Expansion in British gastroenterology appears healthy, with consultant jobs continuing to be advertised and appointed. At 30 September 2000 there were 548 consultant gastroenterologists in England and Wales representing a 7.2% rise from the previous year. By 1 March 2001 there were 562 consultants in the specialty, 10 more will take up post in the next few weeks and a further 14 posts have been advertised to date. Competition for these posts is variable, many with a large field of applicants, but 3 of the last 21 posts went to applicants who had not come through the NTN system whilst 2 posts did not appoint at all. This is despite there being (in early March 2001) 56 CCST holders in the specialty - 23 of these obtained CCST within the last 6 months but 33 had CCST for more than 6 months and a few have left the training schemes and lost their National Training numbers.

One of the impossible tasks in Manpower is to try and predict the future. There remain numerous powerful drivers to expansion in the specialty and it seems likely that expansion will continue at 7% or above for the foreseeable future. There is however no central mechanism to ensure this and it depends on local Trusts/Primary Care Groups addressing the need and advertising the consultant post. By estimating the number of retirements (averaging 12 to 13 per year over the next 10 years) and other losses to the consultant body one can estimate the number of replacement posts needed and add this to the predicted number of new posts acquired from expansion. To derive the number of trainee gastroenterologists required one can then try and match the number of consultant posts likely to appear in any year with the number of CCST holders coming out at the end of training. The result is a graph as shown in figure 1. It models 3 scenarios. The top line shows the number of CCST holders in excess of consultant posts on the assumption that everyone gets their consultant post immediately they gain CCST. As this is rather unrealistic the second scenario (middle line) assumes the Consultant post is taken up 6 months after gaining CCST. The third line shows just how fragile the calculations are. It assumes an additional 20 posts come available during 2001 and a further 20 posts during 2002. This data suggests competition for consultant posts to be quite intense until 2004 to 2006 but thereafter it may become more difficult to fill the consultant posts required for expansion due to a shortage of CCST holders.

Figure 1: Prediction of annual cumulative excess of CCST holders over jobs

- (i) Cumulative excess CCSTs
- (ii) Cumulative excess CCST >6 months
- (iii) As (ii) plus 20 new posts 2001 & 2002

Numbers

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Non-clinical scientists
Council has approved a new category of membership for non-clinical scientists. This is intended as recognition of special interest or experience in any non-clinical discipline relevant to gastroenterology. The subscription is set at a lower rate than that of full members. Further details and applications forms are available from the Secretariat.

Hepatitis C Guidelines
The BSG Hepatitis C Guidelines are available on the Gut website: http://gut.bmjjournals.com/ and by now should also be on the BSG website.

Are you meritorious?

Discretionary Points
Consultants at the top of the pay scale are eligible for points or additional points up to a maximum of 8. Eligible consultants should be considered annually by their local discretionary points committee. Individuals who feel they may have been overlooked should contact the chairman of their local discretionary points committee and obtain a CV questionnaire which should be completed and returned to the chairman with a request for a review.

Higher Awards
Higher awards (B and A) are competitive so that a B award under the age of 43 is extremely unusual and an A award under 46 exceptional. Although not essential, nearly all individuals already hold at least some discretionary points.

Each trust has a mechanism for making recommendations to the regional awards committee and in its turn the regional awards committee makes its recommendations to the central committee.

Any individual who feels they have been overlooked should write to the chairman of their trust’s higher awards committee or the chairman of the regional awards committee and obtain a CV questionnaire which should be completed and returned with a request for a review.

The royal colleges and the specialist societies (among others) also submit recommendations to the central committee.

The BSG has a mechanism in place to review all eligible members of the Society and to make recommendations to the central committee. Any individual who feels that their contribution may have been overlooked should write to the executive secretary enclosing a current CV questionnaire.

Major changes are noted but the current system remains in place this year and probably next.

