Promoting the British Society of Gastroenterology

I am frequently asked to outline the Society's opinion on a number of current issues, most commonly the value of screening for colorectal cancer, the aetiology of Crohn's disease and MMR, diet and cancer and nutritional support in the terminally ill. To indicate that the Society has not yet formally developed a view is not the most robust of responses.

The key role of the BSG must remain the promotion of education and research at the annual scientific meeting and publication of original work in the Society's Journal GUT.

The Society has many other responsibilities supervised by Council in addition to education and research, including clinical services, training, sectional interests and links with the Royal Colleges and the Digestive Disorders Foundation.

The Foundation informs the public about many aspects of gastroenterology and the Society itself promotes these issues directly to the public at its annual scientific meeting. However unlike other specialist societies we have not promoted our own specialty or expressed an opinion on matters of public policy. Any such comments have usually been mediated through the Colleges and their informal links to the Department of Health.

Should a specialist society like the BSG become involved in public policy?

Jeremy Sanderson, one of our two energetic secretaries, has been discussing this issue with other specialist societies. This topic was also selected for debate at the annual executive strategy meeting.

From these discussions it is clear that taking an active role would require a major commitment of time, energy and funds. The most constructive advice is to establish an external relations committee, appoint a public relations company to help define and promote the Society's views and identify a chairman who would need to commit 1-2 days per week. This represents an annual investment of some £70,000 or one third of our current surplus which supports research, education and clinical services.

Do members think that promoting public policy is important? If so what are the key issues?

This is one of several important developments within the Society which includes a more open process for election of officers and plans to establish closer links with the AGA governing body.

This evolution in the Society's affairs is invigorating and vital and only possible because of the enormous number of individuals willing to give generously of their ideas, time and energy. I can only express my gratitude and thanks for such unstinting, enthusiastic support. The new chain of office (designed, made and engraved in the jewellery quarter in Birmingham) will shortly be handed on to the incoming president, Professor Nick Wright and I know he can count on your continued support.

Robert Allan

North of England Gastroenterology Society (NEGS)
President: Dr Derrick Martin
The Executive and I are keen to expand the Society and to promote the objectives of the BSG at local level. As long as you have some interest in gastroenterology you will be welcome as a member, and membership is open to career and non-career grades. Membership fee – £25 a year, free to SpRs and those in career grade.

Dr Sarfraz Qureshi, Hon. Secretary/Treasurer, Consultant Physician/Gastroenterologist The Calderdale Royal Hospital, Halifax HX3 0PW
Appointments

Dr A Chilton  Kettering General Hospital
Dr C Fraser-Moodie  University Hospital Nottingham
Dr M Gibbons  Craigavon Area Hospital
Dr S Hearing  Staffordshire General Hospital
Dr K Ragunath  University Hospital Nottingham
Dr D Reffitt  University Hospital Lewisham

British Society of Gastroenterology

Annual meeting  23-26 March 2003
International Convention Centre, Birmingham

Don’t forget to register for the annual scientific meeting. Although you can register on arrival in Birmingham, it will save your time if you do so in advance. You can register online at www.confrex-bsg-reg.co.uk

The full scientific programme is also available on the above website or the main bsg website www.bsg.org.uk

Events

27/28 February 2003. 1st International Conference on Cytokine Medicine, Manchester. Details: Tara Lanigan, Hampton Medical Conferences, 127 High Street, Teddington TW11 8HH. Tel: 020 8977 0055; email: tlanigan@hamptonmedical.com


31 March and 1 & 2 April 2003. Symposium ‘Reflux and the Upper Aerodigestive Tract’, Nottingham. Details from Dr J McGlashan, Senior Lecturer in Otorhinolaryngology, Queen’s Medical Centre, Nottingham. Email: julian.mcglashan@nottingham.ac.uk

6-10 April 2003. 11th Triennial International Symposium on Viral Hepatitis & Liver Disease, Sydney. Details: ISVHLD 2003 Symposium Manager, Tour Hosts Pty Ltd, NSW 2001, Australia. Fax: 00 612 9262 3135; email: isvhld@tourhosts.com.au

7-11 April 2003. Intercollegiate Certificate Course on Human Nutrition, Southampton. Details: Janice Taylor. Tel: 023 8079 6317; email: jmt1@soton.ac.uk

23/24 April 2003. Symposium on Alcoholic Liver Disease, Sheffield. Details: Dr D Gleeson, Royal Hallamshire Hospital. Tel: 0114 271 3652; email: dermot.gleeson@sth.nhs.uk

