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news

BRITISH SOCIETY OF GASTROENTEROLOGY

Message from the President

Ian Forgacs, President

It is a truth universally acknowledged that, for many years, the BSG has produced more accurate and comprehensive data on workforce than any other specialty. Chris Romaya, in our office, has collaborated with a series of committed BSG workforce leads to produce data of unquestioned reliability. It is no accident that the past four directors of the RCP Medical Workforce Unit have been gastroenterologists. Data that good have many purposes but their most important use has been to guide us in planning the number of gastroenterology trainees that should be entering the training programme each year. To make such forward projections is far from easy, but to have the wealth of reliable information to hand, such as the number of projected retirements, historical growth and those who choose to work part time, all helps to make estimates as reliable as possible. It takes on average some 7 years to train a gastroenterologist (allowing for periods out of programme). So, if you wished to decide how many trainees should enter the training programme this year, you would effectively have to have made a decision about how many gastroenterologists the UK will need in 2022. Our specialty has been growing far more rapidly than any other major specialty, but there are many foreseeable, and maybe just as many not so foreseeable, influences that could affect the demand for specialists at any future point.

The BSG, together with the College, have consistently advised the Centre for Workforce Intelligence (whose name often brings a wry smile when mentioned in certain circles) against cutting training numbers in gastroenterology. Our advice has turned out to be spot on. Harriet Gordon (ex-BSG workforce supremo and the latest to lead the RCP unit) has just published the results of the 2013–2014 census of consultant physicians in England, Wales and Northern Ireland (https://www.rcplondon.ac.uk/sites/default/files/2013-14_rcp_census_exec_summary.pdf). In that period, there was an expansion of consultant posts in gastroenterology and hepatology that far exceeded the growth of any comparable specialty, and even surpassed the number of new posts in acute medicine. Growth in cardiology and neurology was more modest, in respiratory and renal medicine was negligible, and consultant numbers in rheumatology, haematology and endocrinology/diabetes have actually contracted. There were, however, a substantial number of unfilled consultant posts, although fewer in gastroenterology than in many comparable specialties and far less than in geriatrics. As many as a quarter of advertised posts were cancelled or no appointment was made. There is wide regional disparity. As the census of higher trainees reveals, they rate location above all other criteria in deciding whether to apply for a particular consultant post. This means that regions with lower numbers of trainees face relatively greater difficulty in recruiting successfully to consultant vacancies. This has led to a very serious issue of understaffing at consultant level in specific regions of which the BSG is well aware, yet it is uncertain whether to initiate a drive to relocate training posts, which would have to be on a substantial scale to address the imbalance and would also take several years to come into effect. I would be pleased to hear ideas and opinions on this (**president@bsg.org.uk**).

This newsletter began with a paraphrase of the most celebrated opening sentence of a novel in English literature, so I am now going to compound that offence by 'bending' the second most well known opening: It is the best of times, it is the worst of times. Trainees enjoy their time in training and most enjoy it very much. We know this from the latest of an excellent series of training surveys conducted among their members by the BSG Trainees Section, a summary of which is published in *Clinical Medicine*. The paper by Neale and Basford (http://www.clinmed.rcpjournal.org/content/current) should be compulsory reading for all trainers and trainees, and indeed those who work with trainees. We have long been aware that demands on training time from general internal medicine (GIM) undermine training opportunities in our specialty, but it is very good to see current data. Almost all trainees seek dual accreditation, yet while most are satisfied with the gastroenterology component, only just over 40% feel satisfied with their GIM training.

The period spent in training should to be among the best of times in a doctor's career so it is not great to read of the negative experience of our trainees in GIM, but the worst of times could lie ahead—and not just for trainees. Were the (reasonable) proposal in the 'Shape of Training' document to include additional generic skills to be implemented, together with the (unreasonable) proposal to shorten higher training by 1 year, this would have a devastating effect on our ability to produce well trained gastroenterologists. Our trainees have expressed their opposition to any reduction through the BMA; the BSG has made its view very clear to Health Education England

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and we are pleased to see the medical royal colleges have finally begun to take a robust stance against any move to shorten training. I have not seen such strength of opposition to a training issue since the MMC fiasco.

