Royal College of Physicians | JAG Joint Advisory Group on GI Endoscopy



Differential attainment in advanced endoscopy: understanding the scale of the challenge

Inclusivity@JAG working group

November 2026

Foreword



Ensuring fairness in training is not only a matter of equality and inclusion; it is essential to the future sustainability and excellence of the UK endoscopy workforce. This report represents an important milestone in understanding and addressing differential attainment within advanced endoscopy, bringing together emerging evidence, workforce data and practical recommendations to support meaningful change.

The findings presented here highlight a challenge that extends beyond individual trainees. When talented clinicians encounter avoidable barriers to progression, the profession risks losing valuable expertise, diversity of thought and future leaders. At a time when advanced endoscopy services face increasing demand, workforce shortages and significant retirement pressures, creating equitable opportunities for all trainees has never been more important.

The Inclusivity@JAG working group has taken a thoughtful and evidence-based approach, combining quantitative analysis with a commitment to understanding the lived experiences of trainees across the workforce. The proposed programme of work provides a clear framework to identify barriers, measure progress and support a culture in which all endoscopists can thrive and realise their full potential.

While this report sets out the scale of the challenge, it also offers a vision for the future: an advanced endoscopy workforce that is diverse, compassionate, inclusive and sustainable. Achieving this ambition will require commitment from trainers, trainees, endoscopy units, professional societies and healthcare organisations alike. We hope this report serves as a catalyst for collaboration, reflection and action across the profession.

Dr Paul Dunckley
Chair, JAG Training Committee

Introduction

In 2023, the British Society of Gastroenterology (BSG) annual workforce report found that 95% of ERCPists were men and 37% were nearing retirement.[1] Proportionally, this makes female ERCPists less common than female neurosurgeons[2] or female pilots. With women making up 42% of gastroenterology trainees,[1] this represents both a large attainment gap and an unsustainable workforce development outcome. The Inclusivity@JAG working group was therefore set up to define and quality assure equality, diversity and inclusion in endoscopy training, with a focus on reducing differential attainment through intersectional analysis of quantitative and qualitative data. The working group reports to the JAG training group and provides updates at each meeting on its progress.

This report outlines differential attainment in endoscopy and how data used to define the current colonoscopy certification process may be biased towards certain groups of trainees. It sets out a five-phase approach to measure and reduce differential attainment in endoscopy, including identifying the barriers experienced by groups who may need additional support, analysing JETS data using intersectional analysis, and exploring how a compassionate approach has the potential to improve outcomes. It also sets out proposals for how JAG can foster diversity while strengthening the UK advanced endoscopy workforce.

It should be noted that the outcome of each phase is likely to influence the next, so the process will remain fluid. Updated versions of this report will be published on the JAG website on an annual basis, with interim analysis shared at each JAG training group meeting as a standing item on the agenda.

What is differential attainment?

The General Medical Council (GMC) has led work to highlight, analyse and close the gap in differential attainment in medical training. It defines differential attainment as:

> **'Differential attainment (DA) is what we call the gap between attainment levels of different groups of doctors. It occurs across many professions.**
>
> **It exists in both undergraduate and postgraduate contexts, across exam pass rates, recruitment and Annual Review of Competence Progression (ARCP) outcomes and can be an indicator that training and medical education may not be fair.**
>
> **Differentials that exist because of ability are expected and appropriate. Differentials connected solely to age, gender or ethnicity of a particular group are unfair. Our standards require training pathways to be fair for everyone.'**[3]

In the context of endoscopy, emerging evidence suggests that differential attainment is reflected in differing outcomes in the workforce.

Evidence of DA in endoscopy

Women make up around 74 % of the total NHS workforce.[4]

- 95 % of ERCPists (of whom the majority are gastroenterologists) are men, while 38 % of gastroenterology trainees are women.[1]
- 14.7 % of all bowel cancer screening (BCS) consultants are women; 31 % of current clinical endoscopists (CE) would like to become BCS accredited, and 76 % of this group are women.[5]
- A UK-wide survey in 2023 found that 26.5 % of endoscopy nurses intend to leave the NHS within 5 years.[5] Although there is planned workforce expansion for advanced endoscopists, only 15 % of nurses are interested in pursuing an endoscopy subspecialty (eg ERCP).

DA in endoscopy is likely to go beyond gender and healthcare qualifications. Early evidence for this can be found through intersectional analysis of the RCP census data toolkit in 2022,[6] which showed that in the UK 24 % of consultant gastroenterologists were women. Women made up 21 % of the consultant workforce in the north of England and 30 % in London, despite similar gender proportions among trainees. This suggests that hospitals in the north recruit fewer women into consultant posts even though they train similar numbers of men and women. Because consultant gastroenterologists make up most advanced endoscopists, this geographical gender gap could further widen the attainment gap in advanced endoscopy.

There is some evidence of an attainment gap in outcomes for endoscopy trainees. In 2022, Sethi *et al*[7] found that:

'A greater proportion of male than female trainees achieved provisional colonoscopy certification during training (55% vs 45%, p=0.005) and female trainees took longer to certify than male trainees (63 months vs 56 months, p=0.004). The total length of training time from primary medical qualification to consultancy was the same for men and women.'

If there is a significant difference in training outcomes in those with legally protected characteristics, then this is likely to have a bearing on the breadth of diversity of the advanced endoscopist workforce.

