‘What are you going to do as the BSG president?’

I’m pretty sure that all new presidents get asked this by numerous colleagues, and I do wonder what they have said in reply. If they were anything like me, probably not a lot. But there is one thing that does concern me, I suppose, and that is the quality of our research in gastroenterology, the prevailing attitude towards medical research generally in this country, its prosecution and funding, the problems we continue to face in the assessment of our research and the increasing disincentives to actually doing research. There are burgeoning research governance issues in the National Health Service, difficulties or in some cases inability to access human tissues and medical records for research purposes, dysfunctional LRECs, and the prolonged, iterative process needed to get even minor changes to your Home Office animal project licence. And this list does not even mention the problems in getting funded in the first place.

There has been discussion about the role of the BSG in public affairs, and I know that there is some concern about this. Members will shortly be asked for their opinions about this, but I want to make a point — lobbying does work and some instances can introduce radical change. I would like to express the view that the BSG should, indeed must, in addition to its other proposed activities in the public sphere, get involved in the debate over matters affecting research, especially as it relates to gastrointestinal clinical and basic science.

Firstly, are my concerns legitimate?

In my view, yes. Bob Allan, in his presidential year, made the perceptive comment that the BSG exists mainly to produce good meetings. Notwithstanding the Society’s increasing awareness of the role it wants to play in training and in improving clinical services, I think his premise this is probably true. We meet for educational purposes and to present the results of our research to our peers. Ipso facto, research should be very high on our agenda.

It does not take a rocket scientist to notice that the number of abstracts we receive is falling. While this could be ascribed to Calmanisation and its sequela, a number of senior members of the Society have grumbled to me about a major reduction in the standards for acceptance. Are they right, or merely old farts bemoaning a golden age which really did not exist? My personal feeling is that while we can, and indeed do, produce gastrointestinal research of the highest international standards, the amount of this is falling, and, possibly more worrisome, I can see people becoming worn down, and very disillusioned, by the problems they face in combining busy consultant positions with clinical research, or in running a research group as a clinical academic and managing protected time with clinical duties and teaching as an additional pressure. This says nothing about the declining funding basis of the MRC – or even the Wellcome’s declining ability to fund research in the current financial climate.

Neither does the outcome of the last Research Assessment Exercise or the White Paper on Higher Education proffer any comfort for gastroenterology. The inevitable concentration of QR funding in a reducing.

continued on page 5

ADVANCED NOTICE
Abstract deadline for 2004 meeting
5 November 2003
Good home wanted

Professor Lennard-Jones would like to find a home for his back issues of Gut (1937-date) and Gastroenterology (1987-2000). If you know of anyone who would like them please telephone him on 01394 387 717.

Advertising Awards


European Society of Gastrointestinal Endoscopy (ESGE)

Grants are being offered by ESGE to fully trained endoscopists who wish to undertake further training in highly specialised endoscopic techniques at an officially recognised ESGE training centre during 2004. Each grant is for 8 weeks and successful applicants will be asked to report concerning the quality of their training period.

The grants (applicants must be under the age of 40 on 1 January 2004) will cover: economy travel, basic hospital/university accommodation; a weekly allowance of 125 Euros and insurance where applicable.

Application forms may be obtained from the BSG Secretariat or direct from the ESGE.Tel: +49 89 4141 9241, fax: +49 89 4141 9245, email: esge@medc.de.

Closing date for applications: 1 July 2003.

