New Zealand Society of Gastroenterology

Issue: 15 August 2010

Health Workforce NZ and NZSG 2020 Vision

By Dr John Wyeth

Predicting the future has not been our core business. Yet it is about to become one of our most important activities over the next couple of years. Let me explain. Last year our Society began a campaign to address chronic shortages in the workforce and to plan for increased demand following the launch of the Colorectal Screening Program. As President, I had already met with the Minister of Health to discuss these issues. Our efforts coincided with the launch of Health Workforce NZ, an organisation chaired by Professor Des Gorman. Health Workforce New Zealand provides leadership, co-ordination and oversight of planning and development of the workforce across the country's health and disability sector.

Our Executive met with Des Gorman recently after being introduced through the Minister of Health. Gastroenterology is one of the key areas Health Workforce NZ wants to focus on. Some preliminary announcements have been made already, in particular plans to have registrar training fully paid for over the 5 year training period. The message given to NZSG is simple – plan for 2020 or it will be done for you.

The NZSG Executive is willing to take on the responsibility of planning for the Gastroenterology and Endoscopy Workforce in 2020. We will not be working alone. Close liaison with the Colleges, Societies for General Surgeons, Colorectal Surgeons and Upper GI Surgeons will be required, in addition to input from NZNO – Gastro Section Nurses and Primary Care. Health Workforce NZ will support us financially and with administration in this process.

There is a tight time frame with a provisional plan due by the end of the year. At this stage discussions are still being held on the potential make up of the working group and defining key areas for planning. One of the major drivers will be the need for change. The present growth within the Health Sector is unsustainable. To quote from the Health Workforce NZ web site: "Innovation is the only way forward if we want to secure a health service for all New Zealanders into the next generation and beyond."

We shouldn't turn our backs on this opportunity. We have too much to lose if we do not engage. We are the experts and we should determine the future. I will keep the Membership informed of progress. I am also willing to discuss this in more detail with you. My email is: john.wyeth@ccdbh.org.nz.

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Notices

Membershp Renewal

The 2010 membership renewal is now underway! Please contact lily.brown@racp.org.nz if you have not received your invoice

Annual General Meeting

The next AGM will be held in Auckland SKYCITY Hotel on Thursday 18 November 2010

Congratulations!

Merrilee Williams has won the Best Research Support Person Award from Southern DHB/ Dunedin School of Medicine, and the Nurses Award from the SDHB. She will attend the UEGW in barcelona this year.

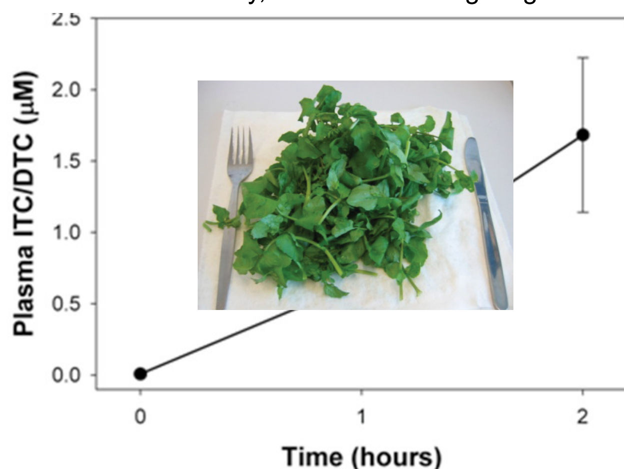
Christchurch Research Update

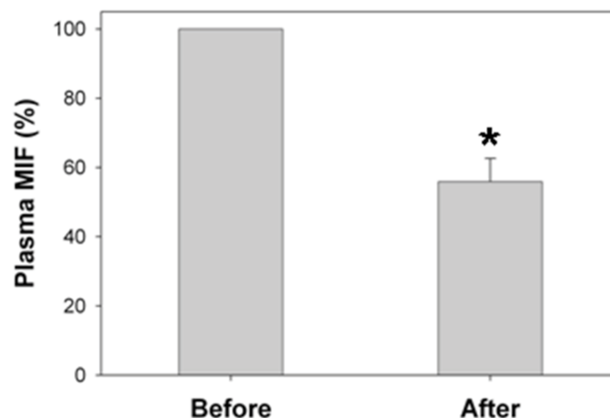
Sprouts, love them or hate them, the fact is the cruciferous vegetables are better for you than your taste buds let on. The isothiocyanates (ITC), a group of phytochemicals, not only give vegetables their pungent aroma and piquant 'bite' but are also responsible for the anti-inflammatory and anti-cancer effects attributed to these leafy delights.