For further information see the Department of Health website at http://www.doh.gov.uk/nhsexec/acda.htm

Appointments

<table>
<thead>
<tr>
<th>Dr R Hammonds</th>
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<td>Dr G Hyde</td>
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<td>Dr J Stewart</td>
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Events


9-12 July 2001. Techniques and Applications of Molecular Biology: a course for medical practitioners. Four day residential course, Warwick University. For further details email: Charlotte.West@warwick.ac.uk

4-7 September 2001. Leeds Course in Clinical Nutrition. For further details email: SARmitage@leeds.ac.uk

13/14 September 2001. 2001 BAPEN Meeting. Royal Free Hospital, London. Further details email: jacarter@ncl.ac.uk


6-11 October 2001. 9th UEGW. Amsterdam.

15-17 November 2001. 10th BAPEN Meeting - Harrogate. Details from: Sovereign Conference, Secure Hold Business Centre, Studley Road, Reddish B98 7LG. Tel: 01527 518777

18 February - 1 March 2002. World Congress of Gastroenterology, Thailand.


18-23 April 2002. DDW. San Francisco.

This is my first newsletter as senior secretary and marks the start of an exciting two years for me. It also marks the end of my two year apprenticeship during which it has been a pleasure to work with Alastair Forbes, who has completed his four year term of office on the BSG Secretariat. Alastair has been a tremendous secretary and I have enjoyed seeing first hand the military precision with which he ran the Society. I would like to thank him personally and on behalf of the BSG for his hard work. Also during the last two years I have had the pleasure of working with two presidents, firstly Lord Turnberg and latterly Prof Tony Axon. Their distinguished experience is punctuated by good humour and I would like to thank them for the enjoyable time I have had. The annual meeting in Glasgow marked the end of Tony Axon’s productive year in office and Prof Derek Jewell was welcomed as the new president. Finally my thanks to Di Tolfree and Chris Romaya who provide continuity and ensure that things run smoothly, and welcome to Jeremy Sanderson who joins me as secretary.

The annual meeting at the SECC in Glasgow was very successful, with 1,850 registered delegates. Last December 618 abstracts were submitted for the meeting and 67% were accepted. Under the direction of Tony Axon, the theme of the meeting was GI cancer. A new introduction to the meeting was the plenary poster session. Ten of the best poster submissions were presented in ‘headline’ form at the plenary session. Snappy 5-minute presentations were made, proving a lively introduction to the plenary morning. Another new feature was the one-day postgraduate course held on the Sunday. This was tried as an alternative to the one-day stand alone education day previously held in the autumn. 700 delegates registered for the postgraduate day suggesting that this was a successful initiative. On the social side, the BSG dinner, which had been waning in popularity over recent years, was replaced by a ‘Scottish style’ reception on the Monday. An opportunity to meet up with friends and colleagues at the end of the day, this proved to be very popular and was well attended.

I am particularly interested in promoting the interests of the specialty associations within the Society, e.g. BASL, AUGIS, ACP and Basic Scientists, so that the BSG may remain multi-disciplinary. Sub-specialisation along with pressure on time available to attend meetings creates competition for attendance at association meetings or those of the BSG. Joint symposia with the associations at the BSG help: for example the BSG Surgical Section, AUGIS and ACP held joint symposia at the Glasgow meeting.

BASL are represented on the College’s Joint Committee on Gastroenterology & Hepatology and AUGIS and ACP are represented on BSG Council. An ideal solution would be to have a Digestive Diseases week where the sub specialty associations would hold their annual meetings in the same week under the umbrella of the BSG. There are a few hurdles to cross such as the associations moving the date of their meetings, and financial ones, but I think we should seize the opportunity of advancing that concept.

The BSG has drawn up a more formal business plan and in it we have studied the relationship of the BSG with the Digestive Disorders Foundation. The DDF has 3 broad remits: fund-raising, supporting research grants and the interface of gastroenterology with the public. Prof John Lennard-Jones has retired as DDF President having expertly steered it for the past 8 years. We would like to thank him for his immense contribution. We welcome Prof Hermon Dowling as the new DDF President and it is clear that he has already got his teeth into many of the salient issues; we look forward to working with him. The outgoing BSG President, Tony Axon dedicated his year towards a cancer theme. He worked closely with the DDF to form a cancer appeal fund for research and has agreed to see the project through to its fruition.