The established surgical workforce is male dominated.[8] In 2023, the Working Party on Sexual Misconduct in Surgery (WPSMS) found that sexual discrimination was 'rife' among the surgical workforce.[8] This was also reflected in the findings of the GMC National Training Survey (NTS) 2025 survey (see Fig 1).[15] Parts of the advanced endoscopy workforce have a more pronounced gender imbalance than some surgical subspecialties. For example, the GMC data toolkit showed that in 2025 90 % of neurosurgeons were men,[2] while 2018 BSG workforce data showed that 95 % of ERCPists were men and 37 % were nearing retirement.[1] Trainees report that ERCP is the most challenging subspecialty discipline to access during training. Unless we remove gender barriers in ERCP training, how can we deliver this service sustainably across all four nations in the future?

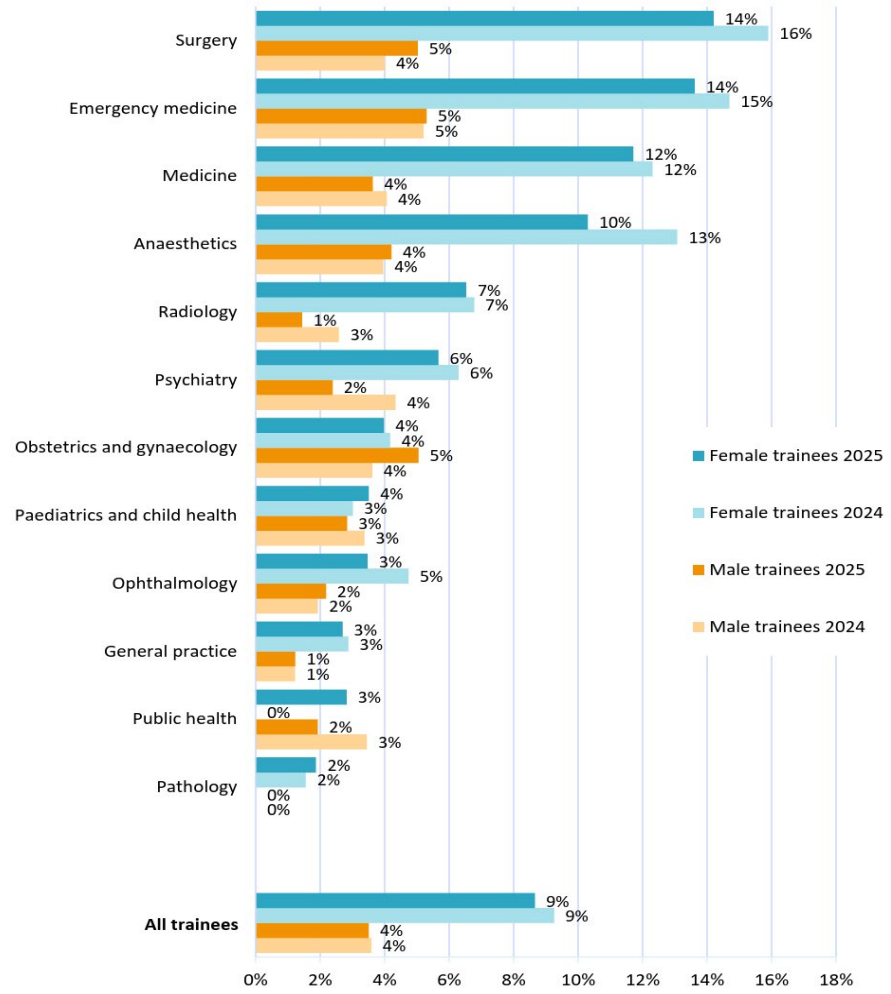


Fig 1: Trainees – in your current post, how often if at all do you experience unwelcome sexual comments or advances causing you embarrassment, distress or offence? By post, specialty and gender, % negative responses 2025 v 2024.

Figure reproduced from GMC National Training Survey 2025 results, p31.

