



Original research

British Society of Gastroenterology survey of UK gastroenterology trainees 2024: how is training shaping up?

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► Additional supplemental material is published online only. To view, please visit the journal online (<https://doi.org/10.1136/flgastro-2025-103114>).

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Received 23 March 2025

Accepted 22 June 2025

ABSTRACT

Objective Gastroenterology specialty training was reduced from 5 to 4 years following the implementation of the 2022 UK gastroenterology curriculum. The last British Society of Gastroenterology (BSG) trainee survey in 2022 revealed concerns about preparedness for consultant roles, which have been echoed in recent national training surveys (General Medical Council and Joint Royal College Physician Training Board).

This study reassessed gastroenterology trainees' perceptions of their preparedness for consultant roles, the impact of increased internal medicine (IM) commitments and barriers to procedural and specialty training.

Method The BSG Trainees Section conducted an anonymised web-based survey between June and July 2024.

Results A total of 429 (65%) trainees across all 18 UK deaneries responded. Most (81.7%) reported exceeding the indicative 25% IM training time. Barriers to endoscopy training were widespread, with 94.4% encountering difficulties and two-thirds voluntarily working on days off to gain endoscopy experience. Only 15.9% of respondents had out-of-hours acute upper gastrointestinal bleeding (AUGIB) exposure, with 98.5% advocating for structured AUGIB accreditation. The removal of colonoscopy accreditation from the hepatology pathway discouraged 43.5% of respondents from pursuing hepatology as a subspecialty. 42.5% of respondents plan to work less than full time as consultants.

Conclusions This study highlights persistent challenges in gastroenterology training, including excessive IM commitments, inadequate endoscopy exposure and concerns regarding the future workforce. The findings support validated

WHAT IS ALREADY KNOWN ON THIS TOPIC

- ⇒ Gastroenterology training was reduced from 5 to 4 years following the implementation of a new gastroenterology curriculum in 2022.
- ⇒ The new curriculum moved away from time-based training in favour of competency-based targets, with an indicative internal medicine (IM) commitment of 25% suggested to enable achievement of both IM and gastroenterology competencies within 4 years.
- ⇒ In 2022, trainees expressed concerns about preparedness for consultant roles, with only 10% feeling they would be 'consultant ready' at completion of the 4 years of training. The impact of IM commitments on gastroenterology training was specifically cited, with many trainees struggling to achieve endoscopy competencies due to excessive IM duties.

training time calculations, structured endoscopy immersion training, AUGIB accreditation and flexibility of hepatology training requirements to ensure competency and retention of future consultants.

INTRODUCTION

Gastroenterology specialty training has been significantly overhauled following the 2013 Shape of Training report. Most notably, it has been condensed from a 5-year to a 4-year programme, with a year of specialty training replaced by a dedicated internal medicine (IM) year. ST5 trainees (ie, trainees in their second year of specialty training) must also now



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To cite: Sivananthan A, Gwenter R, Kerry G, *et al*. *Frontline Gastroenterology* Epub ahead of print: [please include Day Month Year]. doi:10.1136/flgastro-2025-103114

WHAT THIS STUDY ADDS

- ⇒ The survey received the largest ever engagement from a British Society of Gastroenterology trainees survey (65% response rate).
- ⇒ Only 15.8% (64/404) of respondents felt they would be ready to achieve a certificate of completion of training (CCT) as a consultant gastroenterologist on completion of their gastroenterology training.
- ⇒ The majority of respondents' rotas (81.7%) exceed the indicative 25% IM training requirement, which significantly impacts their procedural and specialty training.
- ⇒ The vast majority (94.4%) of respondents reported barriers to endoscopy training, with over two-thirds voluntarily working on days off to gain experience. A paucity of acute upper gastrointestinal bleeding (AUGIB) experience was also highlighted, with overwhelming support from respondents for a structured AUGIB accreditation process.
- ⇒ The removal of colonoscopy accreditation from the hepatology pathway dissuaded almost half (43.5%) of respondents from pursuing hepatology as a subspecialty.
- ⇒ 42.5% of respondents intend to work less than full time (LTFT) as consultants.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

- ⇒ Excessive IM commitments suggest a need for a validated training time calculator to ensure appropriate training distribution.
- ⇒ The significant shortfall in endoscopy training suggests the need for structured immersion training and subspecialty-focused advanced training years. It also supports formal accreditation for AUGIB competency.
- ⇒ The high proportion of trainees planning LTFT consultant careers and/or post-CCT fellowships suggests that expanding trainee numbers alone may not resolve workforce shortages, while the future hepatology workforce may be negatively impacted by the removal of colonoscopy accreditation from the hepatology training pathway.

choose between a hepatology or luminal pathway for their final 2 years of training, with full certification in colonoscopy expected on completion of the luminal pathway.¹