21-25 June 2003. Annual Practical Nutritional Support Course for Clinicians, Southampton. Details: Janice Taylor, Short Course Administrator, Inst. Of Human Nutrition, Southampton General Hospital, Southampton SO16 6YE. Tel: 023 8079 6317; email: iohn@soton.ac.uk


25-27 June 2003. Hepatitis C Past, Present and Future, Dublin. Details: Catherine White, Project Planning International, Montalto Estate, Spa road, Ballynahinch BT24 8PT. Email: catherine@project-planning.com

25-28 June 2003. 3rd ‘Update on H Pylori Research and other Emerging Issues on Digestive Cancer Prevention’, Bologna. Details: Cristiano Canuto. Email: cristiano.canuto@labidee.it

2-5 September 2003. 21st Leeds Course in Clinical Nutrition. Details: C Would, School of Continuing Education, University of Leeds, Leeds LS2 9NG. Tel: 0113 343 3241; fax: 0113 343 3240; email: c.would@leeds.ac.uk

8-12 September 2003, Nottingham. Details: Prof I Macdonald. Tel: 0115 9709465; email: ichern@nottingham.ac.uk

(RCP) Graham Bull prize in clinical science

This award was established in 1988 in honour of the late Sir Graham Bull, first director of the CRC at Northwick Park. A Trust for the Graham Bull Prize was set up to provide money for young research workers under 45 who feel that they have made a major contribution to clinical science. The prize is specifically for an application and not for nomination of individuals. The work can cover a wide range of expertise, such as molecular and cellular biology, imaging technology, psychology or health sciences. The award is open to both clinical and basic scientists who must apply for their own work to be considered. The sum of £1,000 is offered on a competitive basis each year. Closing date for the next award is 31 March 2003.

Application forms are available from the Academic Registrar, Royal College of Physicians. Tel: 020 7935 1174 ext.436; fax: 020 7224 0719; email: conferences@rcplondon.ac.uk
Honorary secretary's column

Looking forward to the annual meeting
Birmingham, March 2003

The next annual meeting of the Society will be held at the ICC in Birmingham, March 2003. Work on the meeting started last year and recently we put the final pieces in the jigsaw with the selection of the free papers. 580 abstracts were submitted. Each category is judged by a panel of experts and 75% of abstracts were accepted for presentation, 25% will be presented for oral presentation and 50% as posters. We continue our mission to raise the profile of the posters and the top 10% are designated plenary posters. Thirty plenary posters will be presented on both the Monday and the Tuesday and formal poster rounds will take place on the Monday and Tuesday lunchtime chaired by eminent members of the Society – you are encouraged to attend. For this meeting we have elected to have three state of the art lectures held in plenary session, at the end of the morning and beginning of the afternoon on the Monday and in the plenary session on the Tuesday. This allows attendance by a large proportion of the Society for prestigious lectures of broad interest. In addition, there are keynote lectures by national and international experts focussed towards specialist sections of the Society and will be held during the symposia. Starting with the postgraduate course on the Sunday and culminating in the endoscopy section’s grand finale live CCTV endoscopy session on the Wednesday afternoon, there should be plenty to occupy the delegates.

This is my last newsletter as honorary secretary of the BSG. It has been a privilege to serve the Society in my four years of office. I would like to thank the four presidents from my period of office, Lord Turnberg, Professors Axon, Jewell and Allan, and my fellow secretaries Alastair Forbes and Jeremy Sanderson, and particularly Di Tolfo and Chris Romaya who keep the show on the road. I am impressed by the goodwill and selfless devotion to the Society by numerous members and officers. The BSG is a strong and active society that admirably fulfils its mission to promote research, define standards of care and training, and as an advocate for gastroenterology.

By Duncan Loft, honorary secretary of the BSG

Report from the Paul Brown travelling scholar – PJ Conlong

Dr Takuji Gotoda of the Tokyo National Cancer Centre directs me as I apprehensively attempt a gastric EMR for an early gastric cancer. The operation fortunately was a success. The lesion measured approximately 4 cm in diameter and lay on the lesser curve. It took one hour to resect – the Japanese are very tolerant. We used the IT knife with a cut/coagulating current. There was a little bleeding during the procedure which we managed to stop endoscopically, and the lesion was closed with endoscopic clips.

The following day the patient was fine and subsequent histological analysis confirmed early gastric cancer with satisfactory resection margins (more than 0.5 cms) and within 500 micrometers of muscularis mucosa.