The 'Be clear on cancer' campaign to promote earlier diagnosis of upper GI cancer has recently finished, so it is not clear what effect this has had either in achieving its primary aim, nor indeed is it yet evident what the full effect has been on endoscopy units that are constantly under pressure to minimise waiting times. The BSG strongly supports evidence based interventions that will either prevent cancer or aid its early detection. We are establishing links with parliamentarians, public health bodies, charities and the media, with the aim of making the public more aware of GI cancer as an issue, and particularly what measures individuals can take to reduce the likelihood of cancer developing, not only by promoting lifestyle measures and symptom awareness, but also encouraging participation in screening. BSG members are centrally involved in making the initial cancer diagnosis, and we have a key role as an organisation in committing ourselves to doing that as early as possible so as to reduce mortality.

We expect to be working closely in this area with one particular individual who has just left the BSG to take up the role as Director of Service Innovation in Beating Bowel Cancer. Tom Smith was the first and indeed the only chief executive the BSG has ever had. Over the past 7 years, he has led the transformation of the Society, and more than any individual has made it the effective force it is over so many areas of activity. He has accepted the invitation to be our guest at the DDF meeting (22–25 June), and the Society looks forward to thanking him formally at the meeting. The annual meeting will also give the many members of BSG who would like to thank him the opportunity to do so, and to wish him well. All the best, Tom

Farewell message from Tom Smith

By the time you read this I will have moved on from the BSG. I have loved my 8 years with the Society, and have learned so much. I am very grateful to the BSG for giving me the opportunity to become its first chief executive, showing a lot of faith in appointing me, aged 36 years. I think we came together at the right time. I wanted to promote service development and improvement. The BSG wanted me to help the Society grow in influence, stature and numbers, and I think we have achieved on all fronts.

The Society is a key voice in national discussions, and in recent years we have worked with partners to improve the NHS in relation to cancer detection, therapeutic endoscopy, IBD standards and focusing minds on improving liver services. We have helped make GI bleeding and alcohol treatment important national issues.

The development of the DDF as well as Endolive, the UK's first live endoscopy meeting, are excellent educational developments. The creation of *Frontline Gastroenterology* is another. And well done to *Frontline Gastroenterology* on their Twitter debate innovation. I am sure that the BSG's educational activity will become even stronger.

It has been really pleasing to see *Gut* soar as well as the development of a BSG clinical research strategy and the blossoming of Clinical Research Groups. The closer working between the BSG and Core has made both organisations stronger.

The BSG is at the vanguard of training and workforce development issues. I cannot claim any credit for that, and credit is due to a number of talented individuals who have built such strong foundations. It has been a pleasure to see the Trainee Section come to life and become the beating heart of the Society. The development of the Taster Course is a superb innovation.

GastroCycle is possibly my favourite memory of the BSG and Core, and the Trainee Section drove it forward, particularly Phil Smith. It was a joint initiative in more ways than one. The Trainee Section did an incredible job of creating such a valuable experience both for participants and recipients, those that will benefit from the research funded at Core. I will be riding again this year and hope you all join me in Cambridge or Braintree (mid-way and the start of the shorter ride). I will be at DDF and am looking forward to it. You might still see me from time to time.

I am staying within the GI family. Working with you all at both BSG and Core has given me a passion for the area. I am joining Beating Bowel Cancer, where I will fill a new role, Director of Service Innovation. The role gives me the opportunity to focus fully on ideas around policy and service development, areas which are my passion.

I want to thank many people. If I try to name all the people that have been wonderful to work with this would be a supplement rather than a newsletter piece. You have been more than colleagues, and I thank you for all the big and small ways in which you have touched me. Thank you to the current president and executive, to past presidents, council members, trustees, section members, friendly faces in a meeting, a conference bar or email correspondent—thank you all. You know who you are.

Thank you all for giving me the opportunity for a genuinely wonderful experience. I am staying in the family and look forward to meeting you again soon. I will be just the same, just wearing a different hat.

