The Nurse Endoscopist

SUMMARY

1. There is increasing interest and demand from within both the medical and nursing professions for nurses to perform endoscopy.
2. Studies have shown that nurses can develop the necessary skills. In addition they have the support of the United Kingdom Central Council for Nursing.
3. Medico-legally a nurse may perform an endoscopy provided he/she has received the appropriate training, has the support of the Health Authority/Trust and is adequately supervised by the responsible consultant.
4. Nurse Endoscopy should be restricted to diagnostic oesophago-gastro-duodenoscopy and sigmoidoscopy with or without biopsy on non-sedated patients at the present time, carried out in a recognised hospital Endoscopy Department.
5. Careful patient selection is essential to exclude high risk patients, those likely to need therapeutic procedures or requiring sedation.
6. Nurse Endoscopist training should follow the same schedule recommended for medical endoscopy by the British Society of Gastroenterology (BSG) and should include attendance at a recognised teaching course in endoscopy. The training should include anatomy and physiology relevant to the type of endoscopy being performed.
7. A designated medical Endoscopist should be immediately available within the Hospital during Nurse Endoscopy sessions.
8. The nurse should be responsible for obtaining consent from the patient prior to endoscopy and for discussing the findings with the patient after the procedure.
9. The nurse should be responsible for preparing the endoscopy report which he/she should sign. However further patient management should remain the responsibility of the supervising doctor.
10. Regular records and audit of the Nurse Endoscopist's work should take place.
11. Continuing education is essential with regular opportunities to attend Endoscopy courses and meetings.

Conclusion
The Working Party supports the proposition that suitably trained and supervised nurses should carry out those types of diagnostic Endoscopy set out above.

1. Introduction

There is increasing interest and a growing demand within the medical profession for advice and information about the creation of Nurse Endoscopy posts. Although we are unaware at the present time of such posts within the United Kingdom, there are several established posts in the United States where nurses perform screening flexible sigmoidoscopies (Ref 1). Specialist gastroenterology nurses, however, have been appointed in the United Kingdom and it is the intention in some of these posts, that in due course, endoscopy may become part of the nurses' role. Furthermore, advertisements for posts for nurses to perform flexible sigmoidoscopies are already appearing in the British Journals.

This ground swell of interest coincides with the ever increasing demand for endoscopy, driven by an increasing range of diagnostic and therapeutic options in endoscopy, purchaser demands for open access endoscopy and by trends in health care nationally, leading to an increased pressure to screen for gastrointestinal malignancy. Where open access is offered, referrals for upper gastrointestinal endoscopy now approach 1% of the population annually.

These demands are beginning to outstrip the capacity for medical endoscopists to provide an effective service. Furthermore these demands may lead to specialist gastroenterologists spending a disproportionate amount of time endoscoping. It is therefore timely to examine the proposed role of 'The Nurse Endoscopist' to complement and increase the capacity of existing medical endoscopy teams.

This report addresses the philosophical and practical issues that arise from nurses taking on the role of Endoscopists.

2. General Considerations and Philosophical Issues

2.1 Is It Appropriate For Nurses To Undertake Endoscopy?
In recent years, the role of the nurse has undergone substantial change and in particular has been extended to provide specialist nurse skills in such areas as I.T.U., coronary care, oncology, nutrition, diabetes, and stoma care. A logical progression of the 'Specialist Nurse' role is in the area of gastroenterology, the large inflammatory bowel disease patient workload perhaps being analogous to the large diabetic or chemotherapy patient workload of the Diabetologist or Oncologist. Nurses have formed an integral and essential part of the gastrointestinal team assisting in all gastrointestinal technical procedures. In many units they have taken on the full responsibility of such procedures as Crosby capsule small bowel biopsies, gastric acid secretion studies, pancreatic function tests and other intubation procedures.

They are an integral part of the Endoscopy team and it would seem logical that they should move towards undertaking gastrointestinal endoscopy.

The United Kingdom Central Council for Nursing, midwifery and Health Visiting (UKCC) has no objection to nurses developing the extent of their professional practice. (Ref 3). What they ask is that the nurses concerned are competent for the purpose and mindful of the personal professional accountability they bear for their actions. (Ref 4).

2.2 Do They Have the Skills?
There is little doubt that nurses can develop practical skills in medical procedures comparable to those of their medical colleagues. This has been demonstrated in units in the United States where nurses have trained in flexible sigmoidoscopy (Ref 1 and 2). It has also been demonstrated in a parallel situation where nurses have become part of a surgical cardiac team salvaging veins for coronary artery bypass surgery. (Ref 5).

