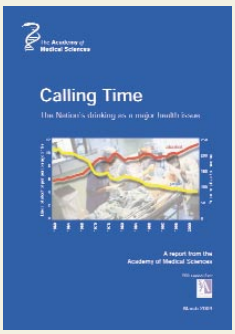
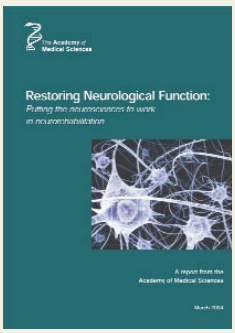
The Academy of Medical Sciences

Fellowship
Newsletter



Calling time

The Academy launched the report 'Calling Time: the Nation's drinking as a major health issue' on 4 March 2004. The report warns of the increasing danger to individual's health from the growing overall consumption of alcohol in the UK. It goes on to call on government to introduce strategies to prevent further rises in alcohol consumption and bring levels back to those of 1970. Media interest in the report was substantial, with coverage throughout the national press. The Academy hopes this report with contribute significantly to the national debate on public health issues.



Road map for research into neurosciences

On 29 March 2004 The Academy published the report, 'Restoring Neurological Function' which sets out a road map for new medical research money to be spent on neurorehabilitation and neuroscience more generally. Closely following the Government's commitments to support clinical research the report provides a framework to help ensure that the enormous potential of research into neurorehabilitation is translated into benefits for patients.

The Academy welcomes feedback from Fellows.

Please email: apollo@acmedsci.ac.uk

Public Health?

Life-style: your health in your hands

Mr Derek Wanless

The prize to be gained from a population fully engaged in seeking good health is clear. Not only can there be significant long-term financial savings but also health services could be in a better position to face potentially very difficult future decades when a larger older population could be joined in poor health by younger people too many of whom have lived unhealthy lives.

The scenarios modelled in my 2002 report illustrated the benefits of high productivity on the supply of health services and of healthy lifestyles on demand. The 2004 report carries these themes further, setting out the changes in approach required if we decide we want to move towards full engagement. "Fully engaged" does not mean simply delivering existing plans; it is much more demanding, requiring high productivity in public health as well as healthcare. Adequate workforce capacity, expanded by self-care and appropriately broad skill mixes, revolutions in information handling and redirection of resource to areas of proven effectiveness would all play their part.

Life-style: your health in your hands continues on page 2

Continued from the front cover.

This year's report is designed to ensure spending is well-directed, whether spent on tackling inequalities, changing personal behaviours or on more attentive and personalised health services. A framework is devised to allow good economics to take root.

A speedy report could not be a comprehensive study of all determinants. We examined a sample to see how well we have been doing and, from that, drew conclusions and made recommendations, by no means all for Government.

The existing definition of "Public Health" may still be appropriate for health protection. But it seems inappropriately narrow now for the domain of prevention. What need to be influenced are the organised efforts and informed choices of society, organisations, public and private, communities and individuals. The report is built on that wider definition.

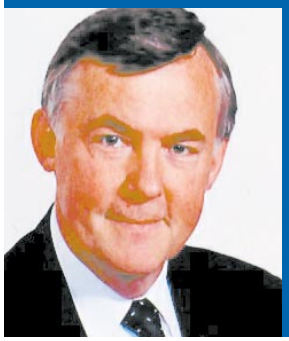
The question is why in recent decades we have done so badly. Not for want of reports. Yet, for example, a quarter of adults still smoke, obesity increases and sexually transmitted diseases rise again.

We examined how targets had been set. We found inconsistencies in ambition, realism and timescales. Smoking targets were unambitious, certainly not "fully engaged"; no obesity target had been set since 1992 and so on. Target setting processes did not encourage a belief that resource management was remotely near optimal.

We need national objectives for all the major determinants to inform resource planning and priority setting. Research, analytic thinking and consensus building are needed. For many determinants, important sub-groups need separate objectives; for example children, ethnic groups and the economically deprived. Three and seven year objectives were suggested to drive short-term action.

All these objectives should be based on independent, professional and practical advice. The Government should establish the structure it will use to get such advice, which should include a process of regular review.

These objectives should inform local decisions but must not lead to the imposition of centrally calculated targets on local organisations. They know best their own local problems, priorities and complex trade-offs. Much planning and delivery will be local; national action, such as resource allocation, objective setting, performance management and audit, must not distort or cause unjustifiable spending to achieve marginal gain. Crude bureaucratic management systems corrode professionalism but well co-ordinated central efforts, for example in advertising or distilling best practice, could be immensely valuable.



Mr Derek Wanless

Why is the evidence base about cost-effectiveness so weak? Lack of funding contributes; so does very slow acceptance of economic perspectives within public health; so does the lack of a clear, coherent set of Government priorities for research. The future research programme will be technically very demanding and will require greater expertise and depth in core disciplines. The collection of aggregated data to aid understanding of the prevalence of disease and opportunities for risk management must not be threatened by the difficulty of obtaining access to data and the Government needs to remove the threat.