I was hoping that my introductory message would be all upbeat, but the BSG has been discussing its strategy against fraudulent research, particularly concerning the case of Banerjee and publication ethics. Fortunately Dr Banerjee resigned from the BSG but the Society may be faced with the decision of whether or not to continue the membership of a doctor who may be temporarily suspended from the GMC. We are seeking legal advice to formulate a policy. Also on this subject, prior to the Glasgow meeting we received an anonymous complaint about the ethics of one of the abstracts. We are investigating this and I hope to be able to report to you in a future newsletter. However, we are hampered by the anonymity and ask that if members do have a complaint about research ethics this could be done either verbally, or by writing in confidence, but to try to avoid anonymous communications.

Finally, back to an upbeat note. The meeting with the Egyptian Society last year went so well that their president has requested another joint symposium. We have suggested that this might be in 2003. We welcome the Egyptian Society’s initiative, not specifically to formulate a regular fixed connection with that society, but to demonstrate to all international societies that we are open to collaboration. A resource we have is expert faculty and this we can export for the benefit of international relations. Watch this space.
BSG sponsored workshops: closer links with related disciplines

In order to foster closer links between members of the BSG and scientists and clinicians in other related disciplines, the Research Committee has funded two workshops, as outlined in the previous reports. The Society has agreed to support two more workshops in the year 2001/2. Proposals are therefore invited from members of the BSG for up to £8000 to support a workshop in any area relating to the interests of the Society. Proposals should be limited to no more than two sides of A4 and should indicate the aims of the workshop, a preliminary outline of the meeting with a list of participants and an outline budget. Applicants should also note that while the workshops may be closed with limited attendance, there will need to be some agreed output, such as a manuscript submitted to a journal or a report in the BSG Newsletter.

Ten copies of the application should be sent to the chairman of the Research Committee at BSG by 1 June 2000 and a decision will be made by the Research Committee by 1 August. For further information, please contact James Neuberger, Liver Unit, Queen Elizabeth Hospital, Birmingham B15 2TH. Tel: 0121 627 2414 or email at J.M.Neuberger@bham.ac.uk

Clinical information systems in gastroenterology

In 1999 the Clinical Services and Standards Committee set up an Information Working Party to explore and define the needs of gastroenterology with regard to computerised record-keeping. A baseline survey identified a low level of computerisation of records in the specialty. One in three endoscopies are still recorded only on paper, and just one in five gastroenterology departments has any form of computerised clinical system. Free-text comments in the survey indicated that many gastroenterologists wish to introduce a clinical computer system to support their practice (not just in endoscopy) and there is considerable frustration with the difficulties in procuring such a system.

In order to address this problem the Working Party has prepared a specification of requirements, which is now on the ‘members only’ section of the BSG website. The aim of this specification is to define the minimum requirements for the functionality of systems which support gastroenterology. It can be built on at a local level but should ensure a degree of uniformity enabling comparison of data captured across sites in due course. Feedback on the specification would be welcome. Comments should be emailed to bsgfeedback@pgms.wales.nhs.uk

HYPERPLASTIC POLYPOSIS (HPP) Have you seen a case?

HPP is rare, underdiagnosed but possibly associated with a marked increase of colorectal cancer. We have ethical approval to examine the natural history and genetics of HPP and have already collected 27 cases. The World Health Organisation describes HPP as 30 or more hyperplastic polyps (HP) throughout the colon and/or 5 HPs (two ≥ 1cm) proximal to the sigmoid colon. If you know of a case, probably detected at colonoscopy and think that the patient may wish to help with research, please kindly write to me, Dr Wendy Atkin, Imperial Cancer Fund Colorectal Cancer Unit, St Mark’s Hospital, Northwick Park, Harrow, HA1 3UJ.
Minimum standards for endoscopy training

As I enter my second year of office a number of issues are clearly concerning endoscopy section members, not least being the future of endoscopy training in the UK. There is some misunderstanding, which I need to address, about the relationship between the BSG endoscopy section and the Raven dept of education at the Royal College of Surgeons. Firstly, I would remind members that the Endoscopy Committee represents physicians, surgeons and nurses in endoscopy, not just gastroenterologists. As a section our aims are to uphold standards within endoscopy and set new standards that we can all aspire to. Sadly, many clinicians do not belong to a specialist organisation, yet still practice endoscopy to a variable standard without access to CME or peer review. Training is also of a variable standard and we need to ask ourselves whether this state of affairs is acceptable in the 21st century.