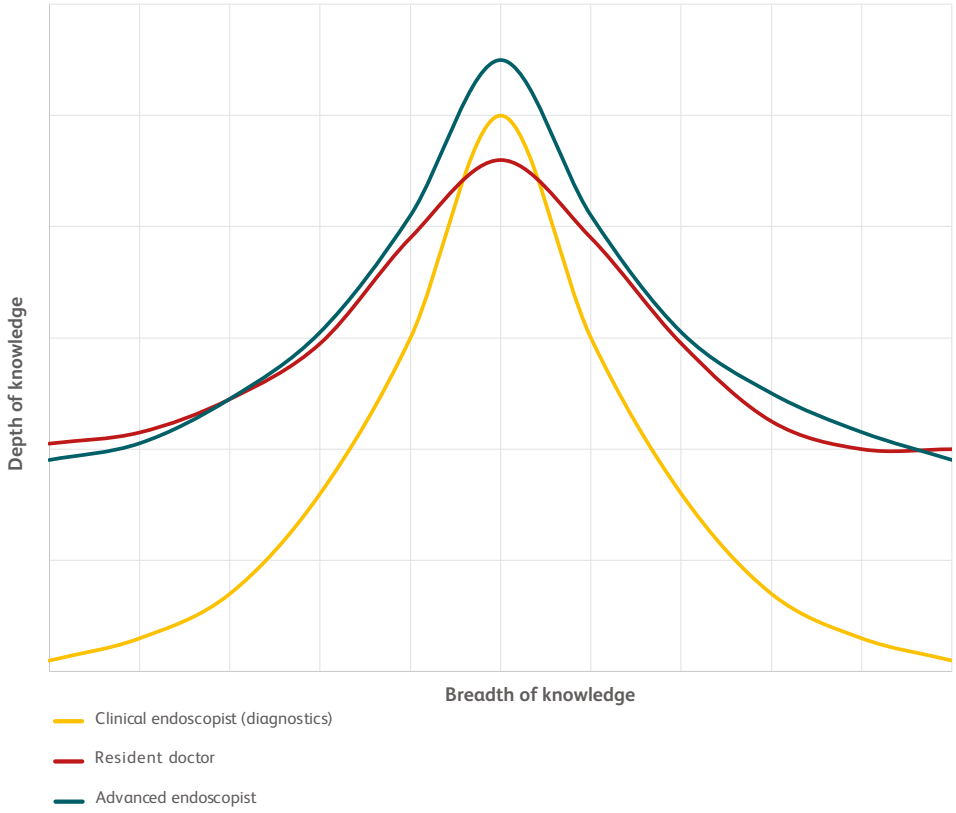


Fig 2: A pictorial representation of the Leng review[9] through the lens of advanced endoscopy, where the peak of the curve represents the field of endoscopy within both medicine and surgery. Breadth of knowledge refers to the wide variety of subject matter found across the gastroenterology and surgical curriculum and experienced by all in the acute unselected medical and surgical take. Depth of knowledge refers to the detail that consultants and senior trainee colleagues have that is greater than their non-medical colleagues across a wider variety of subspecialty subjects, simply due to the nature of their training. This enables them to carry out rapid decision making in complex patients.

Fig 2 shows that carrying out complicated techniques and responding swiftly to any complications requires substantially greater knowledge, experience and higher-level decision making. Doctors in training gain much of this expertise outside endoscopy, eg on the unselected acute medical or surgical take, where they manage patients with complex multiple conditions. This is particularly relevant to ERCP, which is often carried out on patients who may be frail and have multiple health conditions. Clinicians therefore need broad, in-depth knowledge to assess and monitor these patients throughout the ERCP process.

An equality, diversity and inclusion critique of the current colonoscopy certification process

To progress to BCS accreditation, trainees must gain colonoscopy certification. JAG has led the development of standards in colonoscopy training, including an unassisted caecal intubation rate (CIR) of ≥90%. Data highlighting the indicative number to reach the 90% CIR were published by Ward *et al* in 2014,[10] but no intersectional analysis was performed on these data. The information on progress in colonoscopy intubation rate came from trainees who achieved a ≥90% caecal intubation rate between 2009 and 2012. Based on the gender changes among higher specialty training doctors described by Elston in 2009,[11] this cohort is likely to be significantly more male dominated than the current cohort. This work would not have included data on the clinical endoscopist (CE) workforce, which has also significantly expanded in the last decade.

The Ward *et al* paper[10] excluded all trainees who had a gap in training of greater than 90 days from the final set of cleaned data. The analysis therefore omitted those who took more than 3 months of maternity, sick or compassionate leave. Excluding these trainees does not reflect the current trainee demographic. JAG proposes publishing guidance to support people to return to endoscopy training after a period of absence.

These data focused purely on caecal intubation rate despite the overwhelming evidence that endoscopic non-technical skills (ENTS) are a critical part of improving patient safety in endoscopy utilised by JAG[12] in response to the 2004 NCEPOD report on GI endoscopy.[13]

The recently published NHS England medical training review diagnostics report specifically mentions improving access to procedural skills training in subspecialty medical disciplines.[14]

The UK government intends to reduce international recruitment to the NHS to less than 10% by 2035. As there is a link between ethnicity and international recruitment, and the NHS workforce is more diverse than the background population of the four UK nations, this shift may affect workforce demographics.[4] Recently, parliament passed the Medical Training Prioritisation Bill, which is also likely to reshape the overall demographic of the advanced endoscopy workforce over time and provide greater support for established UK-based trainees.

JAG approach to tackling DA

Drawing on the GMC's *Fair training pathways for all*,[3] JAG proposes a five-phase approach to investigate and reduce differential attainment over the next 3 years.

Phase 1: Define the extent of differential attainment in endoscopy training

What barriers, factors and key person specifications contribute to differential attainment? These will provide the key metrics for the Inclusivity@JAG working group's reporting.

Demographics

Baseline information on the core demographics of the endoscopy workforce, including trainees and faculty, will be collated from the National Endoscopy Database (NED) and JETS. Core demographics include: gender, ethnicity, age, endoscopist type and geographical location.

A more in-depth analysis of trainee demographics will be measured in a survey conducted on JETS users (see appendix 1 for a list of survey questions and options for intersectional analysis).

Colonoscopy certification data

Although Sethi *et al*[7] found a 7-month difference in the time taken for trainees of different genders to achieve independent certification, this may reflect the increased likelihood of female trainees taking maternity leave during training. The authors also noted that they did not adjust for the extra time taken to train flexibly.

Options discussed to measure the DA gap included taking serial measurements along the independent certification training pathway, listed below.

- The number of procedures that each demographic requires to reach certification.
- The number of procedures required to achieve an incremental caecal intubation rate according to demographic. Increments to be explored could include: 50%, 60%, 70%, 80% and 90%.
- Improvement of skills acquisition through DOPS progression scores.
- Total procedures performed at the point of certificate of completion of training (CCT).