Trainees have expressed many concerns regarding the introduction of this new specialty training programme, with only 10% of respondents to the last British Society of Gastroenterology (BSG) Trainees Section survey stating they would be 'consultant ready' on completion of the new training programme.² Specific concerns were raised about the interplay between gastroenterology and IM training, as well as barriers to achieving endoscopy competencies. There was also a notable trend towards a preference for less than full-time training (LTFT) and post-certificate of completion of training (CCT) fellowships, which raised the

question of how the predicted growing workforce shortage would be addressed.³

Similar findings have been echoed in subsequent independent national surveys. As recently as last year, 39% of gastroenterology trainees responding to the General Medical Council (GMC) national training survey reported not being on course to complete their procedural numbers, and 63% felt IM service commitments were significantly impacting on their opportunities to gain sufficient gastroenterology training.⁴ Concerns were shared by consultant colleagues, with only 2% of trainers surveyed by the unpublished 2023 Joint Royal College Physician Training Board (JRCPTB) curriculum implementation group feeling that the new curriculum has had a positive impact on gastroenterology specialty training. Now 2 years on following its implementation, we aimed to assess trainees' perception of the ongoing impact of the new curriculum and the current state of gastroenterology training in the UK.

METHODS

The BSG Trainees Section conducts a biennial UK-wide survey of all gastroenterology trainees, including ST4–7 trainees and those on out-of-programme (OOP) pathways. The survey questions were adapted from previous iterations to focus on the most pertinent questions related to current training priorities (online supplemental appendix 1). The survey was developed using a web-based survey tool (SurveyMonkey) and disseminated via email by BSG trainee regional representatives to all trainees within their regions. This provided all trainees with equal opportunity to respond. The survey was also advertised via QR codes at BSG LIVE 24 and via the BSG Trainees Section 'X' account. The survey was open between 6 June 2024 and 10 July 2024. Survey data were analysed using Excel V.16.7. Graphs were plotted in GraphPad Prism V.10.2.0. Figures were generated using BioRender 2025. The denominators varied due to not all questions being compulsory.

Patient and public involvement

No patients were involved.

RESULTS

There was a 65.0% response rate (429/660 gastroenterology trainees) to the survey, with representation from all 18 deaneries (online supplemental appendix 2). 41.5% (178/429) of respondents were female and 57.3% (246/429) were male. Three-quarters of respondents (320/428) were employed on a full-time contract and all training grades between ST4 and ST7 were well represented (table 1).

Impact of IM)

In total, 300 respondents were part of an IM rota. 81.7% (245/300) reported spending more than a

Table 1 Demographic data of 429 survey respondents

Demographic data	Respondents, n (%)
Gender	
Female	177 (41.4)
Male	246 (57.5)
Non-binary	1 (0.2)
Prefer not to answer	4 (0.9)
Prefer to self-identify	0 (0.0)
LTFT	
Yes	108 (25.2)
No	320 (74.8)
Training grade	
ST4	110 (25.7)
ST5	115 (26.9)
ST6	70 (16.4)
ST7	63 (14.7)
ST8	2 (0.5)
Other*	13 (3.0)
OOP	55 (12.855 (12.8))
*Locum Appointment for Training/Locum Appointment for Service/ Academic Clinical Fellow/Academic Clinical Lecturer/Research Fellow). LTFT, less than full time; OOP, out of programme; ST, specialty training year.	

quarter of their training time working in IM, including 15.0% (45/300) spending more than half. The majority (79.2%, 236/298) of respondents viewed the proportion of training time spent in IM as 'too much' and 68.6% (203/296) would find a training time calculator useful to accurately determine the proportion of training time spent in gastroenterology versus IM.⁵ Only 28.0% (83/297) of respondents had dedicated blocks of gastroenterology-specific training. Taking annual leave and study leave while working in IM was possible for only 2.0% and 1.3% of respondents, respectively. For the remainder of respondents, such leave could only be scheduled while working in gastroenterology. For 68.8% (206/295) of respondents, the

requirement to attend 20 IM clinics had a negative or very negative impact on their gastroenterology training.