Veg to Bench-side. Mark Hampton leading a group at the Free Radical Research Group (University of Otago, Christchurch) recently set out to investigate the biological properties of ITC. Using an affinity capture approach he and his group discovered that the cytokine macrophage migration inhibitory factor (MIF) is a major target of ITC, covalently binding and inhibiting its action. In a proof of concept study they subsequently demonstrated that the consumption of watercress (a potent source of ITC) by three volunteers leads to a rapid accumulation of isothiocyanates within plasma and a concomitant decrease in MIF levels. (Figure1)

Macrophage Migration Inhibitory Factor (MIF) is a multifunctional, proinflammatory cytokine implicated in the pathophysiology of numerous inflammatory conditions including IBD. It is a widely expressed, intrinsic component of the innate immune system that is released in response to diverse stimuli including bacterial endotoxin, pro-inflammatory cytokines and hypoxia. Elevated plasma levels have been observed in IBD, where the main site of production is from submucosal macrophage infiltrates, a hallmark of disease activity. In murine models, over expression of MIF increases susceptibility to IBD while MIF knockout mice are protected from the development of chronic colitis. Importantly, the ability of neutralising antibodies to ameliorate murine colitis indicates the potential value of MIF as a therapeutic target.

A novel therapeutic option in Inflammatory Bowel Disease. Dr Joel Tyndall and Professor Robin Smith from the Dunedin campus have used molecular modelling to predict modified ITC that would have improved docking to MIF. Novel ITC have been synthesized and we are currently evaluating their MIF inhibitory capacity *in vitro*. James Falvey is working with Mark on this project, and will use the best performing molecules to investigate the therapeutic effect of novel ITC in murine models of inflammatory bowel disease. Concurrently, we will be investigating MIF in human



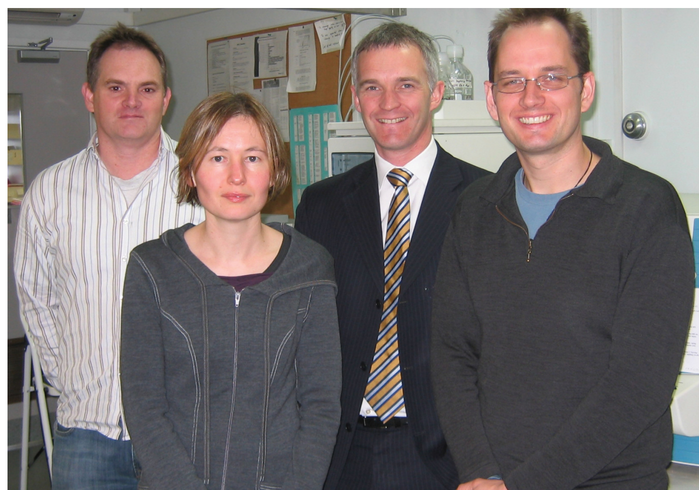


IBD using serum and colonic samples as well as evaluating it's utility as a biomarker of disease activity.

***MIF* promoter polymorphism in the Canterbury IBD population.** Rebecca Roberts has recently genotyped almost 1000 patients from the 'Canterbury IBD Project' cohort (Principle Investigator Richard Gearry) for the presence of a previously described, *MIF* promoter polymorphism (*MIF-173G>C*). In analysing these results, James has identified a novel interaction of *MIF* with the well-established Crohn's disease risk gene *NOD2* that accounts for some of the complexity seen in the published literature. In brief we have discovered that in the absence of common NOD2 mutations, *MIF-173C* confers a 50% reduction of risk for the development of ileal Crohn's Disease, whereas in the presence of a *NOD2* mutation *MIF-173C* confers a seven fold increased risk. Functional studies go some way to explaining this previously unrecognised gene-gene interaction and we hope to develop this field in the future. In the meantime, Rebecca and James are performing further mutation screening of the *MIF* gene with a view to conducting additional, robust genetic association studies using Richard's IBD cohort.

