The role of the nurse endoscopist

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Colorectal nurse specialist roles have developed since the publication of the Calman-Hine report, with most of the post-holders dealing specifically with patients with a diagnosis of colorectal cancer. While posts vary, many of these nurses also perform endoscopy as part of their role.

Nurse endoscopists are not a new phenomenon and their growth in the UK initially mirrored that of similar nurses in the USA (Legge, 2002). Historically endoscopy training was undertaken by nurses working within endoscopy units who expressed an interest in performing diagnostic procedures as part of their role. More recently, however, endoscopy has been performed by nurses from a variety of clinical backgrounds with equally varied roles. The range of endoscopy procedures and innovative services that nurses now provide in this field continues to grow. One only has to read the British Society of Gastroenterology working party report, *The Nurse Endoscopist* (1994), and compare its recommendations at that time with present practice to see how far this area has developed in recent years.

COLORECTAL NURSE SPECIALISTS

Before 1995 the only patients with a bowel disorder who would benefit from specialist nurse input were those with either a stoma or inflammatory bowel disease. However, the Calman-Hine report (Expert Advisory Group on Cancer, 1995) recommended the introduction of site-specific nurses to support patients throughout their cancer journey. Hence, colorectal nursing became a distinct role with clear objectives for cancer but without set parameters, allowing scope for future developments. The Clinical Outcomes Group manual guidance, *Improving Outcomes in Colorectal Cancer* (Department of Health, 1997), acknowledged that the benefit of colorectal nurses was unknown but evidence extrapolated from studies relating to breast cancer provided sufficient justification for these posts. Significantly the Calman–Hine recommendations, although politically motivated, were patient-focused which encouraged many nurses to take on these new roles.

WHY ENDOSCOPY?

The growth in numbers of 'one-stop rectal bleeding clinics' and the subsequent introduction of the 2-week rule targets led to increased demand for endoscopy services, highlighting the dearth of trained endoscopists in the UK (Marks, 2001) (*Figure 1*). Some endoscopy units had already trained nurses of their own to perform upper or lower procedures but these nurses were a finite resource. Another solution was for nurses with an in-depth knowledge of colorectal disease, rather than endoscopy, to be trained to perform endoscopic procedures. Colorectal nurse specialists were ideally placed to meet this need and many were willing to take up the challenge.

Many of the first colorectal nurses had been in post as stoma care nurses and had either chosen to broaden their role to incorporate aspects of cancer care or had changed roles. By definition many of these nurses were from a surgical rather than an endoscopy background and may have been unfamiliar with endoscopic techniques. Significantly they were used to undertaking a nursing role rather than one based on the medical model. The concept

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Figure 1. The '2-week rule' led to the increase in nurse endoscopists.

of nurses from a non-endoscopy background performing these procedures was quite new as endoscopy experience had previously been cited as a prerequisite for formal training courses. A small-scale study from the author's own unit has demonstrated that the clinical background experience of nurses has no bearing on their ability to fulfil this role (McCallum et al, 2000).

NURSE ENDOSCOPIST: A MISNOMER?

The main focus for the colorectal nurse specialist is to manage a caseload of patients, with a diagnosis of either colorectal cancer or benign disease, while undertaking endoscopy as one element of that role. However, the main remit of the lower gastrointestinal nurse endoscopist is to perform diagnostic and therapeutic endoscopy with little or no inpatient caseload. The two roles can differ greatly but the distinction lies not in the performance of the technical skill but the emphasis of the service provided, making nurse endoscopist a misnomer in some cases.

MEDICAL PERSPECTIVES ON NURSE ENDOSCOPY

Any scepticism within the medical profession as to whether nurses would be able to perform flexible sigmoidoscopy to the same standard as a doctor has been dealt with in numerous studies (Maule, 1994; Schoenfeld et al, 1999). These were able to confirm that intubation and diagnostic pickup rates were equitable. Maule (1994) found that patients were more likely to return for repeated procedures if a nurse had performed the initial test.

Duthie et al (1998) demonstrated that an endoscopy training course could be devised for nurses that provided appropriate, relevant theory and clinical skills. However, even though nurses have shown that they can safely and effectively perform both diagnostic and therapeutic endoscopy, some reservations exist within the medical fraternity as to the extent of these roles (Pathmakanthan et al, 2001). Issues regarding relevant knowledge, skills or experience apply equally to doctors in training so there must be more complex reasons for restricting nurses' roles.