Calculating the length of time taken to acquire certification is challenging as it involves taking into account less-than-full-time (LTFT) training and gaps in endoscopy training. Instead, the surrogate marker of training year could be used (ie specialty training status at the annual review of competence progression – ARCP) and this will inherently take into account the stage of training of the trainee.

After careful consideration, the Inclusivity@JAG working group selected DOPS progression scores to calculate the DA gap. It was felt that this measure enabled a broader focus, supporting the endoscopic and ENT skills required by all endoscopists. In future, this could include an ENT score on compassion (see phase 3 below).

Annual monitoring via the ARCP process will help identify early signs of DA moving forwards. JAG proposes starting intersectional analysis with gender and ethnicity to assess whether they impact on certification procedure numbers. The forthcoming JETS survey will help to identify other factors for future intersectional analysis. JAG aims to measure the attainment gap every 2 years to track progress towards phase 5.

Training and non-training list data

The JETS database allows JAG to measure trainees' access to endoscopy lists by trust according to core demographics. A future JETS survey will help identify trusts that consistently struggle to offer appropriate training lists to trainees. Separately, we can also determine whether trainees with protected characteristics face particular barriers. These data could prompt a deeper dive, including specific qualitative interviews with a range of trainees in the flagged centre. Over time, this information could determine whether an endoscopy unit is eligible for accreditation if it is not consistently achieving the appropriate standards for training.

The JETS survey will be used as a biennial barometer of aspects and factors contributing to DA, utilising the established work carried out by the GMC. A list of proposed questions to be asked in the JETS survey can be found in appendix 1. The findings will inform recommendations for phase 3.

JAG census data

JAG conducts a biennial census with JAG registered endoscopy services. Key domains include activity, waiting times, workforce and safety. We will add a section with questions on equality, diversity and inclusion to capture service-level data on factors contributing to differential attainment.

Phase 2: Measure the impact of these factors and unconscious bias through qualitative analysis and survey data

The JETS survey will also be used to measure support in the environment, discrimination and experiences of micro aggression among trainees from other trainees and trainers by adapting established questions from the GMC NTS survey.[15] These questions can be found in appendix 1.

What qualities do under-represented groups look for in role models?

Visible leadership in advanced endoscopy appears to be predominantly male. The Inclusivity@JAG working group is analysing JAG data to assess the diversity of its faculty.

In view of the increasing numbers of women entering the medical workforce in the last 2 decades, the Inclusivity@JAG working group wants to reassess the qualities that today's trainees value in an advanced endoscopist. Qualitative research should explore what women and other under-represented groups look for in an advanced endoscopy trainer. Evidence that women may value different characteristics in role models can be found in the RCP's *Women and medicine* report published in 2009 (see adapted Fig 3)[11] and through pilot data from an unpublished SWiG survey (Appendix 2).

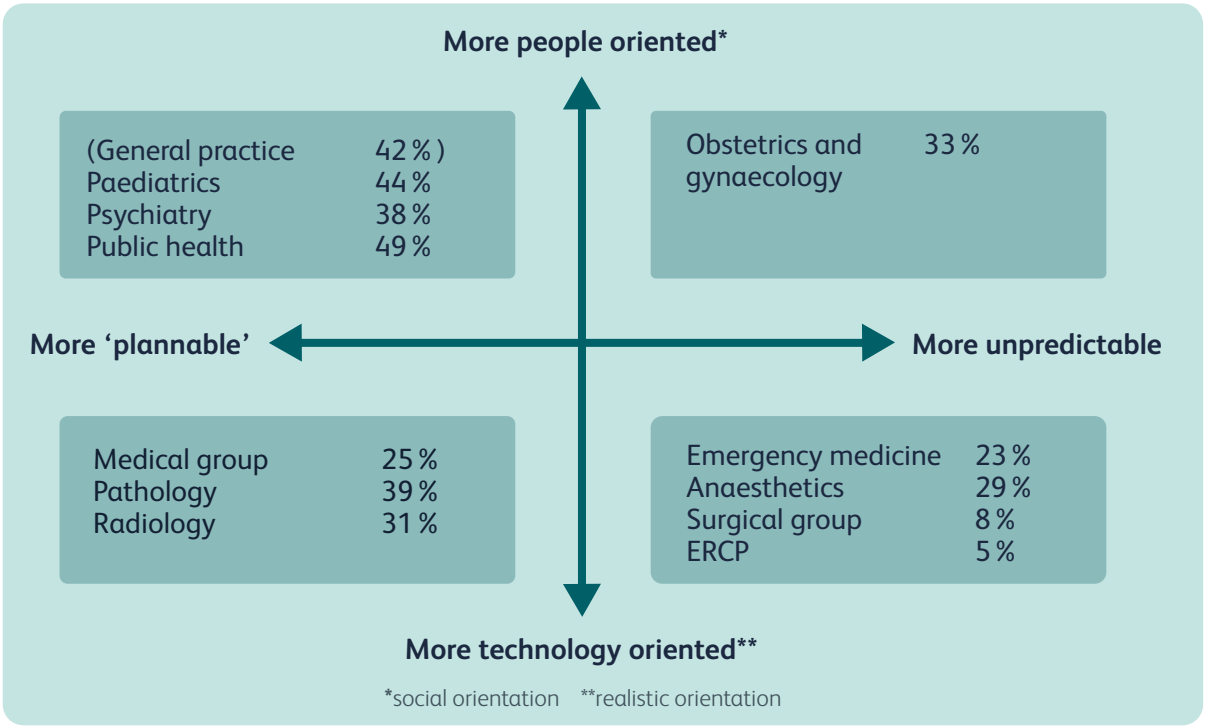


Fig 3: Specialty characteristics: % female consultants (and GPs) data from NHSE 2007.
Adapted from: RCP, 2009[11] to include BSG 2018 ERCP gender data.