Exciting times in Christchurch. We hope our multidisciplinary investigation of MIF in IBD will provide new insight into the genetics and pathophysiology of IBD as well as defining the therapeutic potential of a novel group of molecules. So sprouts? Come on, fair go!

This is one of a number of Gastroenterology Research Projects currently underway in Christchurch.



Dr James Falvey, Dr Rebecca Roberts, Associate Professor Richard Gearry and Associate Professor Mark Hampton

Advance Training Update

Training issues

The new curriculum for gastroenterology has been finalised and should be launched at the AGW in October at the Gold Coast this year. This is a detailed document that will help highlight some areas of teaching that will need to be expanded to cover the range of topics in the curriculum. It may be useful for trainees and supervisors to indentify how to cover the "gaps" particularly in the third year of training. It is clear that any one centre is not able to fully provide training in all aspects of the curriculum. Many other learning opportunities need to be arranged. For example attendance at other clinics – Colorectal, Hepatobiliary, and Upper GI surgical cloinics, Familial bowel cancer, nutrition, alcohol and drug clinics. There should be active participation in manometry and pH studies, capsule endoscopy, nutrition ward rounds (monitoring of intravenous nutrition) etc

New assessment tools will introduced for advanced training in 2011. This will only affect trainees starting in 2011. The SAC has determined that the following assessment tools will be used.

- The supervisors reports will continue as before.
- For each 6-month attachment there will need to be 2 case-based assessments. This assessment evaluates the level of professional judgement exercised in clinical cases by the trainee. A case-based discussion involves a comprehensive review of a clinical case between an advanced trainee and an assessor (taking approx. 30mins). Cases for discussion are chosen by the assessor. Any case in which the trainee has had a significant role in the clinical decision making and patient management can be used. The discussion should reflect the trainee's level of experience and be linked to the relevant advanced training curriculum. Areas for assessment are record keeping, history taking, clinical findings and interpretation, management plan and follow-up and future planning.
- There should be 2 Direct Observation of Procedural Skills (DOPS) every 6 months. This will usually be one gastroscopy and one colonoscopy. This assessment is designed to guide the trainee's learning through structured feedback, help improve technical and practical competency, provide the trainee with an opportunity to identify strategies to improve their procedural skills, be a teaching opportunity enabling the assessor to share their professional. The trainee is given feedback from an assessor across a range of areas relating to technical ability and professionalism. Areas for assessment are understanding of indications, anatomy and technique, pre-procedure preparation, technical ability, post-procedure management, professionalism. The assessment form is generic for all procedures but may need to be altered to be specific for endoscopy. It is hoped that these assessment tools may be also suitable for the Conjoint Committee in Endoscopy
- It is planned than there is one multi-source feed-back (360° evaluation) per year. There is still some work to be done to implement this tool.
- Research projects are an essential part of the training process. Each trainee should complete 2 projects over the 3 year period. It is expected that a project will be of sufficient standard to present at the ASM of the NZSG.

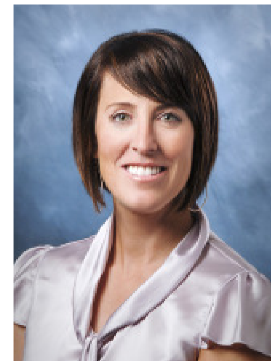
These changes for 2011 are rapidly approaching. It is hoped that there will be a supervisor workshop at the time of the ASM in November (possibly Tuesday afternoon – 16th November

Alan Fraser
Chairperson of the NZ SAC

NZSG 10th IBD Symposium

Rotorua, 25-26 June 2010

The focus of the IBD symposium this time was Pregnancy & Paediatrics. It was well attended with 82 delegates comprising not only Gastroenterologists and Surgeons but also Paediatricians, Registrars & IBD nurses from all over the country. Our keynote speaker, Associate Professor Marla Dubinsky, is the Director of the Paediatric IBD Centre and Associate Professor of Paediatrics at Cedars-Sinai Medical Centre in Los Angeles. She gave two excellent presentations which covered many current areas of uncertainty relating to IBD in pregnancy and also highlighted the growing problems with loss of response to biologics. Other speakers covered a wide range of topics including nutritional therapy in children and pre-biological screening.



