



**BRITISH SOCIETY
OF GASTROENTEROLOGY**

Non-Medical Endoscopists

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Summary

- Non-medical endoscopists, particularly nurses are already an integral part of the national gastrointestinal service and contribute significantly.
- Such practitioners are safe, competent, effective and thorough. There is strong patient approval for their role.
- The practical and legal risks have been addressed by the development of robust training pathways and clinical governance. The Training Programme developed by JAG is a requirement for all endoscopists.
- The role of non-medical endoscopists is developing and expanding to include therapeutic endoscopy and training.
- The development of non-medical endoscopists from non-health care backgrounds is in progress.
- Nurses, like doctors, register with their professional council. Non-medical endoscopists from other disciplines will probably be regulated by the Health Profession Council.
- Endoscopists in training must have a recognised supervisor and a process of mentoring is strongly advised for all independent non-medical endoscopists.
- It is essential that aspiring endoscopists, their medical colleagues, trainers and employing trusts recognise the benefits, risks, medico-legal implications and training requirements.

NON MEDICAL ENDOSCOPISTS

1 General Considerations

Nurse Endoscopists

Since the last BSG Working Party in 1994, Nurse Endoscopists have established themselves and are widely accepted as independent practitioners throughout the United Kingdom.^{1,2} Over 200 nurses contribute significantly to endoscopy services as gastroscopists, flexible sigmoidoscopists, colonoscopists and trainers in these techniques.

They have been shown to be as competent, safe, acceptable and in some areas more thorough than medical endoscopists.^{3,4,5,6,7} Their practice is underpinned by the Nursing and Midwifery Council (NMC) Code of Professional Practice which gives them clear guidance on their development, responsibilities and accountability;⁸ nurses demonstrate clear understanding of the medico-legal implications of their role and it is clear that they have become deeply embedded and welcomed into the fabric of modern endoscopy.

1.2 Endoscopists from other backgrounds

Other professional groups have also engaged in gastrointestinal endoscopy, notably radiographers who had already successfully extended their role as practitioners in ultrasound and barium studies. Since 2003, a Pilot project sponsored by the Changing Workforce Programme⁹ has begun to train non-health care personnel to degree standard as endoscopists. Their further role, responsibilities, career pathways and regulation are under development and will require appropriate evaluation prior to assimilation in the clinical area. They are few in number at present and nurses provide the main body of non medical endoscopists.

1.3 Drivers for Change

The main driver for these changes has been the increasing demand for endoscopy and long waiting-lists. These are exacerbated by open access arrangements, 2 week cancer waits and the expanding programmes for monitoring patients at risk following the treatment of bowel cancer, colonic polyps, Barrett's oesophagus and inflammatory bowel disease.

A national programme of screening for bowel cancer will start in 2006. This will entail a considerably increased demand for colonoscopy and colonoscopists. The current training initiative was devised to address these issues.

Consultants are now required to cancel fixed lists to attend acute emergency duties. Lost sessions are difficult to back fill. The increasing development of complicated, time consuming diagnostic and therapeutic procedures are correctly the responsibilities of Consultants and other highly specialised endoscopists.

The increasing need for close supervision of endoscopists in training further reduces the capacity of consultant lists. As a result of all these changes, consultants are less available than ever before for routine diagnostic and straightforward procedures.

Nurses and other non-medical endoscopists who have been trained to perform procedures to the same level as medical endoscopists are a valuable, flexible resource helping to accommodate these demands. Those who are sufficiently experienced may also assist with the training of both medical and non-medical endoscopists.

There has, nevertheless been some lack of clarity about the reasons for these developments that has engendered uncertainty and resistance among some doctors. There is concern for clinical care but there has also been a perceived threat to traditional medical roles and hierarchies. The establishment of non- medical endoscopists is seen by some merely as a way of obtaining

medical services more cheaply by reducing the need for doctors. However endoscopy is only a relatively small part of most consultants responsibilities, whose depth and breadth of knowledge, skill and analytical approach to overall patient management puts them in a unique position as leaders of multidisciplinary teams. These teams contribute greatly to the timely provision of high quality care.

The aim of this paper is to consider the practical and medico-legal implications of the establishment of non-medical endoscopists with particular emphasis on the risks involved, the training and governance processes required to minimise them.