As a result of extensive consultations between the Royal Colleges, a Joint Advisory Group (JAG) was set up to establish minimum standards for training, this being first published in 1999. These have been refined over the last year and publication of new guidelines is now imminent. JAG represents all the different professional interests associated with endoscopy, initially the minimum standards laid down by this group were criticised because of over-reliance on numbers of endoscopies performed to achieve competency. Whilst experience is important, actual training is even more important and it is this issue which is now being addressed. Endoscopy training to date has been unregulated, haphazard and of variable quality. This cannot be allowed to continue but JAG does not have the resources to devise and implement endoscopy training courses. This task was given by JAG to the Raven department of education under the guidance of Roger Leicester. The aim is to produce training courses for all areas of endoscopy including upper, therapeutic and lower GI and ERCP which can then be implemented by endoscopy centres with the facilities, personnel and training record which will ensure high quality training for any professional wishing to learn endoscopy.

The first course to be developed and approved by JAG is in colonoscopy. Those who attended the BSG in Glasgow will know from the national audit of colonoscopy that this is clearly an area of major concern in relation to the expertise of some endoscopists, which itself reflects poor training. Colonoscopy is a key investigation in the diagnosis of lower gastrointestinal malignancy and the audit results highlight the need for better training without which the NHS Cancer Plan published last year cannot be implemented. The government has earmarked £2.5m over the next three years to improve and increase training in accordance with the NHS Cancer Plan. Herein lies the problem. In order to get things off the ground, centres already running training courses have been asked to submit bids for this limited amount of money based on the premise that these centres would evolve into full time training courses. This does not mean that only those centres will be able to run courses. Many more training centres will be required for the new courses on basic upper GI endoscopy, ERCP etc. So long as JAG approves the course any unit can offer training courses for aspiring endoscopists, which will be self-funding. Members have expressed a view that this is an unfair way of distributing money and as in so many things this money would achieve nothing if spread thinly across the country. In my view this must be seen as a pump priming exercise and endoscopy units that wish to set up as training centres should now start to think about what courses they might run and submit these to JAG for approval. Any units in the vanguard of endoscopy training (starting with colonoscopy) will be able to help other units wishing to go down the same road. It is quite clear that we cannot go on as at present.

The endoscopy skills training courses are an essential requirement to improving and extending endoscopy training in this country. We should all be welcoming this initiative which will be good for gastroenterology and good for patients. The NHS Cancer Plan will not be achieved without it.

BSG Meeting: March 2002
ABSTRACT DEADLINE: 6 November 2001

By Mike Bramble, vice president, endoscopy section

(R) Dr Gerry Crean, President of the Scottish Fiddle Orchestra. The Orchestra treated all members present to a superb short concert of Scottish fiddle music at the reception.

(L) ‘Gut Line’ received 63 calls on the first day of the annual meeting. Ray Playford, Alastair Forbes and Duncan Loft.

Highlights from Glasgow

From the national audit of colonoscopy that this is clearly an area of major concern in relation to the expertise of some endoscopists, which itself reflects poor training. Colonoscopy is a key investigation in the diagnosis of lower gastrointestinal malignancy and the audit results highlight the need for better training without which the NHS Cancer Plan published last year cannot be implemented. The government has earmarked £2.5m over the next three years to improve and increase training in accordance with the NHS Cancer Plan. Herein lies the problem. In order to get things off the ground, centres already running training courses have been asked to submit bids for this limited amount of money based on the premise that these centres would evolve into full time training courses. This does not mean that only those centres will be able to run courses. Many more training centres will be required for the new courses on basic upper GI endoscopy, ERCP etc. So long as JAG approves the course any unit can offer training courses for aspiring endoscopists, which will be self-funding. Members have expressed a view that this is an unfair way of distributing money and as in so many things this money would achieve nothing if spread thinly across the country. In my view this must be seen as a pump priming exercise and endoscopy units that wish to set up as training centres should now start to think about what courses they might run and submit these to JAG for approval. Any units in the vanguard of endoscopy training (starting with colonoscopy) will be able to help other units wishing to go down the same road. It is quite clear that we cannot go on as at present.