TRAINING ISSUES

In-house training was initially the only form of training available for nurses but this was at a time when no formal training programme existed for doctors either. This method provided appropriate clinical expertise but may not always have dealt with relevant theory in sufficient depth. There was also little opportunity to discuss issues with other nurses in a non-threatening learning environment. The first formal training programme for nurses in the UK is well documented and other centres have since followed suit (Duthie et al, 1998).

More recently nurses have been accepted onto multidisciplinary training programmes as part of the initiative to improve endoscopy skills across the board (Waye and Leicester, 2001). There are now courses designed and run by nurses that incorporate skills training for doctors (Vance, 2003). With the Joint Advisory Group on Gastrointestinal Endoscopy recommending the same level of training for all disciplines there is little reason to undervalue the contribution of nurses within this field (Joint Advisory Group on Gastrointestinal Endoscopy, 2001). However, most nurses would accept the note of caution that, without the relevant theoretical knowledge to underpin clinical skills, they can only provide a technical service.

BENEFITS NURSES BRING TO ENDOSCOPY

As traditional boundaries between the nursing and medical profession are broken down it is increasingly difficult to measure the effectiveness each brings to a particular situation. However, the holistic, caring focus of nursing provides a dimension that medicine alone cannot give. Castledine (2001) suggests that a key factor in recovery is in the nurse–patient relationship which encourages the patient to take responsibility for his/her health. Therefore, the extra time spent explaining, reassuring and providing appropriate advice may improve compliance and reduce unnecessary hospital attendance. While it is satisfying to hear a medical colleague suggest that what a nurse can bring to an area such as endoscopy cannot be done by a doctor it remains frustratingly difficult to define what this is (Legge, 2002). The problem for nursing continues to be in proving when the nurse is the best person to fulfil the role and not just a doctor substitute.

LIMITATIONS OF NURSE ENDOSCOPY

Nurses have spent many years trying to move away from a task-orientated culture to one of providing holistic care so the idea of a nurse performing a technical skill all day long has largely been frowned upon in the UK (Legge, 2002). For this reason the majority of posts incorporate endoscopy sessions within a wider role to include managerial aspects, education and

research as well as other clinical responsibilities. However, nurses have to guard against undertaking too many disparate facets of their individual role if they want to perform them all to a high standard. It is important that nurses do not lose the focus of their core responsibilities in the pursuit of new skills.

ALTERNATIVE ROLES

Other colorectal nurses have chosen not to undertake video endoscopy but to concentrate on learning different skills or to focus on the management of benign disease. These nurses may perform rigid sigmoidoscopy, proctoscopy, anorectal physiology or related procedures. Studies have suggested that patients with low risk symptoms wait longer to be seen because of the focus on malignant disease (Thomas et al, 2001). A nurse-led service to counteract this is a proactive way of dealing with this situation.

FUTURE DEVELOPMENTS

The *NHS Plan* (Department of Health, 2000) documents the Government's commitment to supporting the extension of nursing roles. With the introduction of a national screening programme the numbers of nurses who can perform endoscopy will need to increase to match demand. In the future it may be that nurses who perform therapeutic colonoscopy become the norm rather than the exception. What is crucial to the success of such developments is support from medical colleagues (Vance, 2003). These are exciting times for nurses in the field of coloproctology who want to broaden their roles as there are myriad ways that patient care can be enhanced.

CONCLUSION

The updated British Society of Gastroenterology working party report on nurse endoscopy is due for publication in the near future and it will be interesting to see how this differs from the 1994 document. The challenge for nurses, especially in coloproctology, is to demonstrate the added value that they can bring to a particular role. Few nurses would want to exchange their nursing knowledge and skills for medical ones but would prefer to enhance their expertise instead. As long as relevant theoretical knowledge underpins the development of clinical skills and rigorous protocols and audit procedures are in place there can be little reason why nurses cannot continue to develop in this field. **HM**

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KEY POINTS

- Colorectal nursing roles differ from hospital to hospital.
- Flexible sigmoidoscopy is often undertaken by colorectal nurses as part of their role.
- The '2-week rule' target has led to the increase in nurse endoscopists.
- Theoretical knowledge is necessary to underpin clinical endoscopy skills.
- More nurses may undertake therapeutic colonoscopy in the future.