The need for action to achieve objectives is too pressing to allow lack of evidence to excuse inertia. Experiments underway should build the evidence base. We need a framework for evaluation and the sound methodology being developed by NICE should be the base, forcing consideration of costs and benefits and introducing techniques to involve people in making difficult assessments of value.

Capacity problems, the impact of recent organisational change and the lack of alignment of performance management systems limit achievement. PCTs spread resources thinly yet are vital in making new mechanisms work to advantage rather than becoming a diversion away from sound professionalism to opportunistic point-scoring. Close review and evolution of local structures is recommended; wholesale reorganisation is not.

Long term workforce capacity planning, including attention to significant skill shifts, must develop as the future becomes clearer; for example as primary care transforms. How will knowledge of genetic make-up and of individual risk assessment influence personalised health promotion and disease prevention? IT will drive change and marketing techniques will find their place. Pilot exercises are recommended, biased towards areas of inequality where access is such a crucial issue.

Primary care will not be individuals' only support. Many organisations need to be shown the business case, the

self-interest, in helping their employees, members, insurees etc engage. Private sector organisations can help by creating markets which capitalise on individuals' concern about their future health. They should be encouraged.

Government's role extends across all Departments. A Cabinet member, I believe the Secretary of State for Health, should ensure action across Government is having its public health impact assessed and that co-ordinated action is being taken where needed. We must do better than the previous limited assessments, often sector dominated, which have led to situations so difficult to resolve, even in the long-term.

The report suggests principles to govern the Government's choices for action. To help individuals make informed choices, to overcome the lack of full information and confusion of messages, to check whether messages have been received, believed and understood, to ensure people take account of the wider costs of their behaviours, to help shift social norms, to find out what works at acceptable cost and to report on progress annually are all for Government to do.

It is good news that the Government has reacted with its review of arms length bodies, its consultation and its proposed White Paper. All are welcome but not in themselves enough to guarantee success. The report has established a checklist against which the Government's response can be judged. But so can the responses of all those others who have parts to play if we are to achieve the prize of full engagement.

In 2001, Mr Derek Wanless reviewed the long term trends likely to affect UK health services over the next 20 years. His report 'Securing Our Future Health: Taking a Long Term View' was published in April 2002. In 2003, he was invited to provide an update focussing on population health, prevention and reducing health inequalities. His report 'Securing Good Health for the Whole Population' was published in February 2004. ■

Graham Watt FMedSci
Professor of General Practice
University of Glasgow

Life-style: your health in your hands – *A response to the Wanless article*

The best and most welcome feature of the second Wanless Report Securing Good Health for the Whole Population is that it is addressed not only to the Secretary of State for Health, but also to the Prime Minister and the Chancellor of the Exchequer.

When child poverty in the UK tripled during the 1980s, catapulting the UK to the top of the European child poverty league, this stemmed directly from decisions made by the occupants of 10 and 11 Downing Street. The affected generation affected is now leaving school and we are learning the consequences of 30% of young adults having been brought up in households below half average national income. The PM and Chancellor have set out to abolish child poverty, but although their diagnoses and treatments are correct, the doses they have prescribed are too low. The job is only a third done.

An admirable feature of the Wanless report is the call to quantify the contributions to public health that can be made using this and other policy levers. This hard-headed approach is needed nowhere more urgently than in the field of health improvement, where in the last 15 years a newly created army of professionals, with a plethora of projects and schemes, has had generally disappointing results. Government has found it easy to match its rhetoric with evidence of activity, but much harder to demonstrate evidence of effect. Some large projects, such as Health Action Zones, have already come and gone. There is an urgent need to evaluate, not only individual initiatives, but also the big idea that professionally-led action projects can improve public health.

Wanless underestimates, as Acheson did before, the contribution of evidence-based health care to improving public health, principally by the mass reversal of risks and the prevention of disease complications in primary care. By delivering these goods unevenly, the NHS has become a producer, rather, than a narrower, of inequalities in health. The problem is not simple access to the NHS, but access to quality outcomes, which are harder to achieve not just in pockets of deprivation but more generally in the bottom half of society as a result of the cultural poverty of primary care in such areas, the relative lack of NHS resource (including information – which Wanless recognises) and the lack of a public health mindset in general practice.

This persistent blind spot in health policy is due, perhaps, to the fact that for many health researchers, public health experts and policy advisers, general practice remains a foreign country. Wanless calls for increased public health research, but there is also a need for increased research capacity and output in primary care.

Life-style: your health in your hands - a response continues on page 4

Continued from the page 3.

In considering the potential contribution of the new genetics to public health, we should recall that genetic information contributed virtually nothing to the huge health improvements of the last century. Explaining why individuals do or not succumb to risk is no substitute for the proper removal of environmental, social and economic hazards, and barriers, to health. Genetic advances can be expected, of course, and the challenge will be to deliver such advances more equitably than we have delivered effective therapies in the past. Does "Translational Medicine" include this agenda? I wonder.