Tom Smith

BSG vacancies

Vice President, Endoscopy

The Vice President, Endoscopy, is a senior role in the Society, with a seat on key committees, such as council, executive and the strategy group. The role also encompasses chairing BSG Endoscopy and providing leadership to the Society's largest section, including reviewing guidelines and representing endoscopy at senior external meetings. It is a busy role, and it is envisaged that the role will take up approximately 15–18 hours a month, on average. The post is for 2 years. For more information or a job description, please contact Tom Smith (t.smith@bsg.org.uk). To apply, please email Tom with a short CV and a cover letter by **Friday 24 April 2015.** Interviews will be held during the first week of June, and the successful candidate will take up the role following the DDF meeting later that month.

Chair, BSG Research Committee

Professor John McLaughlin will step down as Chair of the Research Committee following the DDF meeting in June 2015, and we are seeking a replacement. The role will involve advising council on strategic directions in research, and liaising with Core and other grant giving organisations to promote the encouragement of research activity by members of the Society. This is a senior role in the Society, and the postholder will be a member of the executive, council and the strategy group. Further details are available from Julie Solomon (j.solomon@bsg.org.uk) to whom applications should be sent by **Friday 24 April 2015**. Interviews will be held during the first week of June, and the successful candidate will take up the role following the DDF meeting later that month.

BSG Secretary

The role of BSG Secretary is a long established role in the Society, and has been held by a number of illustrious individuals. It is an important role in the Society, with the postholder sitting on the executive, council and strategy group. Over time the role has changed and now involves less administrative duties on behalf of the Society. The role now entails more involvement with the Annual Meeting and the DDF meetings, when held. The major responsibility is held by the Senior Secretary into which post the Secretary would move after 2 years to

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serve a second 2 year term, meaning a 4 year commitment in total. In the first 2 years, the Secretary will support and work closely with the Senior Secretary. The BSG is supported by an excellent professional conference organiser with whom the postholder will work closely. The secretary will work closely with the incoming Senior Secretary, Jayne Eaden Edwards. The Secretary role is for 2 years, and the postholder will then become Senior Secretary for a further 2 years. For more information, a job description or to apply, please contact Tom Smith (t.smith@bsg.org.uk) by **Friday 24 April 2015** with a short CV and cover letter. Interviews will be held during the first week of June, and the successful candidate will take up the role following the DDF meeting later that month.

Endoscopy matters

BSG guidelines are among the most well respected in the world, and are now particularly rigorous to meet the standards required by NICE. Producing and revising guidelines involves a considerable amount of work, but is rewarding in itself and leads to highly cited publications. These guidelines have, in many instances, led the way internationally, and have influenced subsequent guidelines from our European and American colleagues. In recent years, BSG members have been increasingly involved in the production of the European Society of Gastrointestinal Endoscopy (ESGE) guidelines, and this opportunity was afforded to myself 4 years ago as an author on the 'ESGE endoscopy and antiplatelet agents guideline'. Both this guideline and the 2008 'BSG guidelines for the management of anticoagulant and antiplatelet therapy in patients undergoing endoscopic procedures' are due for revision, and I have been asked by ESGE to produce a joint BSG Endoscopy/ESGE guideline on this topic, including guidance on the new oral anticoagulants which pose a new challenge for endoscopists. Critically, this guideline will be produced to BSG standards, published in *Gut* and reproduced in Endoscopy. This is the first formal collaboration of its kind for BSG Endoscopy, and may set a precedent for future ventures, although we must be wary not to lose the identity of BSG guidelines.