Appointments

Dr I Beveridge  West Middlesex Hospital
Dr U Dave  Morriston Hospital, Swansea
Dr JV Roche  Macclesfield District General Hospital

Poster ‘Sin Bin’

The following three Posters were not displayed at the recent meeting:

132 Molecular profiles of pancreatic adenocarcinoma (Crnogorac-Jurcevic and Lemoine)
193 Specific serum antibodies are involved in h.pylori-induced platelet aggregation (Corcoran, Kerrigan, Cox, Atherton, Fitzgerald, Murray and Byrne)
280 A method of accurately siting oesophageal prosthesis without radiology (Kooner, Aljabari, Besherdas and van Someren)

The following Posters were put up unacceptably late:

188 Effect of sulindac sulphide on mitochondrial oxygen consumption and membrane potential (Garle, Middleton and Hawley)
344 L-erythro methoaxine is more potent at inducing porcine internal anal sphincter contraction in vitro … (Jones, Thompson, Brding and Mortensen)
387 Glycosylation pattern of AGP could indicate progression from hepatitis to cirrhosis (Anderson, Hayes, Therapondos, Goyter and Smith)

Events

Details: Dr C Moonan.
Tel: 024 7652 3540, fax: 024 7652 3701, email: Charlotte.Moonan@warwick.ac.uk

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

3-5 September 2003. UCL Hepatology – An Evidence Based Approach (course for SpRs). Details: Natalie Day. Tel: 020 7679 6510, fax: 020 7380 0405, email: n.day@ucl.ac.uk

8-12 September 2003. Nottingham. Details: Prof I Macdonald. Tel: 0115 970 9465, email: ichn@nottingham.ac.uk

12-13 September 2003. Immunological Diseases of Liver and Gut (Falk Foundation Symposium), Prague. Details: Falk Foundation. Email symposia@falkfoundation.de


4-5 October 2003. International Workshop on GI Motility and Functional Disorders, Hong Kong. Details: Dr J Wu, Endoscopy Centre, Prince of Wales Hospital, Shatin, Hong Kong. Tel: (852) 2632 2233, fax: (852) 2635 0075.

14 October 2003. Advances in Therapeutics in Liver Disease, Royal College of Physicians, London. Details: tel: 020 7935 1174 ext 300/436/252, email: conferences@rcplondon.ac.uk

15-22 October 2003. XII Falk Liver Week, Freiburg. Details: Falk Foundation. Email: symposia@falkfoundation.de
If you don't put your finger in... the importance of PR

First of all, a warm thank you to Duncan (Loft) who, mainly unseen, steered the Society masterfully (and humourously) during his 4 years as honorary secretary. Other than providing those important words of advice and direction to the president (‘Yes-Minister style’) I suspect most members of the Society wonder what the honorary secretaries do. Quite a lot is the answer, but mainly organise the programme for the annual meeting. And any of you who have organised meetings, local or national, will know what a headache this can be, not only getting section chairman into the same room at the same time but getting them to make a decision too. But there is a knack which Duncan displayed admirably and I shall attempt to follow in his footsteps.

The recent annual meeting seemed to be successful once more. We would welcome feedback on the content and style of the meeting. Birmingham is a generally excellent venue. We are continuing a policy of going to Glasgow one in three years as this is financially advantageous as well as providing different scenery and accessibility. Various issues arise as to the content of the meeting. One chestnut is the relative merit of oral and poster presentations. At the 2002 annual meeting, there was a feeling that the standing of an oral presentation had been somewhat diminished as a result of trying to prevent posters being viewed as inferior. However, the majority view seems to be that an oral presentation should be superior and an honour to attain. Hence at the next meeting, whilst submissions can be marked ‘poster only’, we will select the top scoring abstracts for oral presentation.

On a grander scale, various members have raised the issue of a British DDW which would include a number of other related society meetings, (e.g. surgical, hepatological, endoscopic) under one roof similar to the American DDW. Most seem to agree this is something worth aiming for. However, mountains may have to be moved and, as a result, we are setting up a group of strong-willed individuals to work on this issue.