In May 2026, the JAG training group agreed that once baseline data on the gender and ethnicity of JAG course faculty have been analysed, they will be audited and published annually.

Measuring the attainment gap in specific aspects of advanced endoscopy

This presents an opportunity to look for more detailed differences in attainment in advanced endoscopy disciplines. JETS data on progression in polypectomy competency could be used to perform an intersectional analysis according to core demographics.

This could be investigated by looking at progression in ERCP and EUS training.

Phase 3: Develop and implement a plan to reduce the attainment gap

Phase 3 will be informed by phases 1 and 2. The initial proposals below outline how JAG could help to close the attainment gap.

An ENT for compassion

According to Professor Michael West, emeritus professor of leadership at The King's Fund: 'Compassion invokes cognitive empathy', or the idea of 'stepping into someone else's shoes'.[16]

It is important for us to consider how the current workforce can actively help those trainees who may need additional support to become advanced endoscopists, and how we can embed a more compassionate and supportive approach to training.

JAG is exploring new ways to drive cultural change. We propose measuring compassion in the same way as other endoscopic non-technical skills on DOPS and DOTS forms for both trainees and trainers.

Fundamentally, advanced endoscopy is a high-risk activity. Endoscopy trainers should aim to create a psychologically safe space where trainees who need additional support feel able to take appropriate risks in high-stakes situations. Through nuanced communication, a compassionate approach might demonstrate to all trainees how endoscopists balance risk to achieve an attainable, safe outcome that is beneficial to the needs of the patient.[17]

Identifying trainees who need additional support

In phases 1 and 2 we should start to determine which groups may need additional support and how to help them to thrive. We will need to engage relevant stakeholders to communicate clearly with all trainee groups using targeted messaging supported by qualified mentors[18,19] across all four UK nations.

Supporting a planned absence to endoscopy training
Common reasons for a planned absence in training include maternity leave, compassionate leave, ill health and out-of-programme (OOP) experiences. This work represents an opportunity to produce guidance on returning to endoscopy training after a period of absence.

One option is to offer trainees additional endoscopy academy time to help them to return quickly to their previous skill level. The amount of time in an endoscopy academy will depend on their baseline (eg CIR %), the modality of training and the length of time out. Ideally, Reviewing JETS data could establish a 're-learning curve' showing how many lists or procedures are required to support their return.

Published guidance should support trainees to return to endoscopy training after a period of absence.

Educating everyone to speak up against discrimination
The WPSMS has demonstrated leadership in speaking out about concerns regarding discrimination in its specialty.[8] In the past, the BSG offered a programme for its members to access support through 'active bystander training'. The senior leadership in JAG could look into producing similar training in conjunction with its stakeholders and/or incorporate this into future JAG courses.

Changes to the training pathway
This report outlines the scale and nature of existing challenges in endoscopy. JAG believes that better integration of diagnostic skills training within the current curriculum is essential to creating a fairer training pathway (Fig 4).

The Inclusivity@JAG working group proposes a number of developments to enable better integration with the syllabus. These include:

- 1 year to reach independent diagnostic oesophagogastroduodenoscopy (OGD) certification
- ~3 years for the majority to reach independent colonoscopy status
- personalised ARCP outcomes to monitor annual endoscopy training targets
- personalised ARCP targets for those interested in advanced endoscopy
- better support for advanced endoscopists to enable them to achieve independence in colonoscopy sooner
- better access to advanced fellowships.

The Inclusivity@JAG working group proposes measures to support a more inclusive advanced endoscopy workforce. Options include:

- more access to endoscopy academies
- more NHS training lists (to support optimum expansion in 'Getting ahead of the curve')
- optimum NHS expansion to provide enough trainers in advanced endoscopy
- multiple, more diverse and empathetic regional mentors to improve workforce planning

Fig 4: Options suggested by the Inclusivity@JAG working group to be discussed with the gastroenterology specialist advisory committee (SAC) that might enable JAG to reach phase 5 in the medium and long term.

The approaches outlined in Fig 4 could form the basis of a fairer training pathway in diagnostic endoscopy training for all medical trainees and enable JAG to align with the GMC's expectations. Recently, NHSE created a streamlined training pathway for clinical endoscopists. No such pathway exists for medical trainees, who are likely to take up to 3 years to achieve colonoscopy certification as they also must achieve all the other competencies in their respective curricula.

Phase 4: Continuously measure and reduce the attainment gap

The JETS survey is proposed to be carried out every 2 years, combining a core bank of questions with new themed questions informed by the analysis of the data collected up to that point.

Phase 5: Eliminate surmountable barriers in advanced endoscopy and support an inclusive training environment in which diversity thrives. Targets to be set in phases 1–4.

Key information to be considered when developing targets:

1. The government intends to reduce international recruitment to the NHS to less than 10% by 2035.
2. The targets must include all demographics of the whole workforce and, where possible, level up to reflect the demographic of the future workforce.
3. The target can be challenging.
4. An incremental target will be achievable if we engage all stakeholders.
5. Involvement from other key stakeholders, including the BSG, NHS England, Scotland and Wales, will be crucial to delivering these goals.