Finally, Wanless calls for "full engagement" in the public health agenda. What does this mean for medical schools (and the Academy of Medical Sciences) with their biomedical predilections? And what does "full engagement" mean for a society, whose most affluent and healthiest members have become insulated from the rest, and who have been led to believe that they are over-taxed – looking to the United States, rather to Europe for the model of the society we shall become. Who is going to tackle that particular form of social exclusion? ■

Jonathan Shepherd FMedSci
Professor of Oral and Maxillofacial Surgery
University of Wales College of Medicine

Winner of the Thorsten Sellin and Sheldon and Elenor Gluek Award for "outstanding international contributions to criminology" 2003

'There is more to life than health' –

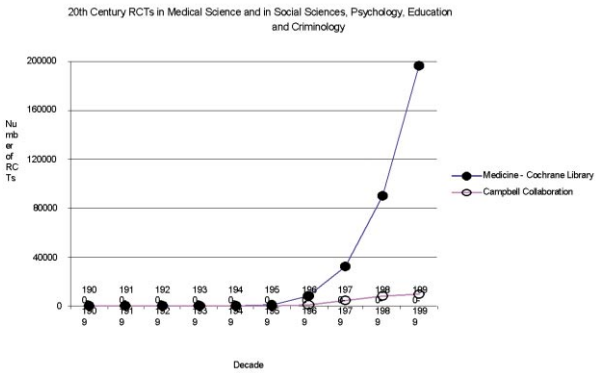
A response to the Wanless article

Derek Wanless has left few stones unturned in his quest to maximise health dividend from every aspect of national and community life, taking account of health impact, economic, cross-sector and cross-government perspectives. Full engagement of public health and the health professions is both desirable and achievable. But for the population there is more to life than health; liberty, community and the pursuit of happiness for example. A population threatened with a lethal pandemic should certainly be preoccupied with health, but probably not otherwise.

Every health service contact should be thought of as an opportunity for prevention. Every clinician needs to be ambitious here. For instance, Emergency Medicine can make a substantial difference to community safety; orthopaedic surgery to injury prevention and maxillofacial surgery to alcohol misuse. The evidence is there. There is too little emphasis on training in prevention: profession-specific public health should be a part of all training programmes and a key principle of the new Postgraduate Medical Education and Training Board.

The NHS still has a long way to go to realise the prevention potential of all practitioners: joining forces to prevent as well as treat, underpinned by joint professional education. Health impact assessments are steps in the right direction but public health needs to go further, realising that there is little epidemiology/public health expertise in other services: sharing expertise with the police service could do wonders for the prevention of violent crime for example.

The evidence-based revolution, led by medical science, has had differential influence on public services, all of



which have major health impacts. The figure contrasts trends in Cochrane and Campbell registered randomised trials in healthcare and social, education and, criminal justice services combined. The message is clear. Medical science should share expertise and commitment to reliable evidence. An ESRC field trials unit, mirroring the MRC clinical trials unit is urgently needed.

Statutory partnerships which bring together health, local government and criminal justice practitioners are fertile ground for propagation of science-based policy and practice. They also provide new opportunities for health to contribute uniquely and distinctively to communities.

Wanless is right about marketing skills: reliable evidence needs to be interpreted responsibly and brought to public prominence by professional groups and individuals to fulfil its potential. The huge shift in practice which has occurred with regard to prophylactic third molar removal had its genesis in trenchant media reporting of the decision and economic analyses which form the basis of the historic first NICE technology appraisal in 2000. IT can facilitate change but cannot drive it.

As regards organisation inside government, it might be most appropriate if the Cabinet Office Strategy Unit together with the Department of Health designed a template for cross-department health impact assessment. Wanless seems ambivalent about the value of 'yet more' reports and performance management. Consistent defined targets, yes: interference in local management, no.

In short, a population fully engaged, if this means preoccupied in seeking good health, is perhaps, a step too far. Fully engaged health services, however, are achievable and urgent action is required to inject scientific public health genes into every healthcare training programme and every public service. ■

A public health approach to skin cancer

– A response to the Wanless article

There are three main varieties of skin cancer, basal cell carcinoma, squamous cell carcinoma and malignant melanoma. Taken together, they have an incidence in Caucasian populations exceeding all other malignancies. This incidence is currently rising and is likely to continue to do so for reasons discussed below. However, the paradox of skin cancer is that it is associated with a very high incidence but a relatively low mortality, as basal cell and squamous cell cancer rarely are a cause of death. The variety of skin cancer responsible for the bulk of skin cancer deaths is melanoma. There are currently around 7,000 new cases annually of melanoma in the UK and 1,700 melanoma-attributable deaths. An additional point is that these deaths are frequently in relatively young adults, so more years of life are lost for each melanoma death compared with for example lung cancer.