Many of you will have read the last newsletter where Professor Allan raised the question of public relations. This has stirred up quite a lot of opinion (at last!) as to the relative merits of the society increasing its profile with the public and with government. To many, the most important aim of this exercise would be to give the BSG a stronger voice with government such that key issues, e.g. manpower, screening and endoscopy services, are given the attention they so desperately need. To others, in tandem with the DDF, raising awareness of GI disease with a view to fundraising for research is the priority. We have enlisted the support of a public relations company, Munro and Forster, to undertake a review of the Society’s needs and priorities in terms of PR. As part of this, all members will have received a questionnaire asking you to list what you feel are the priorities in terms of public policy and awareness of differing disease areas. I hope as many of you as possible will complete this and send it back to us as it will greatly help shape our approach to this issue.

Over the last 2 years, I have witnessed numerous examples of important issues in which the opinion of the BSG has not been sought simply for lack of awareness and, inevitably, members lose out. Like it or not, along with PR comes some gloss and hype. However, as with the other PR, if you don’t put your finger in......

New President’s Chain of Office

The President and Council have commissioned a new Presidential Chain of Office. It was made by Thomas Fattorini Ltd., Regent Street, Birmingham.
number of centres will not do a lot for us. While Oxbridge, Imperial and University College might say that we are the centres who are competing internationally, this is certainly not so in many fields of gastroenterology. Of course there are competitive groups in these places; but if we particularise, and look at say *Helicobacter pylori* research, it is Nottingham, *inter alia*, who now leads the UK effort, as anyone who heard John Atherton’s State of the Art Lecture at the Birmingham meeting will probably agree, and not members of the so called Golden Triangle. And how did they fare in the last RAE? They were part of a Unit of Assessment that scored 4, albeit starred. 4’s are not being fully-funded, the clinical medicine Unit of Resource has been reduced (without consultation), charitable funding does not attract the same overhead, and thus Nottingham has lost money for research – and stumping does not bring any additional funds. There are many internationally-competitive UK groups in the same position – the Liverpool Department comes immediately to mind, and many more. Unless we can establish a new strategy for the next RAE, we could be in queer street.

**What are we then to do?**

Members will know that a review of the RAE is being carried out by Sir Gareth Roberts, and will go out to consultation shortly after this goes to press. I think the Society should respond in this consultation process and make some of the above points. There is no doubt that in any future RAE the concept of consortia and the establishment of ‘Centres of Excellence’ within and also between Higher Education Institutes and NHS Trusts will be mandatory, and our Society, through its Research committee, could inform and assist this process.

While we have been bemoaning the problems of access to fresh and archived human tissues – on which an ever increasing number of us depend for our research and for any contribution we are going to make to the so called ‘post-genomic era’, the Retained Organs Commission has been quietly issuing one consultation paper after another, and are quite possibly in the process of setting up a Human Tissue Authority which will govern all our activities in this area. Our Society, insofar as I know, has not participated in this consultation, despite its enormous stake in the outcome. Hard cases, such as Alder Hey, make bad law, and make no mistake, new legislation is coming, probably next year. I have, through the Pathological Society and the Academy of Medical Sciences, made robust responses to each of these consultation papers, and am somewhat more hopeful than I was. But if you want ethical but ready access to human tissues for your research, and do not want to ricochet around the Midlands – or anywhere else for that matter, tracking down patients or patients’ relatives to get permission to take a few sections off their Barrett’s biopsies, your Society had better get involved in this debate, and fast.

I don’t know if you have read the enormous DoH paper on Research Governance, but I have, and where it can be understood by mere mortals, it makes uncomfortable reading. By April 2004 now, all Trusts or HEIs which do clinical research under the NHS banner must be a sponsor, and the increase in administrative infrastructure needed to underpin this bureaucracy is considerable. Again, I think the Society should have a view, and help begin the process of introducing some realism and sense into this new tier of research administration. The new arrangements for LRECs will also be a challenge, and we should help monitor this process closely.

