Committees are essential for the running of the Society and heaven knows the BSG has enough! Of necessity they concentrate on current issues relating to the day to day running of the Society and its meetings. The danger is that they do not lend themselves to crystal ball gazing and thus we tend to have a short-sighted view of what is happening and don't look sufficiently ahead.

Somehow the Society needs to make time to gaze into the future, to throw ideas about however outrageous, to brainstorm and to plan for a long term strategy. What are we about? Where are we going?

In the past, away days have occurred intermittently to try and achieve this aim. On 27 April the Executive Committee held another away day. I would like to share with you some of the ideas that were discussed during this day.

Away Days and Strategy Group
These should be annual events in the Society's calendar and furthermore a Strategy Group should be inaugurated, chaired by the incoming President and this group should meet on a regular basis.

Presidential Term of Office
There are many within the Society deserving of the honour of being President. The annual term of presidency maximises the chances of sharing this honour around. However with the increasing complexity of the Society, the pressure upon it and the greater need to engage the public and politicians, a one year term of office does not allow time to understand the job and influence change. Logistical problems make a 2 or a 3 year term of presidency difficult for reasons I won't elaborate here.

The consensus was that the existing arrangement provided the best compromise but needed consolidating. This consists of a President-in-Waiting for one year, becoming President-elect for a further year and then President for the third year. In the two year run-in to the presidential year there is increasing commitment to Society work, chairmanship of committees and in addition increasing responsibilities.

In future the President-in-Waiting will serve on the newly created Strategy group, the newly created Public Relations group and the Clinical Services and Standards Committee. The President-elect will chair the Strategy group and sit on the Public Relations group and the Clinical Services and Standards Committee. This graded structure of involvement will allow Presidents a 3 year opportunity to develop ideas and influence the direction of the Society.

President of the society
2006-2007

Proposals or self-nominations for the position of President of the Society for 2006-7 are now called for. Confidential applications must be sent to the Chairman of the Nominations Committee with a reference, a one-page CV and a 200-word manifesto no later than 1 November 2004. The Nominations Committee will then select the name of the candidate/s to be put to Council and appointed, by vote if necessary. The President serves on Council for two years prior to taking up office. Anyone wishing to discuss the role is welcome to call Dr Jeremy Sanderson.

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### Regional Representatives

The following members have been elected to represent their region for the next three years:

- **Northern**
  - Dr D Burke
- **Trent**
  - Dr M Donnelly
- **Wessex**
  - Dr D Fine
- **North Western**
  - Dr C Babbs
- **North Wales**
  - Dr R Sheers
- **South Wales**
  - Dr GAO Thomas
- **Scotland (Grampian)**
  - to be confirmed

### Events

- **1 September 2004.**
  Masterclass in Inflammatory Bowel Disease, Oxford. Details available from Professor Jewell's secretary: Toria.summers@ndm.ox.ac.uk

- **7-10 September 2004.**
  22nd Leeds Course in Clinical Nutrition. Contact: Carol Would, School of Continuing Education, University of Leeds, LS2 9N G. Tel: 0113 343 3241; email: c.would@leeds.ac.uk

- **26 October 2004.**
  Symposium on Upper Gastrointestinal Cancer; RCP Edinburgh. Details: Eileen Strawn, Tel: 0131 225 7324; email: e.strawn@rcpe.ac.uk

- **4 November 2004.**
  RSM Conference 'The Unruly Gut', Birmingham. Details available from Mrs Alyson Ling, RSM, 1 W impole Street, London W 1G 0AE (tel. 020 7290 3844) or register online at www.rsm.ac.uk/diary

- **5 November 2004.**
  BSG/ACP Study Day on Pancreatobiliary Pathology, Hulme Hall, University of Manchester. Details: tel 0161 276 8841; email: ray.mcmahon@man.ac.uk

- **17-18 November 2004.**
  Annual BAPEN Meeting, Telford. Details: tel. Sovereign Conference, 01527 518777; email: association@sovereignconference.co.uk