2 RISKS

Endoscopy carries inherent risks: these include the hazards of sedation, respiratory, cardiovascular and cerebrovascular damage, bleeding, perforation and even death. Anyone embarking on a career in endoscopy must understand and reconcile themselves to these risks.

The risks of endoscopy by non-medical endoscopists are not different from those of their medical colleagues.^{2,3,6,10} This assumes that the training of all endoscopists is the same and that everyone practices only to the level of their competence. Medico-legal risks arise if practitioners, whoever they are, undertake procedures for which they are not competent. Whilst a trainer may be accountable for actions of a trainee, once an endoscopist is "signed off", independent practitioners are personally accountable. **An employing Trust or Unit is at risk if it is has failed in its training, risk management or governance arrangements.**

Nurses are trained to a greater degree than doctors to work to guidelines and protocols. Thus it could be argued that they may be even safer than doctors in this environment. However medical training may enable a doctor to be better prepared to deal with unexpected emergencies and areas of uncertainty. In a crisis, responses are often intuitive, based on experience and broad medical knowledge; doctors may be better able to judge the balance of risks and benefits than their non-medical counterparts. This is a further cause of concern within the medical profession. During training it is essential therefore to ensure that non-medical endoscopists have the same level of knowledge of the overall management of endoscopic procedures as their medical colleagues. Extended roles for nurses and others offer exciting opportunities for professional and personal development which may enhance the recruitment and retention of high calibre trainees and the development of professional leaders.⁹

3 MEDICO-LEGAL ISSUES

Concern has been expressed by nurses for the legal implications of endoscopy practice and the need for full medico-legal cover in the event of complications. The legal implications of employing non-medical endoscopists also need to be clearly understood.¹¹

The common law of negligence requires that at all times a reasonable standard of care is practiced. The interpretation of what is or is not reasonable depends upon expert opinion. 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 will depend on expert opinion being able to satisfy the court that at all times a reasonable standard of care had been attained. A person who holds her/himself as possessing special skills will be judged by the standard of the specialist. Anybody responsible for a procedure will be judged according to the standards of a 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 had the procedure been done by a properly trained endoscopist (*Bolam v Friern Hospital Management Committee* 1957). Therefore training and supervision are essential until competence has been satisfactorily demonstrated.

The following extract, taken from the General Medical Council book on “Professional Conduct and Discipline: Fitness to Practice”,¹² deals with the responsibility for standards of medical care and the delegation of medical duties.

“Delegation involves asking a nurse, doctor, medical student or other health care worker to provide treatment or care on your behalf. When you delegate care or treatment you must be sure that the person to whom you delegate is competent to carry out the procedure or provide the therapy involved. You must always pass on enough information about the patient and the treatment needed. You will still be responsible for the overall management of the patient.....”

“You must be satisfied that such health care workers are accountable to a statutory regulatory body and that a registered medical practitioner retains overall responsibility for the management of the patient.”

In order to protect patients, practitioners and Trusts, clear job descriptions must define limits of practice and specific responsibilities. These will include obtaining consent, prescribing and administering drugs, patient management before and after procedures and audit. These arrangements must be in line with Trust risk management policies and governance arrangements. Trusts must ensure that non medical endoscopists are properly trained, adequately mentored and that their performance is audited in line with the Trust’s governance arrangements.

4 GUIDELINES FOR CONSENT

The taking of consent by all endoscopists must comply with Trust policies, the DOH instructions¹³ and the GMC¹⁴ and NMC¹⁵ guidelines. Now that endoscopy is a service much like radiology, both the doctor who requests the investigation and the investigator have a responsibility for ensuring that the patient has given valid consent.

The DOH advice states:

“the clinician providing treatment or investigation is responsible for ensuring that the patient has given valid consent before treatment begins, although the consultant responsible for the patient’s care will remain ultimately responsible for the quality of medical care provided” (DOH 2001)”

The GMC advice states:

“If you are the doctor providing the treatment or undertaking the investigation, it is your responsibility to discuss it with the patient and obtain consent. Where this is not practicable, you may delegate these tasks provided you ensure that the person to whom you delegate is suitably trained and qualified...”

It is important that a patient is informed and understands who it is who will perform the procedure. The issue is rarely a problem but little is known about patient responses to these changes in medical practice and units need to be explicit in their patient information literature. There is evidence to suggest the majority

of patients are happy with these arrangements.^{2,3} It is equally important to ensure that patients are aware if trainees, whatever their discipline, are performing endoscopy under supervision and that they have confidence in these arrangements. Although training is an integral part of many units this may not be apparent to patients.

