesthesia in the school, as a result of which, although not without difficulty, both space and technical assistance were made available. One of the problems was a proposal, successfully resisted by Professor Aird, that a chair of anaesthetics occupied by a physician should be created in the Postgraduate Medical School. It is interesting that, some 10 years later, a similar proposal was successfully resisted in Oxford when Sir Robert Macintosh retired in 1962.

It was in this rather favourable environment that the Anaesthetic Research Group was launched, although it has to be admitted that when the proposal was first made the response from senior anaesthetists was, to say the least, lukewarm and in one instance at least openly hostile. Fortunately a few influential leaders of the profession, such as Ronald Woolmer and John Gillies, were strongly supportive. As John Gillies put it: “Get it going and they will all be there”—and how right he was!

The purpose of the Group was to provide a forum for the presentation and discussion of original research in anaesthesia and, while it was accepted that the established research societies such as The Physiological Society and The Pharmacological Society were always willing to consider anaesthetic research papers on their merits, it was also recognized that there was a need for a more dedicated approach to anaesthetic research. Membership of the Group was open to anyone who had a major involvement in anaesthetic research regardless of discipline, and from the beginning physiologists, pharmacologists, physicists and chemists were welcomed as members and this multi-disciplinary approach became one of its strengths.

The philosophy behind the Group was to
provide the opportunity for those engaged in anaesthetic research to discuss their objectives openly and frankly with similarly minded colleagues. The need for constructive criticism at all levels was widely accepted and the early discussions were frequently forthright, but rarely acrimonious. No aspect was free from criticism, whether it was the design of the experiment, the presentation or the quality of the slides. The need to obtain advice on particular aspects from those members with specialist knowledge was generally recognized, and it was for this reason that attendance at the informal dinner after the meeting was strongly encouraged. Deliberately, the Group had no permanent officers and policy was decided by the members at a business meeting held under the chairmanship of the host immediately after the scientific presentations. There were, of course, no membership fees and the running costs were absorbed by the host department.

This essentially democratic approach was no problem as long as the membership remained small and consisted essentially of a peer group, but it became more difficult to sustain as the membership grew and different categories of membership were established. Ultimately it was accepted, albeit reluctantly, that changes were inevitable and in 1968 the Group became the Anaesthetic Research Society with elected officers, a management committee and a membership fee. Several factors were involved in the change. First, although discipline is enforced fairly easily and, indeed, is self imposed when a group is small and all members are known to each other, it is less easy when the members are relative strangers, so that it is difficult to separate guests from members. Second, once a membership fee was imposed the conversion to a society offered certain tax advantages which were not available to a group. Third, there is a further financial advantage in that it is much easier, especially for junior members of staff, to obtain study leave and even financial support to attend a meeting of a recognized society as opposed to an informal group.

The subject of recognition draws attention to the problem first raised by Dr (later Professor) E. A. Pask, who opposed the formation of the Anaesthetic Research Group on the grounds that it would lead to the development of an elite in anaesthesia. Undoubtedly this was a legitimate argument although it could be argued equally well that anaesthesia needed such an elite. Whether or not the Anaesthetic Research Society provides it must be a matter for conjecture, but what cannot be denied is that the Society has become an important influence in anaesthesia and that membership is regarded by young research workers as sufficiently prestigious to justify mention in applications for grants or posts.

Such status puts substantial responsibility on members of the Society, and more particularly on the officers, to maintain the standards originally defined by the Anaesthetic Research Group. Regrettably, this is not always the case. The quality of the criticism at meetings sometimes leaves a great deal to be desired; some members seem more concerned with exhibiting their own special expertise than with helping their younger colleagues. It is noticeable, too, that some of the more vocal critics rarely present papers and the lack of a uniform standard in the acceptance or rejection of papers must be a cause for anxiety; moreover, very occasionally there seems to be a lack of objectivity in some of the criticism. It is also important that when members of the Society present their results at national and international meetings, they should maintain the standards of the Society, and this is not always done. If the Society is to continue to prosper, members must be seen to set an example, both in the form of their presentations and in the manner in which they criticize the work of others.

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