Having recently spent an hour being grilled by our own local animal ethics committee over relatively minor changes in our project licence, I sympathise with anyone who has to cope with the again proliferating bureaucracy surrounding this process. The Society should consider adding its weight to the mounting pressure to streamline these procedures. On the bright side, from a Party whose draft manifesto in the Kinnock election included the abolition of all work on transgenic and knockout animals (removed by successful lobbying, mainly by the Research for Health Charities Group), and whose 1997 manifesto promised a Royal Commission on Animal Experimentation, our Government has come a long way. There is no doubt that pressure from the scientific community promoted these changes. Your president was one of 100 individuals who signed an open letter to Lord Sainsbury complaining about the enormous bureaucracy which surrounds animal experimentation. While this has led to further dialogue, there is a long way to go in making change here, and I think the Society does have a locus in this process.

I am sure that we all noted, with some pleasure and relief, the passing of the Bill enabling research towards human therapeutic cloning in the UK. Now I see, only this week, that the European Parliament is discussing legislation which will try to stop this in member states. We cannot expect much support from the renewed special relationship across the Atlantic on this one, and, as a scientific society we should, in my opinion, also have a collective view – on the supportive side I would hope – on this issue.

There is also something we can do about the funding of gastrointestinal research. As citizens, and as a society we can lobby for an increase in the science vote, and as
There was much at the BSG meeting in Birmingham to excite the enthusiastic endoscopist. Free paper sessions revealed new data about the morphology, diagnosis and behaviour of colonic polyps, experts in endoscopic ultrasound showed exciting material about diagnosis and EUS-guided therapy, educationalists informed us of innovations in training and appraisal. Some of the discussion at these sessions was relatively animated; it was particularly lively following a paper reporting patient views of the consenting procedure. Such discussion is particularly helpful since it often sows the seeds for projects undertaken by the section. The poster round was resurrected after some years of dormancy – I thought this a success since it concentrated the minds of the poster presenters, but I would like views supporting or disagreeing with this impression. The three symposia (one from our American colleagues) were superb state of the art affairs and the contributors deserve our thanks. A feature of next years endoscopy contributions in Glasgow will be the Hopkins prize presentation; applications for this prestigious award which are an acknowledgement of important contributions to endoscopy made by members of the society and their teams, will be sought via Gut later in the year and I urge all of you who have contributed to the science or development of the subspecialty to apply.

It is pleasing to report that JAG have received support from the society to develop training courses in ERCP and in therapeutic endoscopy. Those in basic endoscopy skills and colonoscopy are proving very popular and are currently oversubscribed. There is clearly an increasing awareness of training needs and deficiencies in the UK and this has been highlighted by the disappointing results of the colonoscopy audit reported at presentations in previous BSG meetings. There is an impression that the Department of Health will push for National colon cancer screening in the near future and this will undoubtedly increase pressure on endoscopy services and training units led by JAG. The JAG are also taking on a role – in conjunction with the SAC in gastroenterology – of inspecting endoscopy units in order to confirm that they comply with minimum standards in terms of facilities, equipment, health and safety and overall performance of endoscopy. This is clearly a tall order and will require devolution to groups of experts who will act on behalf of the group. Clearly the joint advisory group are under considerable pressure and their funding needs must be addressed if they are to develop their role in these ways.

A series of working parties are currently updating old guidelines and producing new ones. The disinfection and cleaning of endoscope report is at an advanced stage of preparation, a sedation update is in the hands of the audit committee, the ‘nurse endoscopist’ project has been renamed to take account of the fact that now and in the future endoscopy will almost certainly be done by a range of paramedical personnel in addition to doctors. A guideline for managing common bile duct calculi has been commissioned in conjunction with the surgical endoscopy society. We hope that these guidelines are of use to units and endoscopists but they can consume much time and effort for the authors. We are conscious that other groups have produced excellent guideline documents and we do not need to re-invent expensive wheels; thus in response to a request for guidance in undertaking endoscopy in anticoagulated patients we have pointed out that the ASGE have published excellent recommendations.