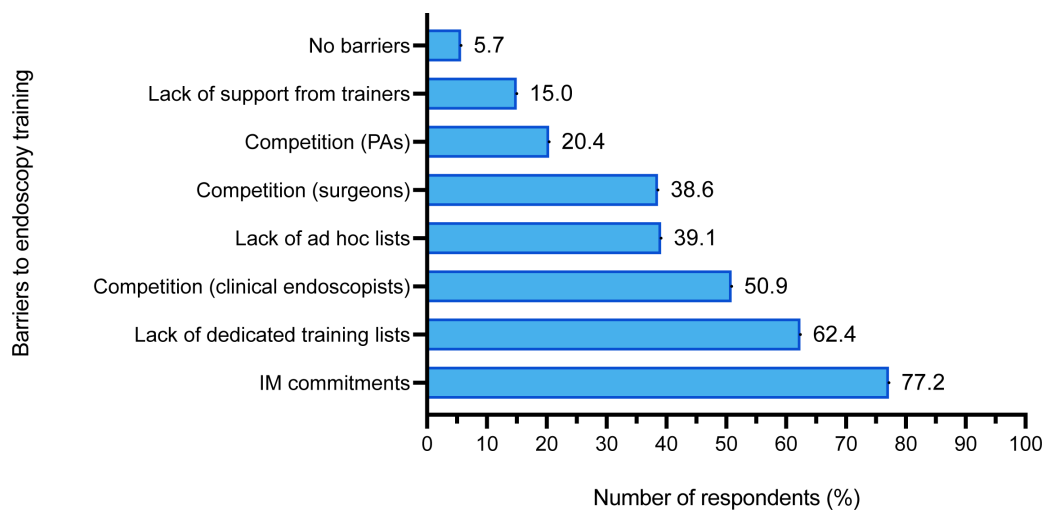
Endoscopy training

Accreditation in diagnostic upper gastrointestinal (GI) endoscopy had been achieved by 79.5% (330/415) of respondents. This was the case for 90.4% (103/114) of ST5s and 98.6% (68/69) of ST6s. Those training in upper GI endoscopy reported being able to attend a median of 3 training lists per month, and 44.3% (85/192) were able to participate in immersion training. Of ST7 respondents, 68.2% (43/63) reported independence in foreign body removal, 65.1% (41/63) in nasojejunal tube placement, 55.6% (35/63) in percutaneous endoscopic gastrostomy (PEG) placement and 31.8% (20/63) in upper GI dilatation.

With regard to colonoscopy, 21.4% (88/411) of respondents had achieved accreditation, 64.7% (266/411) were training towards this, and 13.9% (57/411) were not training in colonoscopy. Only 45.6% of ST7s training in colonoscopy had achieved sign off (26/57). Those training in colonoscopy reported being able to attend a median of 3 lists per month, and 29.4% (103/350) were able to participate in immersion training.

Barriers to endoscopy training were reported by 94.4% (385/408) of respondents. 77.0% (314/408) cited IM commitments negatively impacting training opportunities, while 62.3% (254/408) and 39.2% (160/408) reported lack of dedicated training lists and ad hoc lists, respectively. With regard to available training opportunities, 50.1% (208/408), 38.5% (157/408) and 20.3% (83/408) of respondents reported competition from surgical trainees, clinical endoscopists and physician associates (PAs), respectively (figure 1).

Two-thirds (66.7%, 272/408) of respondents had voluntarily worked on their days off for endoscopy

**Figure 1** Barriers to endoscopy training. IM, internal medicine; PAs, physician associates.

experience, with 9.6% (39/408) doing so weekly and 15.7% (64/408) doing so fortnightly.

Acute upper GI bleeding endoscopic competence

The opportunity to contribute to a bleed rota for out of hours experience in acute upper GI bleeding (AUGIB) management was available for 15.9% (64/402) of respondents. In terms of in hours experience, 16.7% (67/402) had regular ad hoc exposure, 47.8% (192/402) had occasional ad hoc exposure and 19.7% (79/402) reported no exposure. 27.9% (112/402) of respondents had not delivered endotherapy for AUGIB in the last 3 months, while 38.3% (115/402) reported delivering endotherapy for 1–2 AUGIB cases within this time.

Among ST7 respondents, 84.1% (53/63) reported independence in managing both oesophageal variceal and non-variceal bleeds. A minority reported independence in management of gastric variceal bleed (38.1%, 24/63), Sengstaken-Blakemore tube placement (49.2%, 31/63) and Danis stent placement (17.5%, 11/63).

Of all respondents, 98.5% (398/404) felt they would benefit from spending at least 6 months on an out-of-hours on-call bleed rota. 45.0% (182/404) have attended a haemostasis course, of which 95.6% (174/182) judged it to be beneficial. Of those who had not attended a haemostasis course, 96.4% (214/222) felt doing so would be beneficial. The majority of respondents (82.9%, 334/403) felt trainees would benefit from a formal accreditation process for AUGIB management (ie, formal assessment of competency to manage AUGIB independently).

Training pathways

A quarter of respondents (25.7%, 110/429) work LTFT, while over a third of full-time respondents (34.4%, 110/320) are considering this during their gastroenterology training. For those considering LTFT or currently working LTFT, the most common reasons for doing so respectively were work–life balance (65.5% (72/110) and 57.1% (60/105)), family and friends (50.0% (55/110) and 55.2% (58/105)), experiencing/being concerned about burnout (50.0% (55/110) and 25.7% (27/105)) and to reduce the burden of IM commitments (40.0% (44/110) and 19.1% (20/105)).

In total, 30.1% (131/423) of respondents are either currently or have previously been OOP. Of the remaining respondents, 47.9% (140/292) are currently applying or considering applying. The most common reasons for choosing or considering going OOP were to pursue specialist interests outside the curriculum competencies (70.6%, 190/269), to enhance curriculum vitae (61.3%, 165/269), to meet curriculum competencies (36.4%, 96/269), to reduce the burden of IM commitments (29.0%, 78/269) and for work–life balance (29.0%, 78/269).