Conclusion

This report identifies a differential attainment gap in endoscopy and sets out the steps needed to understand and address it. Phase 1 of JAG's approach to tackling differential attainment is already underway. We will publish annual progress updates on this work as well as presenting data on ethnicity and gender to relevant governance groups.

We encourage the advanced endoscopy workforce to embed a compassionate approach into all aspects of advanced endoscopy.



Dr Shairoz Samji
JAG EDI lead for training



References

1. Samji S. *British Society of Gastroenterology workforce report 2023*. British Society of Gastroenterology; 2023. Available from: https://www.bsg.org.uk/workforce-reports
2. Unpublished data from the General Medical Council data toolkit [Accessed July 2025].
3. General Medical Council. *Fair training pathways for all: final report*. GMC, 2016.
4. Mallorie S. NHS workforce in a nutshell. The King's Fund, 2024. https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/nhs-workforce-nutshell [Accessed July 2025]
5. Siau K, Elder L, Samji S *et al*. Career intentions of the UK endoscopy workforce: results from the 2023 UK-wide pan-workforce survey. *Frontline Gastroenterol* 2025;flgastro-2024-103039. https://doi.org/10.1136/flgastro-2024-103039
6. RCP census data toolkit for 2022. RCP, 2023.
7. Sethi S, Kumar A, Clough J *et al*. Women in gastroenterology: the UK trainee experience. *Frontline Gastroenterol* 2022;13:484–489.
8. Working Party on Sexual Misconduct in Surgery. *Breaking the silence: an independent report into sexual misconduct in the surgical workforce*. WPSMS, 2023.
9. Leng G. *The Leng review: an independent review into physician associates and anaesthetic associates*. 2025.
10. Ward ST, Mohammed MA, Walt R *et al*. *Gut* 2014;63:1746–54. https://doi.org/10.1136/gutjnl-2013-305973
11. Elston MA. *Women and medicine: the future*. Report prepared on behalf of the Royal College of Physicians, 2009.
12. Ravindran S, Cavilla R, Ashrafian H *et al*. Development of the TEAM-ENTS behavioural marker system. *Endoscopy* 2023;55:403–412. https://doi.org/10.1055/a-1959-6123
13. National Confidential Enquiry into Patient Outcome and Death. *Scoping our practice: the 2004 report of the National Confidential Enquiry into Patient Outcome and Death*. NCEPOD, 2004.
14. NHS England. *The medical training review: diagnostic report, part 1*. NHSE, 2025.
15. General Medical Council. National Training Survey 2025 results.
16. West M. *Compassionate leadership: sustaining wisdom, humanity and presence in health and social care*. The Swirling Leaf Press; 2021.
17. Byrne M, Campos C, Daly S, Lok B, Miles A. The current state of empathy, compassion and person-centred communication training in healthcare: an umbrella review. *Patient Education and Counseling* 2024;119:108063.
18. Kotha *et al*. Gender disparity in hepatobiliary endoscopy training and delivery: results of a nationwide survey. *Endoscopy International Open* 2025;13:a25056019.
19. Rabinowitz L Tal Grinspan L, Zylberberg HM *et al*. Survey finds gender disparities impact both women mentors and mentees in gastroenterology. *Am J Gastroenterol* 2021;116:1876–1884. https://doi.org/10.14309/ajg.0000000000001341

Appendix 1: JETS survey questions

Demographics

Gender: Male/Female/Prefer not to say

Endoscopist background: Gastroenterologist/Surgeon/Clinical Endoscopist

Primary healthcare qualification according to country of graduation:

	Medical degree	Nursing degree
UK		
Non-UK		

Ethnicity (as per UK Census):

Asian or Asian British
- Indian
- Pakistani
- Bangladeshi
- Chinese
- Any other Asian background

Black, Black British, Caribbean or African
- Caribbean
- African
- Any other Black, Black British, or Caribbean background

Mixed or multiple ethnic groups
- White and Black Caribbean
- White and Black African
- White and Asian
- Any other Mixed or multiple ethnic background

White
- English, Welsh, Scottish, Northern Irish or British
- Irish
- Gypsy or Irish Traveller
- Roma
- Any other White background

Other ethnic group
- Arab
- Any other ethnic group
- Prefer not to say

Age in yr groups: below 30yrs/30-34yrs/35-39yrs/40-44yrs/45-49yrs/50-54yrs/55-59yrs/60-64yrs/65+yrs/prefer not to say

Subspecialty interest according to endoscopy workforce background:

Clinical Endoscopist	Physician assistant	Medical consultant/ trainee subspecialty interest (s)	Surgical consultant/ trainee subspecialty interest	Radiology consultant subspecialty
Endoscopy nurse	Acute gastro ward training	Luminal – split further to: IBD/nutrition	UGI	UGI
Non-medical background	Other medical specialty	Hepatology	Colorectal	LGI
IBD nurse UGI/bariatric nurse	Surgical training	Advanced endo split into: lower GI therapeutics (incl BCS/ ERCP-EUS/3rd Space endo	HPB: ERCP and/or EUS	HPB: ERCP and/or EUS
Acute gastro ward training				
Surgical background (incl theatres)				

Sexual orientation:

- Heterosexual or straight
- Gay or lesbian
- Bisexual
- Other
- Prefer not to say