2.3 How Important Is A Medical Training In Endoscopy?
Nurses can observe reliably and can accurately record their findings (Ref 1), thus they have the skills required to act as endoscopy ‘technicians’. Furthermore, gastrointestinal units are increasingly being equipped with video recording equipment enabling hard copy of examinations to be made where required.

Such issues as interpretation of findings and diagnosis rely more on experience and a medical training and this is where supervision by an appropriately qualified clinician is essential. Management issues are likely
to remain the province of the clinician or clinician in conjunction with the Nurse Endoscopist but not the nurse alone.

2.4 Do Nurses Want to Endoscope
Anecdotal reports demonstrate that there are nurses who are both enthusiastic about learning to endoscope and those who have no intention of doing so.

In a recent small survey carried out on behalf of the Nurse Associate Group of the British Society of Gastroenterology (BSG), of those nurses questioned approximately 50% expressed interest in learning to endoscope.

2.5 Should Non-Medical Personnel Besides Nurses be Encouraged to Endoscope?
By the nature of the procedure, those patient relationship skills developed during a nursing or medical training would seem to be essential requirements for someone performing endoscopies. It is felt therefore that for the present, non-medical or non-nursing personnel should be discouraged from learning gastrointestinal endoscopy. This report therefore confines itself to the issue related to nurses learning endoscopy.

2.6 Combined Procedures
Certain procedures such as the placement of percutaneous endoscopic gastrostomy tubes (PEGS) and trans oesophageal endoscopic echocardiography may involve both the combined skills of a doctor and nurse. When acting purely as an assistant in these procedures, the nurses' role remains that of an Endoscopy Nurse Assistant. However if it is proposed that the nurse assisting should be responsible for passing the endoscope then the nurse will need to have undergone the full training for 'The Nurse Endoscopist' outlined in this report.

3. Medico Legal Issues
Understandable concern has been expressed by nurses with respect to the potential legal implications of endoscopic practice and the need for full medico-legal cover in the event of complications. The legal implications of
supervising Nurse Endoscopists also needs to be clearly understood by the doctor.

The common law of negligence requires that at all times a reasonable standard of care is attained. The interpretation of what is or is not reasonable depends upon expert evidence and the standard varies with time according to advancements in scientific knowledge, techniques, etc. If a patient suffers avoidable harm in the course of an endoscopy a successful defence of a claim for compensation would depend upon expert evidence being available to satisfy the court that at all times a reasonable standard of care was attained. A person who holds her/himself out as possessing special skills will be judged by the standard of the specialist. Thus if a nurse is to be made responsible for a procedure such as endoscopy he or she will be judged according to the standard of the reasonably competent Endoscopist. It would be no defence to a claim for compensation to say that they were inexperienced but doing their best if, in the judgement of the court, the patient would have avoided harm by having undergone the procedure in more experienced hands. Therefore training and supervision are essential until proficiency has been satisfactorily demonstrated.

The following abstract is taken from the General Medical Council book on 'Professional Conduct and Discipline Fitness to Practice' which deals with the responsibility for standards of medical care, delegation of medical duties to professional colleagues and delegation of medical duties to nurses and others.

'Delegation of Medical Duties to Nurses and Others. Para 42: The Council recognises and welcomes the growing contribution made to health care by nurses and other persons who have been trained to perform specialist functions, and it has no desire either to restrain the delegation to such persons of treatment or procedures falling within the proper scope of their skills or to hamper the training of medical and other health students. But a doctor who delegates treatment or other procedures must be satisfied that the person to whom they are delegating is competent to carry them out. It is also important that the doctor should retain ultimate responsibility for the management of these patients because only the doctor has received the necessary training to undertake this responsibility.' (Ref 6).
It is clearly essential for those employing or supervising the Nurse Endoscopist to ensure the nurse is properly trained and is properly supervised.

Furthermore a clear definition of the nurses' role needs to be documented, specifying what the nurse will be doing - i.e. consenting the patient, using sedation or not, what type of endoscopy, counselling responsibilities etc.

In the event of a claim for compensation for alleged sub-standard care several issues would arise for consideration. First the facts would be carefully established and an assessment would be made of the adequacy of the training of the personnel involved. Secondly, expert opinion would be taken as to whether or not a reasonable standard of care was attained. The defensibility of the case would depend on establishing to the satisfaction of the court that a reasonable standard of care was attained throughout. If it was agreed or adjudged that the care was deficient, compensation would be payable, provided that the plaintiff could establish cause and effect - i.e. that the alleged harm was directly the consequence of the alleged sub-standard care.