The removal of colonoscopy accreditation from the hepatology pathway had discouraged 43.5% (180/414) of respondents from pursuing the hepatology pathway. Of those on, or considering, the hepatology pathway, only 13.8% (15/109) were not interested in colonoscopy training. Of the remainder, 18.0% (17/94) were signed off for colonoscopy, 51.1% (48/194) were currently training towards sign off and 30.1% (29/94) had been advised to stop colonoscopy training due to lack of access to training lists.

Almost half of respondents were considering post-CCT fellowships (47.5%, 200/421). Reasons for doing so included to pursue a specialist interest outside of curriculum competencies (72.0%, 140/200), to enhance curriculum vitae (53.5%, 107/200) and to meet curriculum endoscopy competencies (52.0%, 104/200).

Workforce planning

Trainees were surveyed regarding the degree of exposure they had to subspecialties when determining if they would like to pursue these as a consultant. The highest reported subspecialty exposures (rated as ‘good’ or ‘sufficient’) by respondents were inflammatory bowel disease (68.2%, 283/415) and hepatology (64.8%, 269/415). The subspecialties with the lowest reported exposure were small bowel enteroscopy and lower GI, advanced endoscopy (7.7%, 32/414), upper GI advanced endoscopy (10.4%, 43/415) and endoscopic retrograde cholangiopancreatography/endoscopic ultrasound (10.4%, 43/414) (figure 2). Respondents’ preferences regarding consultant subspecialty interests are outlined in figure 3.

While 80.5% (325/404) of respondents felt they would be ready to CCT as a consultant in IM after 4 years of training, only 15.8% (64/404) felt they would be ready to CCT as a consultant gastroenterologist within this time. Only 14.4% (58/404) intend to pursue a consultant post with IM commitments, and 42.5% (176/414) of respondents stated they plan to work LTFT as a consultant.

The majority of respondents felt that PAs had a role in gastroenterology ward work (72.6%, 294/405), but only 23.2% (94/405) felt they had a role in outpatient clinics and 5.9% (24/404) felt they had a role in performing endoscopy. As a future consultant, only 7.4% (30/405) of respondents would want to train or supervise a PA endoscopist.

DISCUSSION

This survey elicited the highest response rate of any BSG Trainees Section survey of gastroenterology trainees, improving from 40.3% in 2022 to 65.0%. This may reflect the strength of feeling about the provision of gastroenterology specialty training now that trainees have had sufficient experience of the new curriculum.

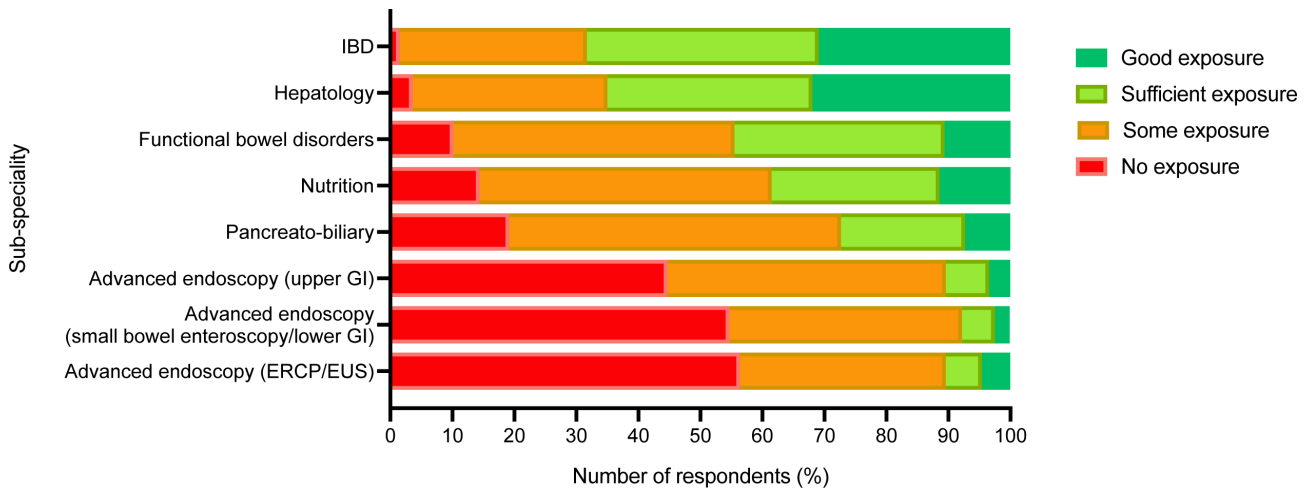


Figure 2 Respondents' perceived subspecialty exposure. ERCP, endoscopic retrograde cholangiopancreatography; EUS, endoscopic ultrasound; GI, gastrointestinal; IBD, inflammatory bowel disease.