Working status:

- Full-time
- LTFT 60 % /LTFT 80 % /other
- If LTFT do you participate in a slot share on the general internal medicine (GIM) rota

Primary reason for LTFT training: caring responsibility/mental health disability/physical health disability/work/life balance/academic programme
(type of caring responsibility: elderly/disabled parent/child (number of children)
other relative with special needs [mental or physical])

Are you currently in-programme/or OOP

Reason for OOP: approved clinical training (OOPT), research (OOPR), career break (OOPC), clinical experience (OOPE), ATSM

Is the OOPR/OOPE to pursue an interest in advanced endoscopy? Yes/No

Geographical location according to training environment:

England: Endoscopy academies/Scottish deaneries/Welsh deaneries/NI

Staff contract type:

- IMT trainee
- Core surgical trainee
- LED according to rota slot– Tier 1 Med Rota/Tier 2 Medical Rota/Surgical reg rota/middle grade surgical rota
- NTN in gastroenterology
- NTN in surgery
- Locum consultant gastroenterologist
- Substantive consultant gastroenterologist
- Associate specialist

Modality of training (include combinations)

OGD/colon/UGI bleeding/ERCP/EUS/lower GI therapy/third space endoscopy

NTN trainee level:

ST4 gastro/ST5 gastro/ST6 gastro luminal/ST6 gastro hep/ST7 gastro luminal/ST7 gastro hep/ATP – hepatology

Surgical NTN trainees: ST3/ST4/ST5/ST6/ST7/ST8 +

subspecialty interest, eg gen surgery/colorectal/UGI/HPB

Access to training and non-training lists

Do you currently receive access to a reduced training list in your current modality of training on balance once a week when you are not on-call or on annual leave? Yes/No

Do you currently receive access to a service in your current modality of training list on balance once a week when you are not on-call or on annual leave? Yes/No

Do you attend additional training lists outside in your own time eg annual leave, 'off days' etc. Yes/No
If yes, daily/weekly/monthly/less than a month/never

Is there a cold site (an endoscopy unit within your trust that is situated away from acute inpatient work in which you support) in your current trust? Yes/No

If Yes - Are you provided with access to protected training lists at all cold sites?
once a week/once a month/rarely/never

Are you interested in a career in advanced endoscopy? Yes/No

If yes select top three reasons why

- Inspiring male role models
- Inspiring female role models
- Perceived gender equality at senior level
- Good access to mentorship
- Good exposure to this subspecialty within the training prwogramme
- Good access to advanced fellowships outside of training programme
- Opportunities to get involved with research in this subspecialty
- Perceived as one of the highest competitive entry subspecialties
- Perceived as one of the lowest competitive entry subspecialties
- Opportunities for more predictable job planning including flexible working patterns
- Greater emphasis on technical skills
- Greater emphasis on communication skills

If no, why?(select top three reasons)

- A lack of inspiring female role models
- A lack of inspiring male role models
- Perceived gender bias and inequality at senior level
- Lack of access to mentorship
- Lack of exposure to this subspecialty within the training programme
- Lack of access to advanced fellowships outside of a training programme
- Lack of opportunities to get involved with research during training
- Lack of opportunities to get involved with research after completion of training
- Perceived as one of the highest competitive entry subspecialties
- Perceived as one of the lowest competitive entry subspecialties
- Lack of opportunities for predictable job planning including flexible working patterns
- Training in this subspecialty usually requires moving/commuting long distances
- Requirement for work commitments during anti-social hours
- Greater emphasis on technical skills over communication skills
- Greater emphasis on communication skills over technical skills

If no to advanced endoscopy ask all-comers:

What further initiatives would support you to choose a career in advanced endoscopy? Please pick the three most important:

- Subspecialty-specific mentorship and sponsorship schemes
- Subspecialty trainee networking events
- More exposure to this specialty within the training programme
- Access to advanced fellowships which do not require moving or commuting long distances
- Access to training opportunities (including advanced fellowships) which allow flexible training
- Access to research opportunities which do not require moving or commuting long distances
- Access to research opportunities which allow flexible working patterns
- Increased awareness and elimination of existent bias within this subspecialty

Other, please state

Would you like to be put in touch with your regional endoscopy academy lead to make a 1:1 enquiry about accessing advanced endoscopy training in either BCS or ERCP-EUS? By clicking Yes you are consenting to your details to be automatically passed on to your regional endoscopy academy led or four nations equivalent.

Options Yes/No

Experiences of discrimination

Environment questions:

My current endoscopy unit provides a supportive environment for everyone regardless of background, beliefs or identity positive/negative
Established endoscopy staff are always treated with respect positive/negative

Discrimination questions:

Do you hear insults, stereotypes or jokes in your presence on the grounds of a person's protected characteristics? daily/weekly/monthly/less than a month/never

Do you experience micro-aggressions, negative comments or oppressive body language from trainees in your current unit? daily/weekly/monthly/less than a month/never

Do you experience micro-aggressions, negative comments or oppressive body language from trainers in your current unit? daily/weekly/monthly/less than a month/never

Are you given the same training opportunities as your peers at the same stage of training? daily/weekly/monthly/less than a month/never