The apportionment of liability as between doctors and nurses is somewhat academic in the context of an NHS Trust/Direct Managed Unit claim. Under the provisions of Health Circular HC (89) 34, the Health Authority/Trust is responsible for the financing and management of medical negligence claims. However, a dispute about apportionment might arise in circumstances where the ultimate employer of the supervising doctor and the Nurse Endoscopist were different (e.g. in a private sector setting). In those circumstances, the apportionment of liability would be thrashed out between those representing the doctor and the Nurse Endoscopist but, in default of agreement, the court itself might have to make an apportionment of liability. In deciding such issues, it would be helpful to be able to establish that the training of the Endoscopist met the requirements of the BSG guidelines and that the procedure had taken place in a reputable specialist Endoscopy Unit with adequate medical supervision by trained specialists (Ref 7). The managers of the Nurse Endoscopist should agree (in advance) the nature and scope of the work to be undertaken. It is also important for there to be good understanding between general practitioner, other purchasers and the Endoscopy team concerning the exact nature and scope of the service being offered.
It is important that it is made clear who is to make the decision about patient fitness to undergo endoscopy. This could be the supervising Endoscopist. If it is to be the Nurse Endoscopist then it is important that the referring GP or hospital doctor is aware of this and a carefully prepared questionnaire presented to the patient for completion. Any untoward symptoms should then lead to a medical assessment before the procedure is carried out.

4. Risks

Endoscopy carries significant risks. There is a widely held perception that with improved technology, endoscopy has become a safer procedure. But studies have demonstrated that contrary to the impression that endoscopy complications are getting less frequent, complications are continuing to occur at a fairly constant rate. (Ref 8 and 9). The risks generally recognised are those relating to therapeutic procedures. However the apparently small risks relating to diagnostic endoscopy may be misleading and may have resulted in a degree of complacency. Recent evidence shows that when patients who have had endoscopy are more rigorously followed up and for more than 24 hours after the procedure, the complication rate is in fact far higher than expected. In a study from 2 regions in the United Kingdom reviewing the experience of 13,036 diagnostic endoscopies there was a mortality rate of 1 in 2,000 and a morbidity rate of 1 in 200, cardio-respiratory complications being the most common. (Ref 10).

These risks cannot be ignored and emphasise the fundamental importance of adequate training and supervision for anyone undertaking endoscopy. Nurse Endoscopists must be capable of recognising the usual foreseeable complications of endoscopy and taking appropriate action to deal with them.

Damage to teeth, bridges, crowns and other expensive dental restorations may be a potent source of litigation. The Nurse Endoscopist should recognise patients at risk and know what precautions to take to minimise dental damage (Ref 11).

5. Practical Issues
5.1 What Type of Endoscopy?
Because of the risks associated with therapeutic endoscopy the Working Party considers that at the present time the Nurse Endoscopist's work should be confined to diagnostic oesophago gastroduodenoscopy with or without biopsy and flexible sigmoidoscopy with or without biopsy.

All therapeutic procedures, Endoscopic Retrograde Cholangio Pancreatography (ERCP) and colonoscopy should be excluded.

5.1.1 Who to Endoscope?
Careful patient selection is essential and should be the responsibility of the supervising doctor in conjunction with the Nurse Endoscopist. Patients with significant cardiac or pulmonary disease or other diseases which place them in a high risk category and those who might require therapeutic procedure or sedation should be excluded.

5.1.2 Sedation or not?
Complications particularly cardiopulmonary are most commonly associated with endoscopy performed under sedation (Ref 10).

At the present time, apart from rare exceptions, nurses are not allowed to prescribe drugs and it is standard practice that they do not give the first intravenous injection of a prescribed drug. Thus, as things stand, if Nurse Endoscopists were to endoscope sedated patients a doctor would need to be present to prescribe and give the sedation. As this would negate the benefits of nurses performing endoscopy the Working Party believes it would not be appropriate for nurses to perform endoscopies on sedated patients at the present time.

Endoscopy without sedation would avoid the complications referred to above and would bring with it certain advantages, a shorter stay in hospital, better communication with the patient and no need for an accompanying person.

It is accepted that during the training period the initial learning stages would probably need to be carried out on sedated patients under the immediate supervision of a doctor.

However the Working Party acknowledges that limiting endoscopy to non-sedated patients, restricts the type and number of patients suitable for
endoscopy and may create practical problems in patient selection. Not all patients who choose unsedated endoscopy can tolerate it.

The Working Party considers that the above proposals are a necessary first step in the development of nurse endoscopy. However it believes that in a climate of change when the role of the nurse is expanding and nurse prescribing developing, Nurse Endoscopists should in the future be trained in administration of intravenous sedation and the endoscopy of sedated patients.