Concerningly, 84% of trainees do not feel they will be ready to be a gastroenterology consultant after 4 years of training, with many taking or considering additional OOP or post-CCT training in order to achieve the necessary competencies. Whereas post-CCT training was historically viewed as an opportunity to acquire additional subspecialty skills, we now risk it becoming a component of achieving basic curricular outcomes. Two thirds of respondents attend endoscopy training on non-working days in order to achieve their endoscopy competencies. Taken together, these data demonstrate the current shortfalls in training, particularly with regard to procedural competencies. It also highlights potential threats to trainee well-being and the risk of burn-out.

The concerning impact of disproportionate time spent in IM on gastroenterology training is a clear theme throughout our results. Interestingly, similar concerns about the impact of IM on procedural and specialty competence were raised in the recently

published consensus statement by cardiology trainees, suggesting this is not a specialty-specific issue.⁵

When the 2022 curriculum was introduced, gastroenterology was the only group 1 specialty with a 4-year curriculum that received GMC approval for an indicative 25% time limit on IM training. This was felt necessary to preserve the time trainees would require to achieve the heavy procedural training demands of gastroenterology as a 'craft specialty'. It was acknowledged that changes to IM rotas would be required in trusts heavily reliant on gastroenterology trainees to sustain on-call rotas.¹ Concerns about ensuring adherence to this were raised by the BSG Trainees Section in 2021 to the JRCPTB.⁶ However, no mechanisms were established to monitor or ensure adherence to this limit, which has enabled trusts to fill medical on-call rotas as they see fit. Furthermore, the 25% IM training time should reflect the inpatient management of IM on specialty wards, participation in IM clinics, as well as IM on-call duties and managing the acute unselected

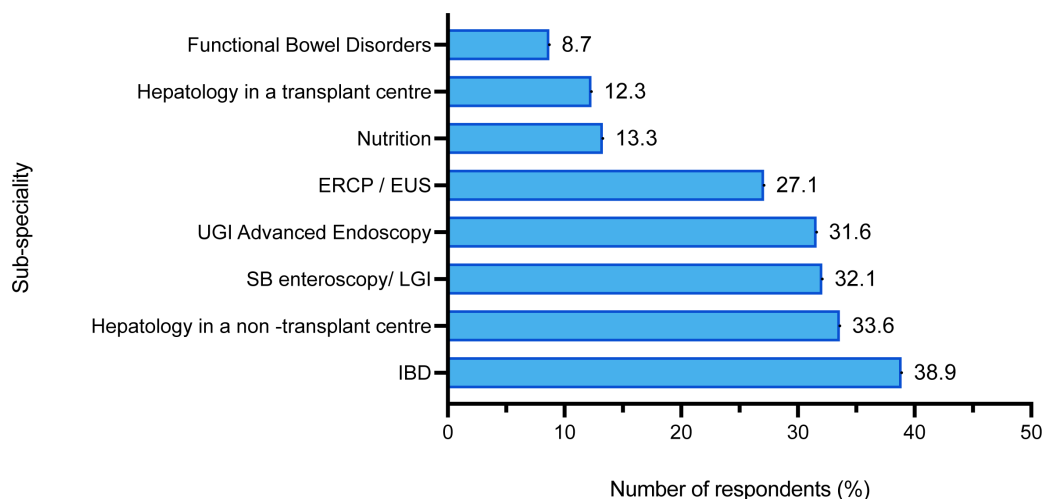


Figure 3 Respondents' preferences regarding consultant subspecialty interests. ERCP, endoscopic retrograde cholangiopancreatography; EUS, endoscopic ultrasound; IBD, inflammatory bowel disease; LGI, lower gastrointestinal; SB, small bowel; UGI, upper gastrointestinal.

take (AUT). Gastroenterology trainees already achieve considerable exposure to IM given the wide range of non-gastroenterological comorbidities encountered among patients on gastroenterology wards in addition to their AUT and on-call experience. In the absence of a robust mechanism to monitor training time proportions, although based on self-reporting of working patterns, we have identified that the vast majority of respondents participating in an IM rota are having to far exceed the indicative 25% IM training time with this one component of IM training alone. Importantly, this is also increasingly taking the shape of out-of-hours management of the AUT, where consultant supervision and opportunities for feedback are limited. Prolonged failure to protect gastroenterology training time has led to an unjustifiable reduction in the specialty time available for trainees.

Once again, endoscopic competence has been highlighted as an area for further focus. There is a growing demand for endoscopy provision, and the impact of quality endoscopy on patients and cancer outcomes is becoming clearer.⁷⁻⁹ This is mismatched, however, by a diminishing endoscopic workforce,^{10 11} which will be further stretched by trainees who are unable to meet basic endoscopy competencies during their training.^{12 13} As endoscopy services have recovered in the aftermath of the COVID-19 pandemic, there has been a positive trend in upper GI endoscopy competency rates, with more than 90% of trainees achieving competence in ST5. However, concerningly, only a minority of ST7 respondents had achieved colonoscopy accreditation, despite the expectation of full certification to enable completion of the luminal training pathway.¹ Competence in basic therapeutic endoscopy is also an issue, with fewer than two thirds of ST7 respondents confident in placing an NJ tube and just over half in placing a PEG. These procedures are required by a broad range of patients. If trainees are not receiving adequate training to provide these endoscopic interventions as qualified consultants, it raises the question as to how future gastroenterology services will be able to continue offering them.