- **11-13 December 2004.**
  6th International Workshop on Therapeutic Endoscopy, Cairo. Details: beta@alfamedical.com

- **23-25 January 2005.**
  Hepatology 2005: Royal Free Hospital London. Details: Terri Dolan, tel. 020 7433 2851

- **9 February 2005.**
  St George's Gastroenterology Teaching Day, London. For details email: jykang@sghms.ac.uk

- **4-7 May 2005.**
  6th International Gastric Cancer Congress, Japan. For details email: igcc6@sc.itc.keio.ac.jp

### Appointments

- **Dr A Bell**
  Weston General Hospital
- **Dr A Cahill**
  Stobhill General Hospital
- **Dr A De Silva**
  James Paget Hospital
- **Dr A Rahman**
  St George's Hospital London

### Obituaries

We are sorry to learn of the tragic death of Richard Cobb, consultant surgeon at Birmingham Heartlands Hospital. Dr Robin Walker, consultant physician at Aintree Hospital also sadly died earlier in the year.

**RCP Gastro Gang, L-R:** Rodney Burnham (Director; Medical Workforce Unit), Roy Pounder (Vice-President), Parveen Kumar (Academic Vice/President), Richard Thompson (Treasurer), Ian Gilmore (Registrar), Brian Cooper (Censor) and George Cowan (Medical Director; JCHMT)
Gearing up for the 2005 meeting

Planning is now well underway for the 2005 Annual meeting in Birmingham. Just to remind you, the 2005 meeting marks the change to a Monday to Thursday format with the Postgraduate course on the Monday and the main meeting on the following three days, including all day Thursday. The Postgraduate course is on Inflammatory Bowel Disease and some excellent symposia are planned for the core meeting. We are also planning more in the way of awards for the best oral and poster presentations, poster rounds and there will be “Question the expert” breakfast meetings on Tuesday, Wednesday and Thursday. The latter seemed to be successful in Glasgow (although one attendee spent all but the final minute of the infliximab meeting in a deep sleep. Bad mistake to sit in the front row!).

The case presentations will be on a series of PCs once more but please note that you will NOT be able to answer e-mail on these. However, I am arranging, hopefully, for a BSG Internet Café to be set up for the whole meeting so that you can e-mail your loved-ones to your heart’s content.

My co-secretary, John de Caestecker, has done some excellent work on modelling a British DDW and this project is still very much on course. There is clearly plenty of work to be done by the Society on how to sort the financing of a much more complex meeting but the enthusiasm of all the various societies/organisations involved suggests this really is going to work. I hope so.

Case presentations of the month

For the last three years, the BSG has encouraged the submission of interactive case reports, usually with trainees as first authors. Those accepted have been presented at the Annual Meeting as interactive cases on the computer stand and have been prominently featured as “Case of the Month” on the BSG website. Indeed this year’s Annual Meeting in Glasgow saw the most successful presentation of cases yet. Authors are asked to submit an abstract, and for accepted cases, these will be published with the other abstracts in Gut. Prizes will be available for the best cases.

Submissions should be subdivided into the following categories:

1. Case presentation
2. Case discussion
3. Four or five multiple choice questions with 5 answers per stem, occurring throughout the above
4. Concise learning points as a conclusion
5. Full academic references

In addition submissions should:

- Be approximately 1000 words in length
- Carry a stimulating title which reveals the essence of a case, but not the specific diagnosis, to the reader
- Possess an imaginative style – appropriate humour is acceptable!
- Feature a graphical component – images or video

NICE colorectal cancer service guidance

The NICE Colorectal Cancer Service Guidance has now been released. You will find a link to the document on the BSG website: www.bsg.org.uk/clinical_practice/guidelines.htm

BSG manpower census

Thank you everyone who has returned their census forms. As usual, the response has been very good. If you have not yet returned your forms to the Secretariat it is not too late!