5.1.3 Throat spray
It has been suggested that there may be a link between the use of local anaesthetic sprays and development of pneumonia after gastroscopy (Ref 10). However, in view of the increased technical difficulties endoscoping unsedated patients without throat spray it was felt acceptable that nurses should have the option to use throat spray.

They should be trained to do so and be aware of the potential dangers and safeguards.

5.1.4 Location
Endoscopies should be performed within a fully equipped and fully staffed endoscopy unit as described in the BSG guidelines (Ref 12).

5.1.5 Endeoscopy Assisatants
The Nurse Endoscopist would require the same Nurse Endoscopy assistant support as recommended in the BSG guidelines - i.e. 2 nurses accompanying the Endoscopist during the procedure and one nurse to supervise recovery. At least one of the assistants and the recovery nurse should be qualified (Registered) nurses. The employment of a Nurse Endoscopist must not be used as a reason to perform procedures with fewer staff.

5.2 Training
The training of a nurse endoscopist should follow the same schedule recommended in the BSG guidelines on endoscopy with reference to diagnostic endoscopy. (Ref 7). It is difficult to define precise numbers of procedures required before a nurse is competent to endoscope without a
medical Endoscopist being present all the time. As with trainee Medical Endoscopists, this will very much depend on the individual's skills and will need to be left to the discretion of the supervising Medical Endoscopist in the individual units.

However the nurse trainee should undergo a prolonged closely supervised, apprenticeship prior to embarking upon independent endoscopy. This should include principles of safety and instrument care and the attendance at a formal teaching course on basic endoscopy approved or organised by the Endoscopy Committee of the BSG (Ref 7).

5.3 Consent
It is appropriate and legally acceptable that consent for endoscopy is obtained by the Nurse Endoscopist prior to the procedure. (Ref 13). The patient should be given the opportunity to discuss the procedure and/or consent with the nominated supervising doctor should he/she so wish.

5.4 Supervision of the Nurse Endoscopist
Once trained, the Nurse Endoscopist could undertake independent endoscopy but there should always be an experienced designated medical Endoscopist immediately available within the hospital in the event of complications and the need for technical or diagnostic advice.

Nurse Endoscopists should comply with the BSG recommendations for standards of patient monitoring during gastrointestinal endoscopy. (Ref 14).

5.5 Records and Reports
The endoscopy report with or without supporting photographic/video data would be prepared and signed by the Nurse Endoscopist. However further management of the patient should remain the responsibility of the supervising clinician.

A photographic or video record is not considered a pre-requisite for Nurse Endoscopists once fully trained, but should be taken as and when indicated for clinical or educational reasons. Although of value during the training period, it is considered impractical to retain for review, video records of all nurse endoscopies.
5.6 Counselling of Patients and Relatives
It is appropriate and important that the Nurse Endoscopist talks to the patient and/or relatives after the endoscopy to give a factual account of the endoscopic findings and to inform the patient about further plans - i.e. outpatient follow-up, referral back to the GP etc.

However where the findings are equivocal or serious pathology suspected with the need to break bad news, it may be necessary or more appropriate for the nurse to defer giving specific information and refer the patient for discussion of findings and outcome back to the referring doctor or to the supervising doctor in the unit.

5.7 Diagnostic and Management Issues
The trained Nurse Endoscopist will be able to accurately record the examination findings. Diagnostic and management issues must remain the province of the clinician be that the referring General Practitioner or the hospital doctor. It is for this reason and to avoid unnecessary delay in taking action on the endoscopic findings that all Nurse Endoscopy reports should be reviewed at the earliest opportunity and preferably the same day by the supervising doctor.

5.8 Audit
It is essential that careful and full records are kept by the Nurse Endoscopist of all endoscopic procedures carried out. This could be done in the form of a personal log book. This should include complications and where there is a visual record of the examination this should be indicated. These records should be reviewed at regular intervals by the supervising clinician.

5.9 Continued Education
NHS Trust and non-Trust Hospitals must be aware that Nurse Endoscopists should have regular opportunities to attend recognised courses in endoscopy, and the BSG meetings in order to keep up to date with advances in techniques and equipment, and funding needs to be made available for this.
6 References


2 Disario J A, Sanowski R A Sigmoidoscopy Training for Nurses and Resident Physicians Gastrointestinal Endoscopy 1193 39 1 29-32

3 'The Scope Of Professional Practice' UKCC 1992

4 'Code Of Professional Conduct' UKCC 1992


6 Professional Conduct and Discipline - Fitness to Practice The General Medical Council December 1993.


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