The significant majority of trainees did not feel PAs had a role in endoscopy or clinic but did have a role on the ward. Potential expansion of PAs in endoscopy could exacerbate training issues. PAs may be better placed to support the ward base in a more supervised environment while allowing trainees more access to endoscopy. The scope of practice of PAs is beyond the remit of this paper, but only 7% would be happy to supervise or train PAs in endoscopy, which may indicate the feeling of the future consultant workforce.

Despite the high mortality associated with AUGIB, only a minority of respondents had exposure to an out-of-hours bleed rota, and final year respondents reported insufficient competence in managing variceal bleeding independently—despite their upcoming role on a consultant bleed rota. It is imperative that

those who are soon to be responsible for delivering potentially lifesaving emergency interventions receive the appropriate training. The demonstrated relative absence of this training alongside the lack of a safeguard for assessing independent competence in this endoscopic modality represents a significant patient safety concern that must be addressed as a priority. When it comes to future discussion and negotiations regarding curriculum design, the crucial role of the endoscopy service to patient care, and its reliance on suitably skilled endoscopists, must be recognised.

Nutrition training is a mandatory core component of gastroenterology specialty training. Despite this, nutrition outcomes were inexplicably omitted from the 2022 curriculum, which necessitated an application to the GMC to have these reinstated.¹⁴ Concerningly, only 38% of trainees reported sufficient or good exposure to nutrition during training. This raises serious concerns about our specialties' ability to deliver appropriate nutrition support services in future and necessitates amendments to the curriculum and improvements in the exposure and experience that trainees receive.

A limitation of this study was its reliance on subjective reporting. However, competence in training is notoriously hard to measure objectively, and experienced trainees' assessment of their own competence should be deemed a reasonable surrogate marker and merits consideration. Indeed, the Annual Review of Competency Progression Capabilities in Practice are now based on the combined subjective judgement of both trainees and their educational supervisors as thresholds for competence.

Proposed solutions

Internal medicine

A clear reported barrier to achieving gastroenterology training competencies is the impact of excessive IM service provision. There must be robust safeguards to protect gastroenterology training time. We, therefore, recommend the introduction of a validated training time calculator, as employed by cardiology trainees and accepted by the cardiology Special Advisory Committee (SAC)¹⁵ as a mechanism for trusts and regional training leads to ensure that the indicative 25% IM training proportion is not exceeded. We note the JRCPTB document recently shared with training leads that advocates for block training and agree that blocks of pure gastroenterology training time with no IM commitment should be built in across the training programme, in order to ring-fence gastroenterology training time and benefit training continuity and the acquisition of procedural and sub-specialty skills (figure 4). Another solution to protect gastroenterology training time is to ensure that accrued leave can be taken equitably. Fewer than 2% of respondents have been able to take any annual leave or study leave during their IM training time, which further exacerbates the imbalance of training time as all leave must