The necessary work involved in revising guidelines to the current rigorous standards may be contributory to the fact that many BSG guidelines are overdue for revision. We are working hard to redress this in the Endoscopy Committee, and several former guidelines are undergoing revision, as well as the production of new guidelines. An excellent new guideline on the management of non-pedunculated colorectal polyps has been produced under the leadership of Matt Rutter and has been submitted to *Gut* for external review. One particularly important and relevant guideline, at an advanced draft stage, is 'Guidance for obtaining valid consent for gastrointestinal endoscopy procedures'. This is a revision of the 2008 BSG guideline, but is essentially an extensive rewrite from scratch to encompass recent legislation. A multidisciplinary authorship is being led by Simon Everett, and formal legal advice on its content will be obtained before submission for publication. This will be a very authoritative and informative document, relevant to all of our practice. While we all strive to obtain fully informed two stage consent for endoscopy, there are challenges to many aspects of this which we all face, and in my own service there are aspects which require some critical review. We look forward to publication of this guideline which will cover consent comprehensively including, for example, aspects such as postal consent, nurse consent, the Mental Capacity Act and consent for retention of tissue.

In addition to producing guidelines, the Endoscopy Committee is being innovative in producing position statements. These have been produced by European and American societies, but not previously by BSG. These will be on selected highly relevant topics for which there is insufficient evidence to produce a formal BSG guideline, but for which there is a demand for authoritative and informative guidance. They will also set out the key research questions on which to base future studies and funding applications. Currently work is underway on a position statement on the clinical management of serrated polyps, and a further is planned regarding improving quality in upper gastrointestinal endoscopy. We are open to suggestions for other topics for consideration, and are keen to collaborate with other BSG sections and other professional societies.

Andy Veitch, Vice President, Endoscopy

Update from the BSG Vice President, Hepatology

There are a number of themes to the development of hepatology. The future of specialised commissioning and what that may mean for liver services, the recently released *Lancet* commission into liver disease, new drugs for hepatitis C and how they may be managed, probably being the most pressing. I apologise if the following has a very English rather than UK flavour, but the devolved nations, particularly Scotland, are well ahead of England in their strategic approach to liver disease, and most of the new structures and changes are England specific. I will attempt, in future, to give some feedback on how things may work in Wales and Northern Ireland.

The Hepatobiliary Clinical Reference Group (CRG), which advises NHS England on specialised services, met again in October. There has been a 3 month 'pause' to most workstreams in NHS England while Simon Stevens assessed the future strategy of the NHS. The exception to this pause was the hepatitis C programme, which continued recognising the magnitude of new developments and the implication for patients.

The early access programme (EAP) to sofosbuvir (with either daclatasvir or ledipasvir) continues and represents a strong commitment from NHS England to fund hepatitis C virus (HCV) therapy for those in greatest need (in this case patients with decompensated cirrhosis). There are now 550 patients who have started therapy across the country, and the outcomes will be monitored through HCV UK where almost all patients are registered.

The EAP set the framework for how high cost drugs may be allocated by NHS England in future, with a bidding process for coordinating centres working with networks of clinicians delivering care locally. At the present time, it is not clear how NHS England will deal with sofosbuvir post NICE (the review should be finalised this month), and it seems clear that existing mechanisms for drug application, which vary markedly across England, will need to continue in 2015–2016 as there is little time for a bidding process similar to the EAP to be staged. We continue to await NHS England guidance on simeprevir; the Scottish, as usual, are ahead in approving this with a 'cost per cure' approach. We do not yet know what NHS England wishes to do although replacing telaprevir/boceprevir with simeprevir seems a sensible and relatively low cost option which may take some of the pressure off the sofosbuvir debate.

The EAP has been regarded as a significant success by NHS England, and the principles of networked arrangements really should guide us in how liver services in areas other than HCV should develop.

The NHS Forward View (in my view one of the most sensible documents to emerge from NHS England in the post-Lansley era) details new models for how care could be provided in future (http://www.england.nhs.uk/ourwork/futurenhs/). These include:

- allowing GP practices to join forces into single organisations that provide a broader range of services, including those traditionally provided in hospital;
- creating new organisations that provide both GP and hospital services together with mental health, community and social care;
- helping patients needing urgent care to get the right care, at the right times, in the right place, by creating urgent care networks that work 7 days a week;
- sustaining local hospitals where this is the best solution clinically and is affordable, and has the support of local commissioners; and
- concentrating services into specialist centres where there is a strong relationship between numbers of patients and the quality of care.