The main environmental agent identified as an aetiological agent for all skin cancers is ultraviolet radiation. This has until recently been exclusively from natural sunlight but the rise in popularity of artificial tanning apparatus in the past decade has added a new hazard. In Scotland between 1979 and 1998 the incidence of melanoma trebled in males and doubled in females. The main reason for this increase, which appears to be real and not due to changed pathological diagnostic criteria, is considered to be greater opportunities for sunlight exposure. Family holiday habits have changed and many infants are now exposed to Mediterranean sun before their first birthday. Epidemiological studies of migrants to and from Australia and Israel indicate that early childhood sun exposure does increase the risk of melanoma in later life. At the other end of the age spectrum the number of individuals in the UK aged over 70 is increasing and many older people are taking relatively early retiral and relocating either to high UV areas of the UK or spending significant periods of the winter months in warmer climates. These facts suggest that it will be difficult to reverse the current upward trend in the increase of skin cancers.

While this increasing incidence will not necessarily be accompanied by an increase in mortality, all skin cancers do require treatment, usually minor surgery. While some of this can be carried out by appropriately trained general practitioners, the majority is performed by plastic surgeons or dermatological surgeons and is putting considerable pressure on understaffed departments, with in many cases long waiting times between clinical diagnosis and excision of these tumours. This is very apparent in traditional retiral areas of the UK such as the south coast towns.

A public health approach to this problem should include consideration of the cultural and psychological factors leading to the belief that a tan on Caucasian skin is "healthy". If the norm or desirable state were for paler skin, some of the social pressure to acquire a tan would be lessened. This would be particularly valuable in reducing the use of artificial tanning devices either in salons or in the home. The ultraviolet emitting tubes used in sunbeds emit a higher proportion of long wave UVA than is found in natural sunlight. Sun bed manufacturers are keen to promote the idea that longer wave UVA is either non-carcinogenic or less carcinogenic than shorter wavelength UVB. Recent high quality laboratory studies have however shown beyond any doubt that UVA alone is a carcinogen and promotes malignant differentiation of keratinocytes.

A further requirement is accurate documentation of the number of non-melanoma skin cancers diagnosed annually in order to sensibly plan the required minor surgery workload. Nationally cancer registries have no uniform policy with regard to registration of basal cell carcinoma and squamous cell carcinoma. For example, Thames records no cases of basal cell carcinoma while other cancer registries record only the first lesion for any given individual. This seriously underestimates the workload, as multiple basal cell carcinomas are extremely common. There are similar problems with squamous cell carcinomas, with 6 registries recording only the first squamous cell carcinoma. Cancer registration of every individual skin cancer requiring treatment would enable an evidence-based approach to workforce planning.

Skin cancer prevention activities require to be centred on an informed approach to excess UV exposure. This should involve educating the public concerning the hazards of both sun beds and natural sunlight exposure. Tighter control of salon sunbed use and sale of sunbeds for home use should be explored, as clearly with personally purchased machines, there can be no control of excessive use by any age range, or of use by children. Safe but enjoyable exposure to natural sunlight requires a steady supply of accurate facts with regard to skin exposure requirements for provitamin D conversion to vitamin D, and also the use of physical sun protection with clothing and other physical barriers rather than relying of chemical sunscreens. A useful model for some of these measures can be found in Australia. What is not required is a sunburn Czar. ■

Rona McLeod MacKie CBE FRSE FMedSci
Senior Research Fellow
Department of Public Health
University of Glasgow