Prof Marla Dubinsky

Melissa and I would like to thank Ferring for their ongoing generous support of this excellent meeting and particularily Bronwyn Starke for all of her hard work. We would also like to thank all the NZ speakers for their help in making it such an enjoyable meeting. We look forward to the next meeting in 2012.

Graeme Dickson & Melissa Haines
Gastroenterologists
Waikato Hospital

NZSG Constitutional Changes

Associate Membership

At the Extraordinary General Meeting on 26 June 2010, the membership unanimously passed the Rules change to include provisions for a new membership type - Associate Members. The new Rule 3cand 3f, relating to background and election of associate members, are as follows –

3(c) Associate Members shall be men or women with an interest in the science, study and practice of a specific sub-section of gastroenterology and / or hepatology. Associate members shall be eligible to receive notices, newsletters, access the Website and attend meetings. Associate Members shall have no voting rights and they cannot be an Office Bearer of the Society. They may be co-opted to the Executive in an ex-officio capacity.

3(f) Election of Associate Members - a candidate for Associate Membership of the Society shall be proposed and seconded by a Member or Associate Member of the Society. Any such proposal shall be made upon a form approved by the Executive and will contain information on the candidate's qualifications, professional status and special interest in gastroenterology. After consideration of the candidate's interest in gastroenterology he/she may be declared an elected Associate Member of the Society by the affirmative vote of at least five (5) members of the Executive.

A complete set of the new Rules could be obtained from Lily Brown, lily.brown@racp.org.nz.

Charitable Status

The NZSG is currently a registered charity and is exempt tax. The Society received a letter from the Charities Commission, dated 16 June 2010, stating that Section 13 (1)(b)(i) of the Charities Act 2005 states that a society or institution will only qualify for registration if it "is established and maintained exclusively for charitable purposes. Therefore, in order for an entity to be charitable, the Commission must be satisfied that there is no opportunity for private benefit or profit to an individual if the entity is wound up. The Commission stated that if Clause 19 of the NZSG constitution were amended to provide for a winding up resolution for all assets to be "…given or transferred to some other charitable institution…," it would be sufficient to meet the Commission's requirements. If the NZSG does not satisfy the Commission's definition of a charity, the Society would be liable to pay income tax on its earnings to the IRD. The current company tax rate is 30%.

A change in charitable status may have profound impact on the Society's finances, hence this issue will be discussed at the AGM on 18 November 2010.

Olympus Travelling Fellowship Winner - Rees Cameron

Congrations to Dr Rees Cameron, who is the winner of the 2010 Olympus Travelling Fellowship. Here is brief message from Rees -

Dr Rees Cameron

I'm a Gastroenterologist and General Physician at Wellington Hospital with a special interest in therapeutic endoscopy. In order to advance my skills in this area, and to train in endoscopic ultrasound to help introduce this service to Wellington Hospital, I'm taking up an International Scholar position under Dr Ken Binmoeller at the California Pacific Medical Center in San Francisco. The position begins in March 2011, and is a year long programme. Dr Binmoeller is one of the US' foremost interventional endoscopists, and many will remember his

inspiring presentations at the Annual Scientific Meeting last year. I'm very excited at taking up this opportunity and look forward to passing on the skills learnt there upon my return.

New Executive Officer

NZSG is pleased to announce the appointment of Lily Brown to the position of Executive Officer. In this part time position (0.4FTE), Lily will work closely with the President, John Wyeth, and other Executive members.

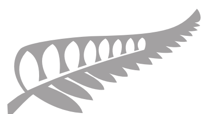
Lily Brown

Lily has had a number of years of experience working at the New Zealand Law Society, most closely with property and family lawyers. At the NZSG, she will be looking after the day to day finance, website development, newsletter and all aspects regarding the smooth running of the Executive Committee and membership services.

Reflecting on her appointment, Lily said

"I am very excited at the prospect of working with medical professionals. I welcome suggestions from members and look forward to meeting them at the November Annual Scientific Meeting."

Her contact details are: DDI (04) 460 8127, email: lily.brown@racp.org.nz.



CONTACT US

NZSG welcomes feedback, suggestions and contributions to this newsletter

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