The BSG will need to respond to this in how it frames its plans, but it does seem to fit well with hepatology, and emphasises the networked principles and moving care out of hospital that we know have to happen if we are to turn around the epidemic of cirrhosis.

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The *Lancet* commission on liver disease was launched on 26 November 2014 and provides a template for the changes we need to make for service delivery. The report will help in producing a series of workstreams which will try to address specific areas, from primary care education through to liver transplant services. The BSG will be a key partner in taking these programmes forward.

Public Health England have a very functional infrastructure and have identified their priorities regionally. This is likely to be another very powerful lever for change if you are in an area where liver disease is a priority. Public Health England have published data on the prevalence of liver disease nationally (http://fingertips.phe.org.uk/profile/), which is vital reading for your local authority areas. I do not know nationally how this has translated into local priorities for Public Health England, and as yet how many areas have liver disease as a key part of Joint Strategic Needs Assessments; this is a key step for ensuring that the whole community is linked together and has a common aim. This will be the focus of a future update.

Stephen D Ryder, BSG Vice President, Hepatology

Update from the IBD Section Chair

Inflammatory bowel disease (IBD) can be very difficult for patients, but there are reasons for us to feel optimistic. There have been significant developments in the range of drugs and their availability, useful guidelines have been published and further guidance is being drafted. The issue of the IBD Registry remains a challenge, but the IBD Audit and IBD Standards have been rolled out. A novel set of quality indicators have been proposed and I will use this opportunity to bring you up to date on these topics.

Anti-TNFs and anti-integrins

The choice of anti-TNFs has suddenly increased. Golimumab was licensed for ulcerative colitis (UC) in March 2014. This coincided with the Go-colitis study, a UK wide pragmatic open label phase 3 study. Marketing has, however, been somewhat limited pending the NICE review of anti-TNFs for UC. The patent for Remicade expired in February 2015. Celltrion have produced a biosimilar infliximab. EMA has announced that this product is a biosimilar and may be used for the same indications as Remicade. The biosimilar will be sold in the UK as Inflectra (Hospira) and Resima (Napp). There are five preparations available for the treatment of IBD: adalimumab, golimumab and three infliximabs. This may lead to confusion. However, in terms of therapy, there are three drugs for UC and Crohn's disease (adalimumab and infliximab), and golimumab for UC. Gastroenterologists will be encouraged to make use of less expensive preparations by their CCGs. I would urge you to discuss 'gain share' with your CCGs so that any savings are used to support other aspects of care for IBD patients: you may suggest that there will be extra demand on the IBD service as patient expectations are raised from NICE decisions (see below) and the potential demand for counselling if new preparations are to be introduced and if alternatives to Remicade are to be prescribed.

NICE

The decision to support the use of anti-TNFs for moderate–severe UC was a great step forward for patients who are struggling with frequently relapsing UC and those faced with a colectomy. The IBD Committee worked hard with partners to bring about this decision. The announcement coincides with the introduction of biosimilars to UK gastroenterology. It is expected that the increased demand for anti-TNFs in UC will be met, in part, by these new preparations.

Meanwhile, NICE is considering vedolizumab for Crohn's disease and for UC. The BSG is actively campaigning for NICE to support this important new class of biologic drug. I hope the news at DDF will be positive.

NICE has supported the use of calprotectin in primary care but uptake appears to be patchy. Gastroenterologists should contact GPs and CCGs to remove this postcode lottery.

NICE are currently looking at drug and anti-drug antibody assays for anti-TNFs. Wider access to these will enable us to make the most of anti-TNFs and inform our decision making when patients appear to be losing response.

Standards and registry

Crohn's and Colitis UK worked with the BSG to launch the updated IBD Standards in 2013. We all aspire to these standards but they are toothless. NICE is drafting a new set of standards for IBD, and publication is awaited. In the meantime, people with IBD have been well served by the IBD Audit. The Registry may by a useful tool to replace the audit and, if funded properly, it may enable us to monitor the safety of biologics, especially now that we have so many from which to choose!