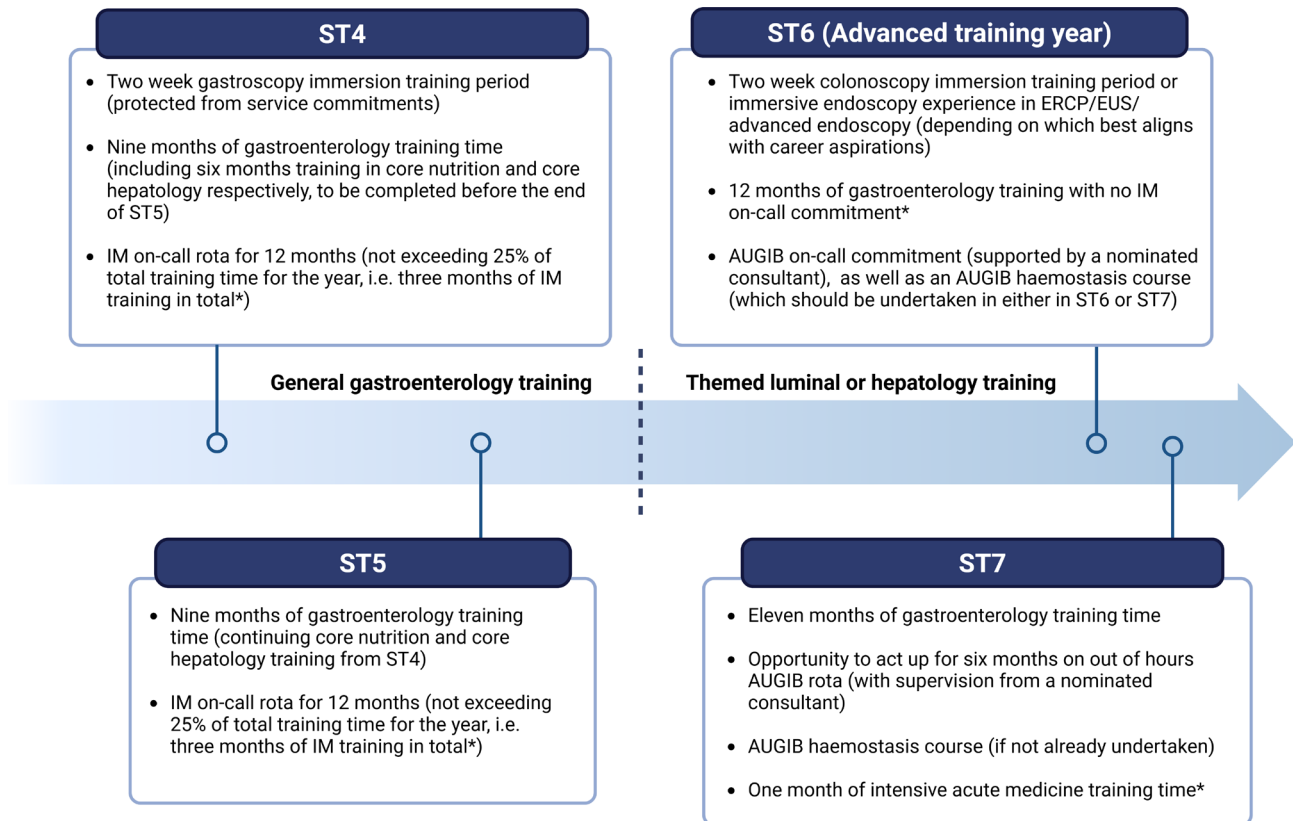


Figure 4 Proposed training pathway model. AUGIB, acute upper gastrointestinal bleeding; ERCP, endoscopic retrograde cholangiopancreatography; EUS, endoscopic ultrasound; IM, internal medicine; ST, specialty training year.

then be taken during gastroenterology training time. The JRCPTB takes a strong stance on annual leave and study leave, stating that this should be taken equally during both IM and specialty training. Specifically, they state that it is “*not appropriate to refuse either during IM blocks of training in order to preserve out of hours rotas*”.¹⁴

Endoscopy training

The benefits of immersion training have been highlighted.¹⁶ We recommend that funding is prioritised to make immersion training more widely available to help optimise endoscopy training through increased and consecutive procedure exposure. We remain concerned about suggestions that the established, accredited and validated Joint Advisory Group (JAG) training models should be replaced by subjective supervisor sign-off. We are also concerned about suggestions of reduced support to attend the basic skills endoscopy courses. Much work is being done on improving the quality of endoscopy, and any removal of the evidence-based endoscopy training schemes would be a concerning backwards step. We propose that endoscopy training should focus on early immersion training, as successfully achieved in some regions.^{17 18} Objective JAG-accredited pathways need to be utilised, with trainees being financially supported to attend these courses.

Opportunities for advanced endoscopy training should be built into the training programme to mitigate the large exodus of consultant endoscopists over the next 5 years. Such steps are essential in order to produce, at minimum, endoscopists who are competent in basic skills, and a workforce suitably prepared to tackle an ever-increasing endoscopy workload.

Acute upper GI bleeding

We advocate that AUGIB certification would allow standardisation of training and empower Training Programme Directors (TPDs) to prioritise trainees' exposure to AUGIB in order to achieve the accreditation criteria. This was supported by an overwhelming majority of respondents. An online module developed by the BSG Endoscopy Section, via the BSG Endoscopy Quality Improvement Programme, would ideally be an additional component of this proposed sign off. We also concur with the AUGIB Steering Committee's recommendation of mandatory participation in bleed rotas, based on their trainee and trainer survey data.¹⁹ We suggest this should include bleed rota on-call exposure in lieu of a proportion of IM on-calls. Trainees should also be supported to attend a haemostasis course to maximise familiarity with less common haemostatic techniques, which may otherwise not be encountered during training.^{19 20}