Annual Forum Lecture

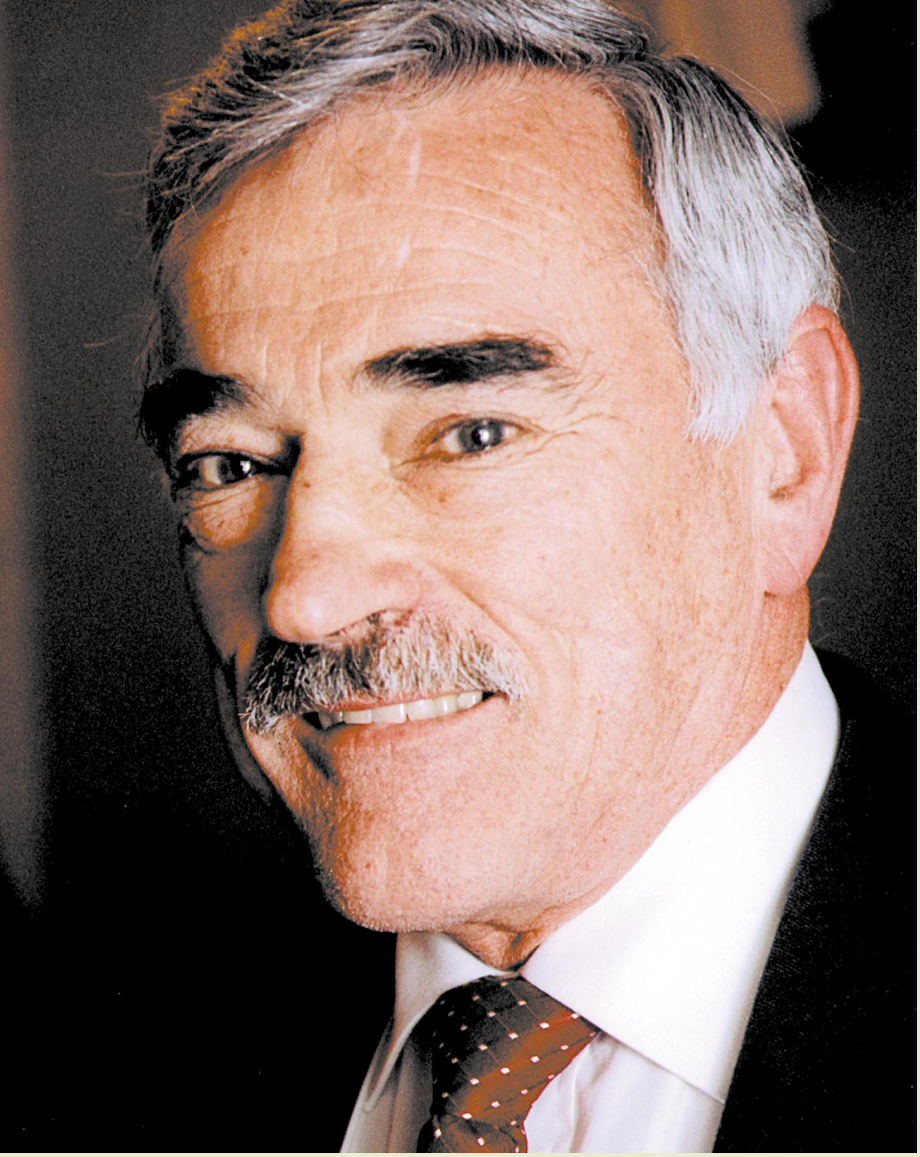


Image (left)
1. Sir Tom McKillop FMedSci, Chief Executive, AstraZeneca

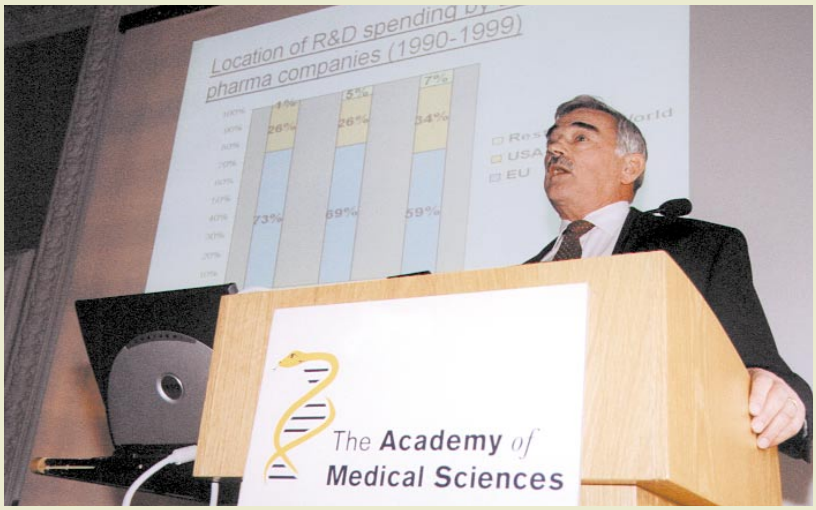
Image (below from left)
2. Dr Charles Penn, Director of Research, HPA
   Professor Trevor Jones, Director General, ABPI

Image (above from left)
5. Mr James Johnson, Chairman BMA
   Professor Roger Williams CBE FMedSci

Can Europe compete in biomedical research?

On 31 March 2004 Sir Tom McKillop FMedSci, Chief Executive of AstraZeneca, delivered the second annual Academy Forum lecture entitled: 'Can Europe compete in biomedical research?'. Sir Tom described how total research expenditure over the last two decades had increased to 2.8 per cent of GDP in the US whilst in Europe it had fallen from 2.4 to 1.9 per cent. Slow adoption of new medicines and unwillingness to reward innovative products has caused a progressive decline in the relative size of the European Pharmaceutical market. To reverse these trends Sir Tom called for a European Biomedical Research Strategy and the European market place to reward innovation. The lecture was followed by a drinks reception rounding off an enjoyable evening for Fellows, Forum Members and guests. ■

Image (from left)
4. Dr George Poste CBE FRS FMedSci
   Sir Keith Peters, FRS PMedSci
   Sir Alexander Macara FMedSci
   Sir Richard Bayliss FMedSci



Images (from (top)

7. Sir Tom McKillop FMedSci,
   Chief Executive, AstraZeneca
8. From left: Dr Barry Furr OBE, FMedSci, Deputy Chairman of The Advisory Board
   Sir Colin Dollery FMedSci

Editorial

by Sir Alexander Macara, FMedSci

Seven decades have passed since Ryle's graphic metaphor divided practitioners of medical science into two different but complementary categories - the 'microscopists' (specialists in defined fields of work who have a limited focus developed in ever-greater depth) and the 'telescopists'(public health practitioners), who scan the whole field and relate the parts to the whole. Leaving aside the tempting gibe that the one is at risk of tunnel-vision and the other of star-gazing, this distinction is useful in resolving the confusion about the definition of 'public health' which arises from the misconception that public health is the exclusive reserve and responsibility of public health specialists - the 'telescopists'. Just as mental health is not exclusively the concern of psychiatrists, or child health of paediatricians, professional responsibility for the public health and for addressing any factor within our competence which affects the health of the public is shared by us all. The challenge to leaders in the medical sciences is to work with those who are responsible for public policy to find effective means to apply professional knowledge, skills and energy to make the most effective use of finite resources in preventing the preventable and treating the treatable.