To conclude I would like to thank Ian Barrison who has completed a prolonged spell as secretary to three endoscopy vice-presidents and is moving to become vice-chairman of the Clinical Service committee. Ian has worked immensely hard for the section and John Morris, who is replacing him has an extremely hard act to follow!
Just how good is our research? continued from page 5

members of the BSG we can support the fundraising activities of the DDF. The DDF, through its Fellowship scheme, has started a considerable number of young people on their research careers, and recently, through the Digestive Cancer Initiative, launched by Tony Axon, is pump-priming the research of four centres in the UK. Fundraising is hard work, and we all have limited time, but Hermon Dowling and the DDF really do warrant our support. So, if you have access to wealthy potential donors, and know the right buttons to push, I am sure that Hermon would love to hear from you.

While on the subject of Fellowships, about 18 months ago senior Government figures became concerned at the rate at which SpRs were progressing through the system to consultant positions, and were told that a major reason for this was the number of SpRs taking time out to do research. Postgraduate deans were told that only individuals with MRC or Wellcome Awards should be allowed to take such time out. Amongst many others, the DDF Fellowship scheme would have been a casualty. Pressure, this time mainly from the Committee of Heads of Medical Schools, stopped this alarming proposal in its tracks. I hope I have convinced you, to some extent that lobbying works.

Finally, there is our journal Gut. Under Mike Farthing’s leadership, it has hunted down most other gastroenterology journals and with its improving Impact Factor it became the flagship of BMA publications and now ambitiously has its sights set on Gastroenterology. It needs our support, so if you have something good and hot, do think about Gut first. Publishing elsewhere might increase your aggregate score in the RAE, but it will not improve our journal’s standing.

So, what are my plans? I suppose to engage the Society in a discussion about our research, the problems we face in doing it, and taking a wider and more prominent role in solving these problems. I should also like to ensure that we evolve mechanisms of vigilance and pre-emptively initiating change as further problems emerge, as of course they will. That’s probably enough.

I’ll be back.

Since the last DDF column, the Charity has made several new research awards, and modified its existing policy (slightly) on research funding.

Thus, the first two year Dame Sheila Sherlock Memorial Fellow (funded jointly by the British Liver Trust and the DDF) is Dr Andrew Holt from Birmingham who will work with Professor David Adams on hepatic stellate cells and immunity. A two year Amelie Waring Fellowship went to Mr Damian Mole whose work in Belfast on portal endotoxaemia in pancreatitis is supervised by Professor Charles Campbell.

On this occasion, none of the applications for the Nutrition Research Foundation Fellowship was considered suitable but the post will be re-advertised in six months time. Despite this, the DDF currently supports no less than 15 full-time Research Fellows!

The Belmont Trust grant, for research into ulcerative colitis, was divided between Drs Dermot McGovern (Oxford) and Thomas Creed (Bristol), while the DDF Research Prize was awarded to Dr Tatjana Crnogorac-Jurcevic for her work on pancreatic cancer, with Professor Nick Lemoine. Given the current economic climate, the DDF feels that it cannot support Fellows for three year periods: its priority should be to support young people at the start of their careers, with ‘entry level’ Fellowships. In the immediate future, therefore, most Fellowships will be for two years maximum although occasionally, awards will be made for one year only ’in the first instance’.

In the 2003 autumn competition, we anticipate awarding two two-year and one one-year Fellowships – one BSG, one Nutrition Research Foundation (see above) and one AP&T Trust Fellow. Once again the DDF is most grateful to the BSG for its continued support of GI research.

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Digestive Disorders Foundation
The Charity for Research and Information on All Digestive Disorders

British Society of Gastroenterology NEWS
Published by the BSG, 3 St Andrews Place, Regents Park, London NW1 4LB. Tel: 020 7387 3534; fax: 020 7487 3734; email: BSG@mailbox.ulcc.ac.uk. Editor: Jeremy Sanderson. Assistant editor: Di Tolfree. Editorial services: Chamberlain Dunn Associates. Advertisements: BMJ.
The British Society of Gastroenterology is grateful for the financial support from Wyeth Laboratories in the production of this newsletter.