Abstract deadline for 2005 meeting:

2 November 2004

Submit on line only at: www.bsgabstract.org.uk after 1 September 2004.
Public Relations
Our interactions with the public, our patients, the media and politicians is no longer a part-time activity but increasingly a major component of the Society’s work.

To meet this demand we are creating a special Public Relations Committee. The Chairman is likely to be someone able to commit two or more sessions a week with easy access to the BSG offices in London. I believe the post need not necessarily be occupied by a Gastroenterologist or indeed a Clinician.

I would be very interested to hear your views and to hear from anyone interested in such a position. The Committee needs to be up and running in the Autumn and certainly in time for the launch of the Society’s Strategy document in March 2005.

The senior Secretary, Jeremy Sanderson, who has played a lead role in developing our ideas about Public Relations has agreed to act as interim chairman until a substantive appointment is made.

Lay Representation
The Government is rightly determined that the profession should engage much more closely with its patients and have lay representation in the workings of medical organisations. The College of Physicians has taken the lead and will have lay representation on most committees. The first lay representative on the RCP Joint College Committee for Hepatology and Gastroenterology has been appointed. I believe we must follow suit in the BSG although it may not be appropriate to have lay representation on all committees.

How does one select lay representatives? The RCP advertised in the national press and has now interviewed over a 100 applicants. Should representatives have an interest in a specific area of gastroenterology or be very general in their experience? We don’t want individuals with an axe to grind! Advertising in the national press is expensive and therefore I have agreed with the RCP that we share their database and appoint lay representatives from their pool of interviewed individuals.

Members Participation in the Society
I remain concerned that there are many within the Society with much to offer to the running of the BSG. Some names come forward through the nominations process but a lot of individuals are clearly reticent to put themselves forward or ask colleagues to do so. Please do not be shy!

We try to stimulate interest through the Newsletter but the responses are often disappointing. For example, with the recent retirement of Alistair Macintyre from the Manpower post, we advertised for his replacement and have had no response whatsoever. This is a key office within the Society.

There is at times criticism that the same old faces keep turning up and I feel slightly embarrassed in this respect (“old” being the operative word here). However, with the increasing democratisation of the Society and the opportunity to self-nominate this really needn’t be the case. Please come forward!

BSG Strategy Document
Work on this important document continues apace. I am about to make my second visit to join the Medical Informatics Working Group in Swansea who are beavering away getting all the essential background information for this document.

I promised feedback from my visit to the new Diagnostic Department of the Department of Health at Quarry House in Leeds last month. There was a lot of enthusiasm and plans for further meetings but increasingly my reaction to encouraging noises from the Department of Health is “don’t hold your breath”. More in my next letter.

Sir Francis Avery Jones BSG research award 2005
Applications are invited by the Education Committee of the British Society of Gastroenterology who will recommend to Council the recipient of the 2005 Award. Applications should include:
1. A manuscript (2 A4 pages ONLY) describing the work conducted
2. A bibliography of relevant personal publications
3. An outline of the proposed content of the lecture, including title
4. A written statement confirming that all or a substantial part of the work has been personally conducted in the UK or Eire..

Entrants must be 40 years or less on 31 December 2005 but need not necessarily be a member of the Society. The recipient will be required to deliver a 30 minute lecture at the Annual Meeting of the Society in Birmingham in March 2005. Applications (20 copies) should be made to the Honorary Secretary, British Society of Gastroenterology, 3 St Andrews Place, London NW1 4LB by 1 December 2004.
The BSG endoscopy section committee has commissioned a group to work on simplified consent forms and patient information sheets for gastrointestinal endoscopy. Miles Allison and Hugh Shepherd have now carried out a considerable amount of work on behalf of the committee and procedure specific consent forms are well underway. This work was provoked by the DoH consent forms 1-4, produced in 2002, which were considered by many endoscopists to be too wordy and not suited to high volume low risk procedures. The Winchester Group had already designed a patient information booklet with an integral consent form for Upper Gastrointestinal Endoscopy and successfully piloted this within the process of postal consent (GUT 2000; 46:37-9). In this system patients can either return their signed consent forms by post or opt to seek more information before signing when they come for their procedure. The Clinical Negligence Scheme for Trusts and National Health Service Litigation Authority have given their blessing to the Winchester and Eastleigh Healthcare NHS Trust patient information literature and integral consent form for patients listed for Upper Gastrointestinal Endoscopy. This consent form has been revised along the lines of a shortened form 1 and a draft version has been approved by the DoH.