Hence, the welcome for the current consultations following the publication in February 2004 of the Report 'Securing Good Health for the Whole Population' to the Prime Minister, Secretary of State for Health and the Chancellor (please note!) by Derek Wanless (Wanless II in the jargon) leading to a promised White Paper. We are grateful to Derek for setting out his stall for us, and for colleagues who agreed to inspect the recommendations on offer from their several perspectives, which illustrate the diversity of tasks, challenges and opportunities. We are only too aware of the educated anxieties which our Fellows have about resources - human and material- notably in academic medical science and in public health, but we may be encouraged by the opportunity to influence developments.

In this context, it is opportune to publicise the Academy's report – 'Calling Time' on alcohol, about whose increasing consumption and related social disruption the authorities are curiously and culpably complacent, and to note the alarming decline in the U.K. pharmaceutical industry's research output which was the subject of Tom McKillop's sobering Annual Forum Lecture.

Please e-mail responses to apollo@acmedsci.ac.uk.

Sir Colin Dollery FMedSci

We continue our series of Officer's profiles with this short biography of the Academy's Treasurer written by Lady Dollery

Colin Dollery was born in Lincoln, where his father was a science master at Lincoln School, the school Colin later attended. He obtained a place at Cambridge, but they wanted him to do his National Service before university, whereas Birmingham would let him train as a doctor first. By doing a B.Sc. and several house jobs, his deferment outlasted military service itself.

While he was at university he took an active part in student politics. He became a Vice-President of the National Union of Students at a time when the centre left managed, for once, to defeat the far left. The strategy and tactics learnt then proved an important education for later political battles. He was also involved in interuniversity politics, which was how I met him (and the Editor of this newsletter!). As Vice-Chairman to his Chairman, we attended a lot of meetings together. On one occasion when Colin had lost his voice, he chaired a meeting through me – a gruelling experience not to be repeated!

How, while doing all this, and being President of his Hall of Residence JCR, Colin managed to get a medical degree with honours, history doesn't relate. He went on to do the two professorial house jobs, and then came to London to do two more, Hammersmith and then Brompton. At this last he learnt the important skill of removing a bottle top with the back of a spoon – beer being provided to fortify the residents against TB, but by tradition, no bottles openers. It was certainly a skill that saved several picnics. At this point Colin should have gone to work for Paul Wood, and then an MRC Fellowship at Oxford, but John McMichael asked him to go to Hammersmith instead. His research into the then new drugs for hypertension, where he wanted to know how and why, led eventually to Clinical Pharmacology. As one of the earliest Professors of Clinical Pharmacology, he built up an outstanding department through which many other future professors were to pass.

We never spent the year in America that so many did as part of their career plan, but we must have spent far more than a year of our lives in the USA. Conferences, meetings, visiting professorships, took us, and our children, all over the world. As President of IUPHAR, we even rated the presidential suite. This has its up and downs – a fabulous bathroom where you could lie in the bath and watch the harbour, but a penthouse where the air conditioning only served the sitting room, the loft being as hot as hell. Even being on the organising committee for several conferences brought unusual problems outside of budgets and breakeven points. There was the overseas delegate who might have been in contact with smallpox, and another who sadly died during a conference. Again, unlike others, Colin stayed on at Hammersmith, though there were occasions when he considered other options. Eventually he became Professor of Medicine and finally Dean, and at the same time pro-Vice-Chancellor for Medicine for London University. This was difficult period, and probably the least happy in his career, with a constant fight with the Government over the reorganisation of London Medicine, and the future of the Hammersmith itself. I think his car wore ruts in the Westway as he sped to and fro lobbying all and sundry.

Retirement in 1996 simply meant a change of workplace. In fact it's difficult to imagine Colin actually retiring. Work is what keeps him active and alive. When we travel, if the guide books says allow three days, Colin has seen everything in a day and a half. His approach to life is much the same. I can't see amateur radio, his one hobby apart from travel, keeping his mind challenged in the same way as pharmaceutical problems or the Treasurership of the Academy of Medical Sciences. ■

M1P is the 1999-2001 contest call of the Crossways Contest Club (G3GAF, G3UHU, G4PWA, G4TNB).