5 REGULATION OF NON MEDICAL ENDOSCOPISTS

5.1 Registered Practitioners

Professions who have a regulatory body such as the GMC for doctors, the NMC for nurses and Health Profession Council for radiographers have clear codes of conduct, established standards of competence, ethics and training. They have registration of practitioners who meet these standards and mechanisms for dealing with those who do not. While acquiring full competence all trainees are under supervision and the medico-legal implications of this are quite clear.

5.2 Unregistered Practitioners

Non-medical endoscopists who have no professional body are at present unregulated. The role is in development and until such time that it can be clearly defined, regulation is not feasible. Such practitioners are under close supervision and their position in Trusts rests with locally agreed protocols, their programmes of supervision. It is the Department of Health’s intention that the Health Profession Council provides a regulatory body for all advanced practitioners who are otherwise unaffiliated.

6 PRACTICAL ASPECTS

6.1 Who should endoscope?

Endoscopy may be performed by anybody who has completed a full training programme and is able to demonstrate sufficient knowledge and competence to satisfy established standards. Endoscopists can include doctors, nurses, radiographers or other non-clinical personnel.

6.2 Mentoring

Most non-medical endoscopists will carry out clearly defined tasks with specific competencies and rigid boundaries. The level of supervision required will be the responsibility of Trusts. We recommend that each endoscopist have a named mentor who would be responsible for ensuring maintenance of competence, professional development and for providing support and advice.

6.3 What endoscopy?

Theoretically there is no limit to the level of practice a non-medical endoscopist might attain; in reality and in the short term they may be more limited. Nurses already perform therapeutic manoeuvres such as oesophageal dilatation, PEG insertion, variceal injections, banding and endoscopic ultrasound. The limits of practice rest with the employing Trust with clear protocols and job descriptions. It is recommended that endoscopists start with basic diagnostic techniques such as gastroduodenoscopy and flexible sigmoidoscopy with biopsy before proceeding to colonoscopy. Therapeutic manoeuvres are learnt once good hand eye co-ordination and fine control have been established. Injection therapy, banding and clipping are relatively simple developments of the same technique. Polypectomy, dilatation of strictures, PEG insertion and stenting take longer to learn. Acquiring competence in these skills is one

thing, being able to make the correct decision to proceed or not in the light of a whole range of broader considerations is another.

There is a widely held opinion that ERCP should be performed only by Consultant Specialists because of the complexity of the decisions that need to be made during the procedure.

6.4 Who should premedicate and sedate?

There is a national standard of 6 months part-time BSc level courses for nurses prescribing. Successful completion gives NMC recordable qualifications. However at present prescribing is limited and nurse endoscopists may not prescribe their own sedation. Such prescriptions must be under the Patient Group Directions¹⁶ These directions permit Trusts to allow appropriately trained non-medical staff to prescribe and administer local anaesthetics, throat sprays, anticholinergics, intravenous benzodiazepines and their antagonists. They can also administer bowel prep. These directions must be signed by a doctor.

Nurses cannot prescribe any class A drugs such Opiates.

6.5 Where to endoscope?

Endoscopy must be undertaken in properly designed endoscopy units or in other places where patients can be safely managed.¹⁷ The guidelines for the development of such areas have been clearly laid out by the BSG and supported by standards of Health and Safety. Endoscopy needs to be delivered to an equal standard in such areas as operating theatres, x-ray departments and intensive care units.

7 SUPPORT STAFF

Non-medical endoscopists require the same support from endoscopy assistants as medical endoscopists as laid down in the BSG Guidelines i.e: 2 endoscopy assistants per room familiar with the procedures and environment must always be present; at least one must be a registered nurse.¹⁷

Non-medical endoscopists are not the same as endoscopy assistants; there must be no confusion of roles. Endoscopy assistants have specific knowledge, skills and responsibilities. Their training and career pathway are distinct and different from nurse endoscopists.