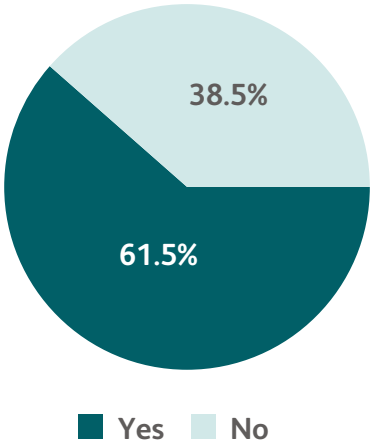
Do you experience unwelcome sexual comments or advances causing you embarrassment, distress or offence? daily/weekly/monthly/less than a month/never

Appendix 2: Snapshot SWiG survey carried out in 2023 on subspecialty career choices for women

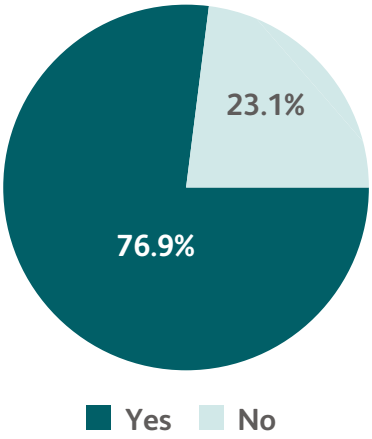
Kindly shared with permission from Dr Misha Kabir

Are there any subspecialty areas within gastroenterology that you believe are attractive or not to women?

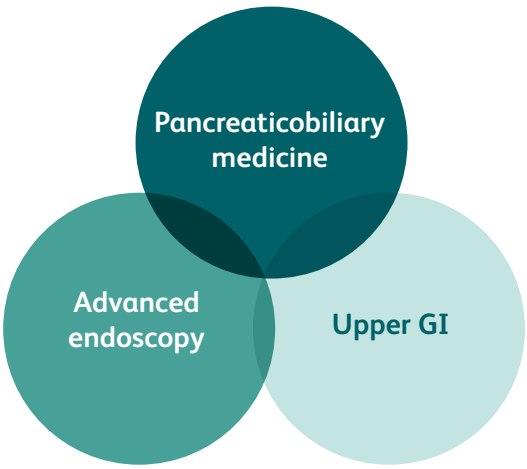
Attractive to women



NOT attractive to women

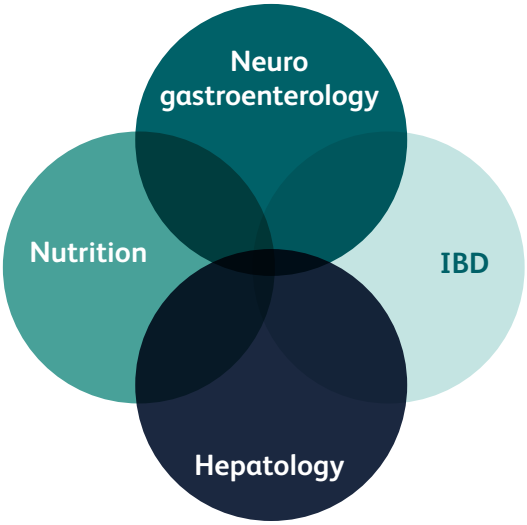


Subspecialty areas not attractive to women?



- A lack of inspiring female role models
- Perceived gender bias and inequality at a senior level
- Lack of access to mentorship
- Lack of opportunities for controllable hours
- Greater emphasis on technical skills over communication skills
- Lack of exposure to this subspecialty within the training programme
- Perceived as one of the highest competitive entry subspecialties

Subspecialty areas attractive to women?



- Inspiring female role models
- Good access to mentorship
- Perceived gender equality at senior level
- Opportunities for more controllable working hours
- Greater emphasis on communication skills
- Perceived as one of the lowest competitive entry subspecialties (nutrition only)

Further SWiG initiatives to support female sub-specialty training with lower representation, eg therapeutic endoscopy

1. **Increased awareness and elimination of existent gender bias within this subspecialty**
2. **Subspecialty-specific mentorship and sponsorship schemes**
3. **Access to training opportunities (including advanced fellowships) which allow flexible training**
4. **Access to advanced fellowships which do not require moving or commuting long distances**

This report was prepared by the JAG team.
The lead author was Dr Shairoz Samji, JAG EDI lead for training, supported by Dr Paul Dunckley, Jessica Butler and the Inclusivity@JAG working group.

With thanks to the JAG stakeholder group and JAG strategy group.

JAG

JAG is an independent endoscopy stakeholder organisation, hosted by the Royal College of Physicians and representing many organisations, including the Royal College of Surgeons, Royal College of Radiologists and Royal College of General Practitioners, along with the British Society of Gastroenterology, the Association of Coloproctology of Great Britain and Ireland and the Association of Upper GI Surgeons.

Royal College of Physicians

The Royal College of Physicians is a registered charity that aims to ensure high-quality care for patients by promoting the highest standards of medical practice. It provides and sets standards in clinical practice, education and training, conducts assessments and examinations, quality assures external audit programmes, supports doctors in their practice of medicine, and advises the government, the public and the profession on healthcare issues.

Copyright

All rights reserved. Applications for the copyright owner's written permission to reproduce significant parts of this publication (including photocopying or storing it in any medium by electronic means and whether or not transiently or incidentally to some other use of this publication) should be addressed to the publisher. Brief extracts from this publication may be reproduced without the written permission of the copyright owner, provided that the source is fully acknowledged.

© Royal College of Physicians, 2026

Royal College of Physicians

JAG Joint Advisory Group on GI Endoscopy