Quality indicators

There is no doubt that the Global Rating Scale has been a powerful tool for raising standards in colonoscopy. A European scheme for assessing and certifying gastroenterology services has been discussed for many years but does not seem any closer. The BSG and RCP have begun work to develop a tool that will form the basis of an accreditation scheme. There are reasons to be optimistic on behalf of our patients and our profession. The IBD Committee has had input in six sessions; it will be my last annual meeting as chair of the IBD Section and I hope to see you there.

Chris Probert, IBD Section Chair

Visit to the Medical University of South Carolina

It is such a fantastic opportunity to report on my experience at the Medical University of South Carolina (MUSC). I was overjoyed to be one of the 10 members of BSG to visit MUSC Digestive Diseases Centre. After much preparation (mostly swapping on call commitments), I managed to arrive a day before the scheduled visit to MUSC. Charleston is a fantastic place, indeed *where the history lives*, as claimed by its official website. The beautifully preserved architecture, plentiful gardens and historic homes, and WWII carrier were all very impressive indeed.

More impressive were the welcoming people at MUSC. It was such a warm welcome by Cynthia Peeples and the ever energetic Phyllis (nurse lead for MUSC). For all his greatness, the legend himself was very friendly and humble. Peter Cotton not only gave a brief peek into his career but also how he came to develop the very well planned Digestive Diseases Centre in the Ashley River tower at MUSC. We also felt very special when he presented his excellent book *The tunnel at the end of light—an endoscopic journey in 6 decades*. All the more happy to see it was autographed by the author!

A superb tour with all the interesting anecdotes by Phyllis made us really appreciate the Digestive Diseases Centre's ethos much better. It was fantastic to observe some of the best endoscopists performing the 'usual chores' and not even a bit nervous about the international crowd intently watching them!

A mini-CME by Dr Arun Sanyal into the pathogenesis of NASH and a full CME the next day with varied topics was truly informative and also entertaining. But the main entertainment, I felt, was on Friday night in a well chosen restaurant. There was relaxed and friendly chat with Peter Cotton, one of the gurus

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of motility, Don Castell, Mrs Cotton, Mrs Cook, Phyllis and the visiting team. We enjoyed great food and friendly banter, not to mention the selfies! It was such a well thought out mix of experience and interests by the BSG; all of us felt the time at MUSC was very rewarding. I would like to thank Tracy Farber (for organising accommodation and a lot more), Cynthia Peeples (fellowship co-ordinator), ever so friendly and patient staff at DDC, Drs Hoffman, Cote, Elmunzer, Castell, Elias, Lodhia, all the fellows and of course Professor Cotton.

I would like to thank BSG and Olympus for supporting this educational endeavour. Most of all, I also need to acknowledge my wife's support for managing on her own with a 5-month- old and a 6-year-old!

Dr Venkat Mahesh

In memoriam

Hugh Baron, founder of the Prout Club

John Bennett remembers the former President of the Society who died peacefully on 11 December 2014 after a short illness

Hugh Baron's much loved scholarship. He described his hobby as 'looking', and from his tall, gaunt frame, familiar to BSG members, his quizzical gaze would peruse scientific data, paintings, buildings and members of committees alike. Many were found wanting, for his standards were high. He was a compulsive writer, including ethics, 'political' aspects of medicine, medical history and art, in and out of hospitals.

His lifelong fascination with the stomach was sparked by Sir Francis Avery Jones, and enthusiasm for epidemiology by Sir Richard Doll. As a registrar, he developed Kay's augmented histamine test of gastric secretion to the concept of peak acid output (PAO). He found that below PAO 15 mmol/h, duodenal ulcers did not occur, and so treatment to induce this lowered acid state would allow ulcer healing. This work led to his DM in 1964 and an invitation to give one of the few quadrennial reviews at the 1970 World Congress in Copenhagen. This was magisterial in tone, and resulted in his 1978 book *Clinical tests of gastric secretion*.