Having now been to the National Cancer Centre in Japan for the second time one cannot fail to be impressed by EMR. Clearly, gastric lesions in the west are less frequent, more proximal and technically more demanding. There will be demand for colonic EMR for flat and depressed lesions, although we need more data to confirm how frequent these lesions are in the west.

PJ Conlong
The DDF currently supports 15 full time research fellows and has committed £0.75 million to fund three programmes in the Cancer campaign. This is possible because of fundraising successes in the past, and a buoyant “pre-9/11” economy. Given the present financial crisis, however, and an obligatory change in accounting methods, there is a period of turbulence ahead. In common with other charities, the DDF will have to tighten its financial seat belt – but hopefully to only a modest extent. Despite this, there are important new developments in the charity’s research awards.

First, we adapted (with permission) the Wellcome Trust’s application forms for research fellowships. This has already helped the Research Awards Committee (RAC) to make more objective judgments about the scientific and training components of fellowship applications.

Second, the retiring chairman of the RAC, Sir David Weatherall, introduced several innovations which include:

(i) identification of lead questioners to interview each of the short-listed candidates,
(ii) co-option onto the RAC of substitute or replacement experts, where gaps exist,
(iii) routine use of external referees.

Based on the results of a survey of supervisors of fellows funded by the charity during the past five years, the DDF Trustees are actively considering an increase in running costs for each fellowship from the current maximum of £2,000, to £5,000-£10,000, per year. However, without an increase in fundraising revenue, this can only be achieved by a reduction in the total number of fellowships awarded. Please let us know what you think about this idea.
Audit, guidelines and the Department of Health

The endoscopy section has, over several years, been particularly active in producing guidelines; indeed there are guidelines in preparation from the section covering sedation for endoscopy, cleaning and disinfection of endoscopes and urgent or emergency endoscopy. You have recently received guidelines from us concerning the management of acute non-variceal gastrointestinal bleeding, Mike Hellier must take much credit for stimulating guideline production and many of us believe that these publications have made us reflect on our individual practices and have improved standards of care. In the spirit of evidence based practice we need however to prove their value. The combination of the recent gastrointestinal bleeding guidelines and the 1990 Royal College of Surgeons audit (leading to the Rockall scoring system) may provide us with the opportunity to determine whether guidelines are actually used and whether this has been associated with improved clinical practice. We are therefore exploring the possibility of repeating a multicentre audit of patients admitted to hospitals because of haematemesis and melaena in order to define the utility of the relevant guideline and to ‘close the audit cycle’. This proposal is early in gestation and I will keep you informed.

I am conscious that groups outside the BSG are auditing aspects of endoscopic practice. NCEPOD (the National Confidential Enquiry into Perioperative Deaths) has extended its remit from looking exclusively at operative surgical episodes to ‘medical’ procedures and has published a report relating to aspects of cardiological practice. As many will know, NCEPOD is currently looking at adverse events following therapeutic upper gastrointestinal endoscopic procedures in England and Wales and will complete data collection in April 2003. An audit of oesophageal interventions will begin early in 2003 and will last for a three month period. I am concerned that many colleagues have apparently heard little of these projects and have not been asked to complete audit forms, but it may be early days!

An important aspect of guideline production and of audit based upon guidelines is clearly to produce hard data which will demonstrate to the Department of Health that gastrointestinal practice is effective, developing and requires continuing resource for equipment and personnel. We do need somehow to improve our access to government and a recent, extremely welcome development has been the appointment of Roland Valori as National Clinical Lead for the endoscopy programme of the NHS Modernisation Agency. Roland has been a consultant gastroenterologist in Gloucester for nearly ten years and is currently a member of both the BSG endoscopy committee and BSG council. His most immediate tasks with the Modernisation Agency are to raise awareness of the endoscopy programme and to support pilot sites in the development of a toolkit designed to enhance the profile of, and access to endoscopy services. Longer term goals include liaison with other professionals, groups and agencies that have a stake in endoscopy, identification and dissemination of good practice and to provide feedback to the Department of Health of the opportunities and challenges that face endoscopy. The Modernisation Agency will have a stand in the Exhibition Hall at the next BSG meeting in Birmingham for those who would like more information about its aims, methodology and achievements.