8 TRAINING

The Joint Advisory Group on Gastrointestinal Endoscopy (JAG) is an association of all the Royal Colleges including Nursing, the British Society of Gastroenterology and the Committees for Higher Training in Medicine and Surgery (JCHMT and JCHST). JAG has made it clear that all endoscopists, whatever their primary discipline, should have completed their training in accordance with the "Guidelines for the Training, Appraisal and Assessment of Trainees in Gastrointestinal Endoscopy (2004)".¹⁸

The guidelines contain specific recommendations not only for medical trainees but for the training of nurses and other non-medical endoscopists and states:

"nurse trainees' education should be at least at a level and depth required to support clinical work and patient management".

This is in recognition of the educational differences between non-medical endoscopists and doctors and highlights the necessity to achieve a common core standard of knowledge in

gastroenterology, anatomy and physiology and pathology. The current University-based courses for nurses and non-medical endoscopists address this.

Courses undertaken including formal University linked training schemes, should be JAG approved and attendance at other relevant JAG courses is mandatory. The document lays out the curriculum, structure of training, the experience required, the assessment and appraisal process and documentation for the registration of non-medical endoscopists. Training should be completed in JAG registered units and be supervised by suitably qualified trainers who have achieved expert practice, competency in the training role and undertaken appropriate Train the Trainers endoscopy courses. Nurse Endoscopists should also be encouraged to undertake the Train the Trainers Courses.

Supervising trainers and employing Trusts must ensure that there is commitment from all involved to complete an agreed programme before embarking on any training. There should be a job description and training contract outlining the timetable for the programme, the duties and responsibilities of all parties, a defined exit strategy and an outlined career pathway.

The subsequent supervision of all endoscopists and their further training will be the responsibility of Trusts through their clinical managers. The establishment of personal development plans incorporating further education, audit and annual appraisals should support this process. All endoscopists should engage with professional societies, attend their conferences and enroll on suitable courses. As new skills and competencies are acquired they will need to be recognised, incorporated into job plans and where appropriate registered with the appropriate regulating authorities eg NMC.

A recent National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Report (2004)¹⁹ has made a critical appraisal of gastrointestinal therapeutic endoscopic procedures and issued strong recommendations including a request for further national guidelines, specifically for ensuring competency in endoscopy. The report stated that "76% of reporting hospitals use a nurse endoscopist for at least one session per week" but that "17% of nurses do **ONLY** one – which may mean they do not maintain (or further develop) their competence". This needs to be addressed in job planning.

A national audit of colonoscopy (Bowles 2004)²⁰ showed that the overall quality of colonoscopy was poor with caecal intubation rates between 56% and 77%. The amount of sedation administered was too high and the perforation rate of 1 – 769 unacceptable for a screening programme. This audit showed the level of training was poor and as a result the Department of Health has invested in the establishment of three national and seven regional centres which run JAG-approved courses in Basic Skills (Foundation in Endoscopy), Basic Skills in Colonoscopy, Basic Skills in Flexible Sigmoidoscopy and Training the Trainers (Endoscopy). Advanced courses in ERCP, EUS and Endoscopy Therapy are also available. These centres are establishing networks of trainers in units throughout their regions, disseminating unified teaching methods in the day to day training of endoscopists. Individual hands-on training can also be arranged. These developments are expected to improve the overall standard of endoscopy as well as training.

Doctors have a broad knowledge base and culture of clinical decision making and taking calculated risks. Nurses and other health professions do not necessarily have this background. Not only must the training of non-medical endoscopists be sufficiently broad and the assessment sufficiently robust to ensure that their endoscopic and attendance skills are equal to that of doctors but that their cognitive, interpretive and decision making skills are also balanced. Particular attention must be given to the risks associated with pre-morbid status, the hazards of sedation, the risks of instrumentation and the dangers of the recovery period.

9 RECORDS, REPORTS, PATIENT MANAGEMENT

Clear local guidelines, patient pathways, operational policies, reporting mechanisms, pathology reporting and follow up arrangements must be established and adhered to by all endoscopists. These issues are central to good clinical practice and should maintain standards of quality. Patient management after diagnosis may follow straightforward and clear pathways. The ability of any endoscopist to respond to situations outside those prescribed areas will depend on the levels of training and experience. Attention must be paid to the interpretation of endoscopy findings, biopsy results and subsequent management pathways. As in the medical model, less experienced endoscopists will need to consult more senior colleagues.

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These guidelines have been prepared by the British Society of Gastroenterology. They represent a consensus of best practice based on the available evidence at the time of preparation. They may not apply in all situations and should be interpreted in the light of specific clinical situations and resource availability.

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