Special report

The nurse endoscopist

The summary of the report of a working party of the endoscopy section of the British Society of Gastroenterology is printed here.

There is increasing interest and a growing demand within the medical profession for advice and information about the creation of nurse endoscopy posts. There are several established posts in the United States where nurses perform screening flexible sigmoidoscopies.

Specialist gastroenterology nurses are being appointed in the United Kingdom and for some of these posts endoscopy may eventually become part of the nurses’ role. Already advertisements for posts for nurses to perform flexible sigmoidoscopies are appearing in the British journals.

The 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 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 and may lead to a disproportionate amount of their time being spent endoscoping. It is therefore timely to examine the proposition that nurses should learn to endoscope to increase the capacity of existing medical endoscopy teams.

The working party report tackles the philosophical and practical issues that arise from nurses taking on the role of endoscopist. The following points summarise the main conclusions of the working party.

Summary of report

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 Medicolegally nurses may perform an endoscopy provided they have received the appropriate training, have the support of the Health Authority/Trust, and are adequately supervised by the responsible consultant.
4 Nurse endoscopy should be restricted to diagnostic oesophagogastrooduodenoscopy and sigmoidoscopy with or without biopsy on non-sedated patients in the first instance, 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 requesting sedation.
6 Nurse endoscopist training should follow the same schedule recommended for medical endoscopy by the British Society of Gastroenterology 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 before endoscopy and for discussing the findings with the patient after the procedure.
9 The nurse should be responsible for preparing and signing the endoscopy report. However, further patient treatment 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.

The working party concluded that nurses already fulfil an essential and integral part of the endoscopy team. They have developed great expertise in assisting medical endoscopists during endoscopy and in handling and taking care of complex endoscopic equipment. It would seem a logical progression of the nurses’ skills to advance a stage further to performing endoscopies. There is no medicolegal reason why nurses should not perform endoscopy provided they have received proper training and are adequately supervised. Such a development has the support of the United Kingdom Central Council of Nurses.

The use of sedation, however, is associated with an increased incidence of complications. It also raises the unresolved issues of nurses prescribing and giving intravenous drugs. It is felt at this stage in the development of nurse endoscopy that nurses should not endoscope sedated patients but that it is right that this should happen in due course.

The working party therefore supports the proposal that nurses should be allowed to perform endoscopy provided it is performed under the circumstances described in this working party report.


Copies of the full report may be obtained from the Secretary, British Society of Gastroenterology, 3 St Andrews Place, London NW1 4LB (price £1.00 to non-members).

Members of the endoscopy section working party
Dr M D Heller (chairman) secretary, endoscopy section BSG, Swindon; Mr R McCloy, Manchester; Mrs M Cox, chairperson, endoscopy associates group, BSG, Chelmsford; Mr M Sheppard, Nottingham; Dr E T Swarbrick, Wolverhampton; Mrs M Littlewood, Dudley, Mr M W L Gear, vice president, endoscopy section, BSG, Gloucester; Dr A L Morris, Liverpool; Dr R N Palmer, Medical director, The Medical Protection Society.