Kel Palmer

BSG Research Committee workshop: cellular signalling mechanisms as targets for chemoprevention of gastrointestinal malignancy

On behalf of the BSG Research Committee, Drs Mark Hull and Jean Crabtree recently organised a second BSG Research Workshop at the Royal Society of Medicine, London on 11 October 2002. Twenty-seven delegates contributed to a successful series of presentations and informal round table discussions on diverse aspects of the biology of GI epithelia pertaining to cancer chemoprevention therapy. As well as established researchers from the UK, the delegate list included several speakers from abroad including Drs Rick Peek and Rifat Pamucku (representing the Gastroenterology Research Group of the AGA) and Professor Michael Naumann (Magdeburg, Germany). Several TiGs delegates, who had previously had little exposure to research, were also able to attend.

The morning sessions covered general aspects of GI cancer research techniques, including animal models and in vivo microscopy, followed by an exploration of the mechanistic links between chronic inflammation and malignant change throughout the GI tract. Topics covered in the afternoon included important second messenger signalling pathways, the potential for dietary components to inhibit cell signalling and the mechanisms of action of NSAIDs. The meeting concluded with an excellent overview by Professor Alex Markham (Leeds). In the evening, delegates tested the effects (preventative or otherwise) of imbibing the red grape constituent resveratrol, whilst continuing informal discussion in a nearby Italian restaurant.
Assessment of competence – developing curricula

The profession is focusing attention on the assessment of competence of doctors and those in training. For doctors this task is being vigorously pursued by the GMC and will form part of revalidation procedures. For the past 2 years the JCHMT of the London, Edinburgh and Glasgow Colleges of Physicians has been reviewing and developing enhanced methods for assessment of competence so that at the RITA and penultimate year reviews there is sufficient valid information on the progression of training to make a decision regarding the award of a CCST which will be defensible in law.

December saw the launch by the JCHMT (www.jchmt.org.uk) of the new competency based curricula for the 25 medical specialties. The curricula have been developed by each of the SACs in conjunction with the training committees of the relevant specialist society. Each curricula is now specified in much greater detail than in the past. Several JSHMT workshops have developed terminology for the global assessment and recording of competence for each curriculum item using a 4 point scale, a grade to be awarded by the educational supervisor at the termination of the training year. The gastroenterology curriculum has 5 sections including endoscopy and liver disease, which have been developed in collaboration with the Joint Advisory Group for GI Endoscopy and BASL respectively. The endoscopy section includes representatives of all groups undertaking endoscopy so that it should be applicable throughout the profession.

One drawback of the curriculum is that the assessment grades awarded by the educational supervisor are subjective and during the past year much effort has been put into developing objective methods to complement these. Three objective tools are now in an advanced stage of development and will be piloted in all 35 specialties in early 2003. They are the mini Clinical Evaluation Exercise (miniCEX), the 360º assessment and the Direct Observation of Procedural Skills (DOPS). The miniCEX and DOPS are snapshot evaluations of the trainee’s abilities by the consultant in charge lasting 15-30 mins including time for feedback to the trainee. For the assessment to be valid, multiple encounters for different curriculum items by several consultants are required and for the pilot study 6-8 over a 3-4 month period are envisaged. Simple instructions for trainees and trainers are included with the standard recording sheet. For the 360º assessment, questionnaires will be sent to 15 health care colleagues of the trainee for return in confidence to the educational supervisor for analysis and overall feedback to the trainee. Should these pilot studies be successful the assessments will be required annually for the RITA reviews.

Two government publications highlight the importance of this work that has largely pre-empted any criticism of the College’s training arrangements in the medical specialties. In Unfinished Business the CMO highlights the development of competence based training for SHOs to complement the acquisition of professional exams and the College’s work on SpR training together with the development of the SHO curriculum should provide considerable help. Looming ahead of us at present is the General Medical Practice and Specialist Medical Education, Training and Qualifications Order which threatens to remove the supervision of specialist training from the jurisdiction of the Colleges and place in the hands of the regional postgraduate Deans. Many gastroenterologists may fear we are entering a phase of enormous bureaucracy but if the specialty does not co-operate we may have more draconian and less effective methods forced upon us by the government ‘in the public interest’.

By Chris Record, chairman, SAC in gastroenterology

BSG Website

We are very disappointed that most members appear to be unaware of the existence of the BSG website and have never looked at it. Log-on to www.bsg.org.uk and take a look. The Clinical Practice page contains all BSG publications and guidelines, including the two recently updated guidelines on Management of Patients with Coeliac Disease, and Dyspepsia Management. Check your entry details on the membership (members only) page and if they are incorrect contact the secretariat.