The Academy of Medical Sciences NEWS

Council for Science and Technology

Congratulations to **Sir Keith Peters**, President of the Academy of Medical Sciences on his appointment as independent co-chair of the Council for Science and Technology. The Council's remit is to advise the Prime Minister and the First Ministers of Scotland and Wales on strategic issues that cut across the responsibilities of individual government departments. Further information can be found on: www.cst.gov.uk/cst/

Awards

In March this year Academy Vice-President **Sir John Skehel** received the 2004 Sir Ernst Chain prize, which is awarded to a UK career scientist who has made an original and substantive contribution to the field of science that has furthered, or is likely to further, understanding or management of human diseases.

Civil honours

The Academy would like to congratulate the Fellows listed below for their inclusion in the 2004 New Years Honours list and the Queen's Birthday Honours:

Knight Bachelor:
Sir Robert Boyd, FMedSci
Sir Alasdair Breckenridge, CBE, FRSE, FMedSci
Sir Alan Craft, FMedSci
Sir Martin John Evans, FRS, FMedSci
Sir Peter Harper CBE FMedSci

CBE:
Professor John Collinge, CBE, FMedSci
Professor Keith Gull, CBE, FRS, FMedSci
Professor Annette Karmiloff-Smith CBE, FMedSci
Professor Robert Souhami, CBE, FMedSci

Sir Peter Morris FRS, FMedSci has been appointed a Companion of the Order of Australia. The Academy would also like to congratulate Lord Broers, FREng FRS, on his peerage.

New Appointments in the Academy office

Ms Mary Lovelock Fellowship Officer, Dr Helen Munn Policy Officer and Ms Roz Morton Corporate Affairs Officer. Mrs Chris Straw has joined as interim Finance Manager.

At the end of June the Academy will bid farewell to Dr Sarah Coppendale, who has worked tirelessly as the Academy's Finance Officer since 1998. Sarah will be well known to many Academy Fellows, and we wish her well for the future.

Recent Publications and Responses to Government Consultations

- A Forum symposium, Progress towards assuring the safety of vaccines was held on April 20 at the HPA, Colindale. A summary of the discussion and speakers abstracts can be found on the Academy website.
- A Forum symposium, Medicines for Children was held on June 14 at RIBA. A summary of the discussion and speakers abstracts can be found on the Academy website.
- Response to the Treasury/DTI/DfES Science and Innovation consultation (April 2004)
- Response to the HEFC's and Department of Employment and Learning Northern Ireland consultation on the Research Assessment Exercise 2008: panel configuration and recruitment (May 2004)
- Response to the Department of Health's Choosing Health? consultation (June 2004)

A copy of all the documents can be found on the academy website, **www.acmedsci.ac.uk**

Fellows elected to the Academy of Medical Sciences 2004

The Academy warmly congratulates the new Fellows who will be formally admitted on 29 June at the Admission Ceremony.

Carlos Caldas	Professor of Cancer Medicine	Department of Oncology, University of Cambridge
Barklie Clements	Chair of Virology	Institute of Biomedical and Life Sciences, University of Glasgow
Rory Collins	Professor of Medicine and Epidemiology	Clinical Trial Service Unit, Radcliffe Infirmary
Colin Cooper	Section Chairman	Department of Molecular Carcinogenesis, Institute of Cancer Research Haddow Laboratories
Stuart Cull-Candy	Professor of Neuroscience	University College London
Nicholas Franks	Head of Biophysics	Department of Biological Sciences, Imperial College of Science, Technology & Medicine
Philip Goulder	Wellcome Trust Senior Clinical Fellow	The Peter Medawar Building for Pathogen Research, University of Oxford
Alan Hall	Director MRC Cell Biology Unit	MRC Laboratory for Molecular Cell Biology, University College London
Andrew Hattersley	Professor of Molecular Medicine	Department of Molecular Genetics, Peninsula Medical School
Philip Hawkins	Professor of Medicine & Clinical Director	Acute Phase Proteins Department of Medicine, Royal Free and University College Medical School
Fiona Karet	Wellcome Trust Senior Fellow in Clinical Science	Department of Medical Sciences, University of Cambridge
Stanley Kaye	Professor of Medical Oncology	Department of Medicine, Institute of Cancer Research
John Krebs	Chairman, The Foods Standards Agency	Department of Zoology, Oxford University
Sanjeev Krishna	Professor of Molecular Parasitology and Medicine	Department of Infectious Diseases, St.George's Hospital Medical School
Alan Lehmann	Chairman	Genome Damage and Stability Centre, University of Sussex
Paul Lehner	Wellcome Senior Clinical Fellow	Department of Pathology, University of Cambridge
David Lodge	Research Advisor	Eli Lilly & Co. Ltd.
Peter Machin	Senior Vice President	Chemistry and Screening Sciences, GlaxoSmithKline
Alexander Markham	Chief Executive, Cancer Research UK.	Cancer Research UK
Kevin Marsh	Director	KEMRI-Wellcome Trust Collaborative Programme Kilifi, Kenya
Ian McKeith	Professor of Old Age Psychiatry	Institute for Ageing and Health, University of Newcastle upon Tyne
William McKenna	Professor of Cardiology	Department of Cardiology, University College London
Richard North	Vice President and Dean of Faculty of Life Sciences	University of Manchester