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President’s column

Developing the research capacity of the BSG

Like all good events, the annual meeting of the Society seems to have faded into the past despite the months of preparation. One wonders what is occupying those parts of our brains which were so busily focused on Glasgow 2001! I hope you all enjoyed the meeting. The conference centre works well, the weather was extraordinarily kind to us and there was no lack of education for us all. Perhaps the most striking event was the postgraduate day, not only because over 700 registered for it but because it was on a Sunday. The programme was excellent and it looks as if this will become an established feature over the next few years - at least, until a new generation with new ideas takes over. However, it has made me think about our purpose as a Society.

We really have three major roles, namely: CPD, training and communication of original research, though not necessarily in that order. Our input into training is perhaps the least obvious but has been vitally important in the years following implementation of Calman. Our 3 representatives over the last year on the SAC in Gastroenterology have been John Gibson, Kel Palmer and Michael Hellier (also its chairman). They, and their predecessors, have put a vast amount of time and energy into organising curricula and training programmes for which we are very grateful. It is also good to have such active participation from the trainees - TiGs continues to flourish and has a particularly good meeting in Glasgow. Dr Hellier has now finished his term on the SAC and I feel honoured to have been nominated to take his place. There are many problems with our current training system because of its inflexibility and the fact that protocol hidebound in legislation is more interested in manufacturing a 'standard product' than intelligent, inquiring and motivated individuals. The Royal College is promising to develop a more flexible programme and, at the same time, is in discussion with the Academy of Medical Sciences about academic training. In the meantime, I have been alarmed at an increasingly large cohort of young gastroenterologists who are applying for consultant posts with minimal exposure to research training. It is very hard to reconcile evidence-based practice as a consultant with a training programme which does not necessarily include an opportunity to formulate hypotheses, develop means to test them and to assess the data in relation to a critical reading of the literature (and not just the Medline summary!)

I am not alone in leaving Glasgow with the feeling that I had heard very few free papers. Over the years, we have worked hard on the poster sessions with considerable success, especially as both Glasgow and Birmingham offer the space for good interaction between author and audience. Nevertheless, the oral presentation seems to have been almost devalued, not only by the limited number of sessions, but by the reduction from 15 minutes to 10 minutes. Next year we hope to return to 15 minute presentations but of course it will give the programme committee a major headache to increase the number of oral communications as well as increase their time. Nevertheless, scientific presentation and discussion is as important as education and is particularly important to keep an active basic science group, vital to our academic units but almost on the endangered list.

Should BSG have a fourth role, namely in research? Clearly we should, despite the recent demise of the research unit, but we need to define how that is best done. It is not appropriate for BSG to be seen to provide research monies from its profits to its own members. Thus, I am delighted that the ABM approved Council’s decision to provide an annual sum of £100,000 to the Digestive Diseases Foundation over the next five years. This is in addition to that already promised to the Digestive Cancer Campaign. We should see DDF as the research arm of the BSG, alongside but at least equal to the DDF’s role in public education and awareness. There is active dialogue between both organisations at present which promises to extend research activity into exciting new areas provided new funding initiatives can be developed. It would be good if, between us, we could develop funding for joint projects whether in the form of epidemiological studies, registries or clinical trials.

Finally, you will all know that our Society was founded by Sir Arthur Hurst in 1937 but very few will know that this year marks the centenary of his graduation from Magdalen College, Oxford. I hastily acknowledge Mr James Thompson for this piece of information but I feel particularly proud that the presidency is held in Oxford for this particular year and am highly honoured to succeed Professor L.J. Witts (1954) and Dr Sidney Truelove (1974), the two previous Oxford Presidents.