During a year at Mount Sinai Hospital, New York, he showed that pancreatic secretion correlated with PAO. He then made his crucial move to the Royal Postgraduate Medical School in Richard Welbourn's surgical department. This close collaboration with surgical researchers was unusual but productive, and he was also able to work closely with Stephen Bloom and Julia Polak in investigating regulatory peptides. Later, when *Helicobacter pylori* came on the, scene he collaborated with John Calam.

Baron was delighted in the seeming oxymoron when Wilfred Lorenz of Marburg revived the title of 'theoretical surgery' and together they founded a journal with the title. He was made Fellow and later Hunterian Professor of the Royal College of Surgeons of England.

He practised clinically at St Charles' Hospital for over 20 years until a merger with St Mary's Hospital in 1991 established him there. On retirement, he donated his entire library to St Mary's.

He was gregarious, and travelled widely, lecturing as he wrote—clearly, trenchantly, authoritatively. His tall figure at the lectern (speaking with received pronunciation and extravagantly rolled Rs) became a familiar sight worldwide. He enjoyed discussion, and speakers quailed as they saw him unfolding himself and, with hands together as in prayer, eyes closed and facing upwards, he courteously demolished an argument or corrected a mistaken fact.

He was an enthusiastic member of the BSG, and was its archivist for 16 years, chairman of the Golden Jubilee committee for 1987 and wrote a history of the Society in a special edition of *Gut*. The biographical vignettes he composed of every Society officer for 50 years were models of compressed detail. He was President from 1988 to 1989. He always regretted that he had never been invited to give the Arthur Hurst lecture.

He was a clubbable man and a 'joiner' of societies, so he liked being an apothecary, a member of the Oxford and Cambridge Club, and even founded one. In 1972 he created the Prout Club for researchers of the stomach. This met at the BSG meeting for dinner and debate, and still continues.

After retirement in 1996 he rejoined Mount Sinai Hospital as honorary professorial lecture. He made forays into ancient medical records of institutions on both sides of the Atlantic to reveal the story of 4000 years of the stomach, published in 2013.

He correctly summed himself up as a restless polymath and said "I knew from experience how to accept the unchangeable, but still persisted, sometimes successfully, to change the unacceptable".

Dr Paul Mapleston Smith

Professor Roger Williams remembers his former research fellow and a former President of the BSG

I was much saddened, as will be his many friends, on learning of Paul Smith's death on 12 December 2014. He was my first research fellow on the Liver Unit at King's, having met him when he was on a year's rotation at Southampton where I had moved too temporarily. During his time there he was of the greatest support to me, both clinically and in keeping research going. I seem to remember there were some 80 beds attached to the appointment at Southampton General Hospital, and Paul was redoubtable in his efforts in identifying those of hepatology interest where we could have some input. He was much liked in the hospital and indeed had been doing quite well until he decided to complain about the food in the residents mess! To this day I remember vividly our leaving Southampton for King's in late July 1966 in Paul's battered VW Beetle, in which we managed to transport all of our laboratory equipment on the back seat.

During the year in Southampton, Paul established a number of studies on iron body clearance using the whole body counter at the Royal Navy Physiology Laboratory at Alverstoke, Hants. During the subsequent 2 years at King's, he carried out research into iron metabolism, completing his MD on 'Aspects of haemochromatosis' in 1968.

After 2 years at King's, he was successful in obtaining an overseas research fellowship in Boston, USA, where he worked on fetal bilirubin metabolism with Dr Roger Lester and Dr RM Donaldson. On his return to the UK, he completed his clinical training with a senior registrar position during 1970–1972 at University College Hospital, with clinical sessions at St Mark's Hospital.

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In 1972 he was appointed Senior Lecturer in Medicine to the University of Wales College of Medicine and in 1978 Paul became an NHS hepatologist/gastroenterologist at Llandough Hospital, Penarth and at the University Hospital of Wales.

Over the subsequent years he built up a first class hepatology and GI setup for the region. His main research interests were in endoscopic management of bleeding oesophageal varices and he also did important investigatory work into the relationship between exposure to vinyl chloride monomer and development of angiosarcoma of the liver, based on studies of a local chemical factory at Barry, which brought me into contact with him again. During 1995–1996 he was a popular and effective President of the BSG.