Linda Partridge	BBSRC Prof Fellow, Weldon Professor of Biometry	Department of Biology, University College London
Jeremy Pearson	Professor of Vascular Biology	School of Biomedical Sciences, KCL
Matthew Ridley	Author	International Centre for Life, Newcastle
John Rothwell	Professor of Human Neurophysiology	Sobell Department, Institute of Neurology, University College London
David Rubinsztein	Wellcome Trust Senior Clinical Fellow	Medical Genetics Department, University of Cambridge
Barbara Sahakian	Professor of Clinical Neuropsychology	Department of Psychiatry, University of Cambridge School of Medicine
Julian Sampson	Professor of Medical Genetics	Institute of Medical Genetics, University of Wales College of Medicine
Caroline Savage	Professor of Nephrology	Renal Immunobiology Unit, University of Birmingham
Gavin Screaton	MRC Senior Clinical Fellow	MRC Human Immunology Unit, Weatherall Institute of Molecular Medicine
Robert Sinden	Professor of Parasite Cell Biology	Department of Biological Sciences, Imperial College London
Jonathan Slack	Professor of Developmental Biology & Head of Department	Department of Biology and Biochemistry, University of Bath
Daniel St Johnston	Wellcome Trust Principal Fellow	The Wellcome Trust/Cancer Research Institute, University of Cambridge
Karen Steel	Principal Investigator	Wellcome Trust Sanger Institute
Pamela Taylor	Professor of Forensic Psychiatry Department of Psychological Medicine	Department of Forensic Psychiatry, University of Wales Medical School
Marc Tessier-Lavigne	Senior Vice President, Research Drug Recovery	Research Department, Genentech Inc
Douglas Turnbull	Professor of Neurology	School of Neurology, Neurobiology and Psychiatry, University of Newcastle upon Tyne
Mark Williams	Principal Research Fellow	Department of Psychiatry, University of Oxford
Norman Williams	Professor of Surgery	Academic Department of Surgery, The Royal London Hospital
Daniel Wolpert	Professor of Motor Neuroscience	Sobell Department of Motor Neuroscience, Institute of Neurology
Nicholas Wood	Professor of Clinical Neurology and Neurogenetics	Department of Molecular Neuroscience, Institute of Neurology

Forthcoming Events

FORUM
Symposium on Cancer Biomarkers and Imaging
Monday 25 October

2 Carlton House Terrace, London SW1
The symposium will comprise of four sessions:
Metabonomics, Imaging, Proteomics and Gene expression arrays.
The confirmed speakers and chairmen are Dr Richard Frank, Professor Jan van der Greef, Professor Douglas Kell, Professor Patricia Price, Dr John Waterton, Dr Mark O'Connor, Professor Darryl Pappin, Dr Barry Furr, and Professor Carlos Caldas.

Jean Shanks Lecture

Sir Philip Cohen FRS FRSE FMedSci will deliver the 2004 Jean Shanks Lecture on the topic of 'Protein Kinase Inhibitors, the Major Drug Targets of the 21st Century?' The lecture will take place on **Wednesday November 17** as part of the Annual Meeting, held at St Bart's.

Academy of Medical Sciences Annual General Meeting

The meeting will be held at the Robin Brooks Centre at St Bart's on **Wednesday 17 November**. The meeting will commence at 3.00 p.m.

Academy of Medical Sciences Annual Dinner

The dinner will follow the Jean Shanks lecture on **Wednesday 17 November** and will be held, as last year, in the Great Hall at St Bart's. Dr Matt Ridley FMedSci has kindly agreed to be the after dinner speaker. Application forms will be sent out shortly.

The Academy of Medical Sciences annual lecture on International Health

Professor Bernard Moss, Chief of the Laboratory of Viral Diseases at the National Institute of Allergy and Infectious Diseases (NIAID), will be delivering the first lecture in this new series on International Health at Imperial College on **Monday 29 November**. Time is to be announced.

Mentoring Workshops

The Academy's mentoring workshops provide a unique training opportunity of particular benefit to all those who currently undertake a mentoring role. The workshops will take place from 2-5 p.m. at 10 Carlton House Terrace, on:
Tuesday 21 September
Wednesday 20 October, and
Thursday 25 November.
For more information on the workshops, please contact Ms Emma Bennett, Academic Careers Officer on 0207 969 5226. emma.bennett@acmedsci.ac.uk

The independent Academy of Medical Sciences promotes advances in medical science and campaigns to ensure there are translated as quickly as possible into benefits for patients. The Academy's eight hundred Fellows are the United Kingdom's leading medical scientists from hospitals, academia, industry and public service. The Academy's Officers are: Sir Keith Peters, FRS, PMedSci *President*; Lord Turnberg, FMedSci *Vice-President*; Sir John Skehel, FRS, FMedSci *Vice-President*; Sir Colin Dollery, FMedSci *Treasurer* and Professor Patrick Vallance *Registrar*. The Executive Director of the Academy is Mrs Mary Manning.

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