The working party is at present extending the work done in Winchester and by Dr Anthony Mee and is preparing patient information leaflets for Diagnostic Gastroscopy, Therapeutic Upper Gastrointestinal Endoscopy, Flexible Sigmoidoscopy, Colonoscopy and Endoscopic Ultrasound. Each of these leaflets will contain an integral consent form tailored to the procedure including its possible risks and intended benefits. A further leaflet on combined Gastroscopy and Colonoscopy for patients with Iron Deficiency Anaemia has also been suggested and the working party will consider ways of including anticipated therapeutic procedures, for example Oesophageal Dilatation, into the consent process.

The BSG Endoscopy Committee has endorsed the widespread introduction of postal pre-consent for outpatient endoscopic procedures and the use of simplified customised consent forms. It is hoped that these will become available to endoscopy units in early 2005 but it is likely that the use of consent forms 1 and 2 will continue to be advised for inpatients and for lower volume higher risk procedures such as ERCP and Percutaneous Endoscopic Gastrostomy. There will, of course, be no compunction in the use of these forms and hospitals can continue to use the consent forms 1-4 across the board if they so wish. Consent and information are an essential first step towards developing a patient centred endoscopy service which I am sure we should all be striving to achieve.

At the time of writing a document entitled “Access Capacity Planning - Guidance for the period 2006/7 – 2007/8” has come into my possession. Endoscopy is one of the diagnostic services listed in this document which should certainly raise our profile and hopefully our funding but on the evidence so far I would caution an over optimistic reception – more of this later!
Campaign for a health warning on alcohol products

The Cabinet Office announced the Alcohol Harm Reduction strategy for England in March 2004 (www.strategy.gov.uk) and two weeks later the Department of Culture, Media and Sport published draft Guidance for Licensing by Local Authorities. Notwithstanding the £20 billion cost to the nation of alcohol harm the latter document gave only 3 lines of coverage to the former stating that Licensing authorities should familiarise themselves with the Harm Reduction Strategy when published.

The BSG/BASL/BLT campaign, dealing with public education issues recommends:

- As part of the social responsibility scheme, alcohol producers and manufacturers will be strongly encouraged to add messages encouraging sensible consumption alongside unit content, to the labels of its products in a form agreed with the DoH;
- As part of the social responsibility scheme, all retailers of alcohol, both on- and off-licence, will be strongly encouraged to display information setting out the sensible drinking message and explaining what a unit is and how it translates in practical terms to the drinks sold.

The DoH is required to (i) carry out a reassessment of the current sensible drinking message, focusing on developing a simpler format for the message, making it easier to relate to everyday life; (ii) work with others inside Government to identify the most effective messages to be used with binge- and chronic drinkers, and the most effective media for disseminating these messages. A PR company has been commissioned to carry out this work and their report has been received by the DoH.

The alcohol industry will be required to comply with the recommendations on a voluntary basis but the DoH is to work with the UK permanent representation to the EU and partners within government to examine the legal and practical feasibility of compulsory labelling of alcoholic beverage containers. An independent audit will be carried out early in the next Parliament to assess the efficiency of the voluntary agreement.

Finally a communications group is to be formed to ensure that the various government departments will in future speak to each other about measures to combat alcohol harm. A promising start but there are still multiple hurdles to be crossed before an effective alcohol harm reduction strategy becomes operational!