Paul, from his early adult years, suffered from a series of retinal detachments and interference with his vision, but he never complained, and it is as a valiant and loyal soul, always good humoured, that I shall remember him. All his life he loved cricket and being at Lords, was a member of the MCC and enjoyed playing himself for various clubs. Retirement from clinical practice was anathema to him although it did give him more time for his green fingers in the garden to flourish.

He leaves a wife, Ragnheiður, who is a consultant cytopathologist, and two children.

Welcome to DDF 2015

This is the second tri-annual congress of the Digestive Disorders Federation Meeting, first held in 2012. This year there are five DDF partner societies, spanning GI medicine, surgery, nutrition and hepatology, and I have been delighted to chair the Scientific Programme Committee, representing ACPGBI, AUGIS, BASL, BAPEN and the BSG.

This is a unique opportunity for you to enjoy an integrated programme of cutting edge medical and surgical gastroenterology. The programme has been designed to emphasise and exploit our joint working as clinicians, focusing on key topics in our specialties, while still incorporating the traditional emphasis of scientific free papers and poster presentations within our own societies.

I am particularly delighted that the postgraduate education day, which starts the conference on Monday 22 June, has brought together all five trainee groups from our individual organisations to help produce a high quality education day on GI cancer. This is aimed at consultant participants as well as postgraduate trainees, and I would like to thank and congratulate our Society's trainee leads for their contributions to this outstanding programme.

I hope you will agree that the location at Excel and the programme format, together with our industry sponsorship, offers an unrivalled opportunity for clinical education, professional networking and scientific research presentation in our vibrant capital city. I encourage you to register now and take advantage of the early bird registration before 20 March. I look forward to seeing you in June.

Dr Cathryn Edwards, BSG Senior Secretary

Message from Jon Smalldon

As you will know by now, Tom Smith is leaving the BSG for Beating Bowel Cancer. For the past few years he has combined his BSG role with that of chief executive of the BSG's sister charity, Core. With Tom's departure the two posts will, for the time being at least, be separated, and I will be taking over as interim chief executive at Core having worked for the organisation for the past three and a half years as its head of fundraising and communications.

This is a challenging time for Core. Like all charities, the effects of the 2008 crash and its impact on funding are still reverberating, and like many other organisations, we have struggled to get our voice heard in a busy 'marketplace' where we compete with far sexier causes. But, with the support and engagement of the BSG, plans are now in place to improve Core's overall position which will, in turn, support the work of the BSG. In the very near future we hope to further grow the Core office staff to enable it to become a stronger organisation through more effective fundraising and targeted campaigns. This is being done following extensive discussion with the BSG and building on the effective relationship that was able to grow during Tom's tenure.

In addition to growing Core as an organisation, I am also keen to ensure Core and the BSG work effectively together. From now on, Core will be more visible at BSG events, starting at Endolive in March. The BSG, in return, will be more prominent in Core's activities. Many areas of work will be co-branded. The central idea is that both organisations support the work of the other and that they work towards broadly the same goals. For example, I am hopeful that Core will be aiming to direct more of its support for research at themes and projects that have been identified as important by the BSG.

Within this, it is essential that Core creates for itself a solid identity and clear purpose. There has obviously been much discussion about this recently, and there are challenges it faces in achieving this. Cosmetic changes, for example just changing the name, are not a miracle cure. This will take hard work.

For my part, I believe a strong Core, working as a partner with the BSG where appropriate, will be of great benefit to both the BSG membership but also, more broadly, to all organisations and professionals working in the field of gastroenterology. Core has a key role to play in supporting research, informing patients and raising public awareness. I am confident that, given time and support, we can do this.

I am always happy to talk to people about Core, and always happy to listen to people's thoughts and suggestions. Drop me an email (**jsmalldon@corecharity.org.uk**) or call 020 7034 4979, or if you are feeling particularly brave, find me on twitter@jonsmalldon.

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