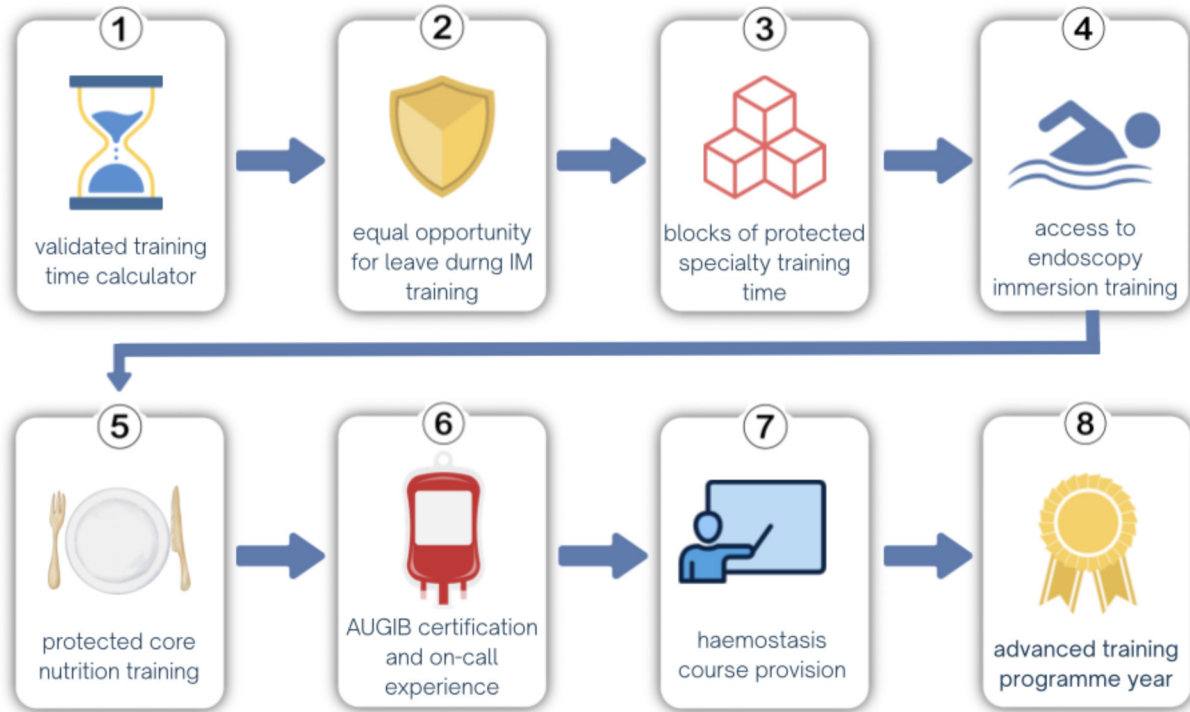


Figure 5 Proposed solutions to improve gastroenterology training. AUGIB, acute upper gastrointestinal bleeding; IM, internal medicine.

Subspecialty training

Nutrition training must be prioritised appropriately. Improved structuring of placements, increased educational opportunities and exposure to this subspecialty at an earlier stage are required to ensure competency in nutrition is reliably achieved during gastroenterology training.²¹ Hepatology has become a less attractive subspecialty following the removal of colonoscopy training. Given a large proportion of hepatology trainees are intending to work in non-transplant centres and given the mounting need for independent endoscopists to meet the growing backlog of colonoscopies, we recommend that there should be a reconsideration of hepatology training requirements to allow the flexibility needed for some consultants to maintain a broad endoscopic skill base. An advanced training programme year taken by all trainees in ST5 or ST6 in a subspecialty with no IM commitment would both mitigate the disproportionate impact of IM and address the concerns about subspecialty exposure within training and meeting of endoscopic competences (figure 5).

CONCLUSIONS

This survey provides a representative and stark assessment of the current state of gastroenterology training by gastroenterology trainees. Our findings are in keeping with those of other surveys from JRCPTB, GMC and other specialist interest groups, which notably highlighted concerns from trainers as well as trainees. A significant and pervading issue is the impact of disproportionate time spent in IM on the craft and specialty training required of the future gastroenterology workforce. There has already

been positive and productive discussion and engagement from many key stakeholders including the BSG Executive Committee, the SAC and the JRCPTB regarding this matter, yet further action is needed. We are fortunate that the BSG remains a strong advocate of trainees and continues to lead on discussions about these training challenges at a national level.

The challenges facing our workforce are well documented, and the growing demand for skilled gastroenterologists to address the increasing burden of GI and liver diseases underscores the urgent need for reform. Yet we have demonstrated that the training programme as it stands is not fit for purpose; failing to prepare today's trainees for their future consultant roles, both in terms of exposure to relevant specialty experience and the opportunity to develop the requisite endoscopic competencies. Without intervention, UK gastroenterology training risks a generational shortfall of adequately skilled consultants.

We have highlighted potential avenues to improve and innovate training, including but not limited to blocks of dedicated gastroenterology training time, AUGIB accreditation and advanced training programme years. Solutions should be mandated to empower TPDs to best advocate for trainees. There is a call for change across the specialty—not just for the benefit of trainees, but for our patient population who deserve high quality care from a well-trained gastroenterology workforce.

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Acknowledgements Abdulhameed Rahimi, Zaw Myo Aung, Daniyal Baig, Heather Blair, Jennifer Cathcart, Yaa Danso, Lucy Gorard, Mujtaba Hasnain, Ian Macpherson, Ciara McAuley, Jessica Shearer, Burhan Uddin, Laura White, Alexander Johnston, Hannah Morgan, Sarah Hancox, Josh Orpen-Palmer, Asim Hamza, Mohamed Shihha, Olivia Taylor, Nikki Husbands and Liz Elder.

Contributors AS, GK, RGw, ES and AJ wrote the manuscript. YH, RGa, AJ and DL contributed to the review of the paper. AS is the guarantor.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not applicable.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement Data are available on reasonable request.

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