With 32 million health care consumers gaining coverage with the Affordable Health Care Act (Fairman, Rowe, Hassmiller, & Shalala, 2010), an integrated, team-based approach will be needed to meet the needs of these patients through doctors, nurses, physician assistants (PAs), and many other health care professionals. The looming shortage of physicians and the increase in demand for quality medical care for the newly insured, as well as the anticipated care needed for the aging Baby Boomer population, may be especially critical in areas of medicine that tend to serve older patient populations (Cummins, 2010). A July 2010 study by the Massachusetts Medical Society found that shortages in many specialties, including urology, were already adversely affecting patient access to care.

Advanced practice registered nurses (APRNs) (including nurse practitioners, clinical nurse specialists, nurse midwives, and nurse anesthetists) and PAs will play critical roles in meeting this demand in part through increasing patient access and bringing greater continuity of care to the patient experience. In the United States, there is still a struggle for acceptance of the APRN and PA roles across all fields of medicine and clinical practice, despite a growing body of evidence that APRNs and PAs are capable of increasing their scope of practice to great patient benefit (Laurant et al., 2005).

Recently, there has been a rise in highly supportive media attention for an increased role of APRNs and PAs in the U.S. health care system. One instance was the October 2010 Consensus Report from the Institute of Medicine (IOM). The report was based on a two-year initiative by the IOM and The Robert Wood Johnson Foundation to devise a nursing blueprint for their integrated involvement in health care services. The IOM (2010) concluded that “Nurses should practice to the full extent of their education and training.” Around the same time, the New England Journal of Medicine echoed similar recommendations: “This is a critical time to support an expanded, standardized scope of practice for nurses...,” and “Fighting the expansion of nurse practitioners scope of practice is no longer a defensible strategy” (Fairman et al., 2010, p. 193).

There has never been a more important time for physicians,
A Recent History of NPs and PAs Performing Cystoscopy

Over the past 20 years, a drastic shift in procedural responsibility has taken place worldwide. Tasks that were once performed exclusively by physicians are now performed by other health care providers. In the case of urology, there is anecdotal evidence that cystoscopy has been performed in the U.S. by NPs and PAs for over 15 years. In the U.K., however, this has been the case for more than 20 years. Cystoscopy is being performed routinely in nurse-led bladder cancer surveillance clinics, and these data conclude that nurses are just as accurate as their physician colleagues in finding bladder tumors (Fagerberg & Nostell, 2005; Gidlow, Laniado, & Ellis, 2000; Radhakrishnan, Dorkin, Johnson, Menezes, & Greene, 2006). This conclusion is largely attributed to the training, competencies, and certification programs developed in the U.K. over 10 years ago as a collaborative effort by British Association of Urological Nurses (BAUN) and British Association of Urological Surgeons (BAUS) (Fagerberg & Nostell, 2005; Gidlow et al., 2000; Radhakrishnan et al., 2006).

The U.K. model provides successful programs that could easily be adapted and built upon to serve the anticipated needs of NPs and PAs in the U.S. One training program is for nurse-run bladder cancer surveillance clinics. Such programs have included two principal components: 1) a didactic element and 2) a practical component.

The didactic portion in the U.K. is similar to pre-conference advanced practice cystoscopy workshops offered during the Annual Symposium of the Society of Urologic Nurses and Associates (SUNA) in 2010 and 2011. The U.K. training program includes intensive instruction in a variety of areas: anatomy and physiology, the evaluation of hematuria, an overview on bladder cancer, review of potential complications (and avoidance of those complications), pre-procedure antibiotic prophylaxis, follow-up protocols, and the basic mechanical workings of the cystoscope. In the U.K., the practical portion includes a training team composed of an experienced nurse cystoscopist (defined as more than two years of experience) and a consulting urologist who works with the trainees performing cystoscopy on live models who volunteered to undergo repeated cystoscopies as part of the training program. In the U.K., deliverables include a training package, competency standards, patient pathways, guidelines, and ultimately the establishment of a successful nurse-led bladder cancer surveillance service.

The educational protocol has been described by Chatterton (2010) and includes 1) an observational period during which the trainee observes a cystoscopy being performed by an experienced cystoscopist (minimum 10), 2) a practical portion in which the trainee performs the cystoscopy under the supervision of the instructor (minimum 50 supervised), and 3) a consolidation phase of practical competence in which the trainee performs an unsupervised cystoscopy (minimum 30 unsupervised) with confirmation of the accuracy of findings overseen by the supervising urologist. These experiences would all be logged in the NP or PA portfolio as evidence of training. More or fewer observations may be necessary, with the endpoint goal that both trainee and supervising physician are comfortable that the skill has been mastered.

Getting Started with Cystoscopy

Until these programs are in place in the United States, NPs and PAs who want to perform minimally invasive procedures, such as cystoscopy, in their clinics will need to continue to take responsibility for their own training and competencies – at least for now. The following is a practical guide to assist NPs and PAs considering performing cys-
Cystoscopy, and will help to clarify any scope of practice issues that might be present when trying to get started.

**Step One: Qualify Your Scope of Practice**

Scope of practice can vary greatly from state to state. One would need to seek out his or her own governing board to ensure that invasive procedures are included in the scope and that the state’s own stipulations are met. The individual’s state and institution’s scope of practice and potential privileges of NPs or PAs need to be investigated. The scope of practice for many states is intentionally vague to allow for expansion that could easily permit NPs and PAs to perform cystoscopy and other invasive procedures.

**Step Two: Get Trained and Define Competence**

In the U.S., there are currently no nationally accredited training programs for NPs, PAs, or even MDs to learn flexible cystoscopy. A collaborating or supervising urologist would need to not only agree to this step, but fully endorse the commitment to performing cystoscopy, provide training, and work collaboratively to define competence requirements. A defined competence should then be written and signed by both the NP or PA and collaborating physician.

**Step Three: Consider the Legal Aspects of Cystoscopy**

Lack of experience is not an excuse from liability, regardless of license. Patients expect that their cystoscopist will provide optimal patient care based on standards of care, and has reasonable knowledge and skill in the procedure being performed. Patients should be given informed consent indicating an NP or PA is performing the procedure. Not doing so could result in charges of battery if the patient assumed the individual performing the procedure was a doctor.

Confirming that insurance carriers will cover NPs and procedures may be prudent as well. Insurance carriers have generally been covering cystoscopy as long as the carrier is covering other NP or PA services.

A supervising or collaborating physician should be immediately available at all times in case of a complication or finding unfamiliar to the NP or PA cystoscopist. One’s own institution or practice should establish privileges for NPs or PAs to perform minor procedures, including cystoscopy, so that if a claim arises, there is no ambiguity. One may wish to verify directly that the malpractice insurance carrier will cover this procedure. The importance of such medical and legal support by a supervising physician and by one’s practice or institution cannot be overstated.

**Ideas for the Future**

As noted above, in the U.K., guidelines for performing cystoscopy have been long-established for the nurse cystoscopist and are currently being updated at the time of this publication (personal communication, September 8, 2011, Lucinda Poulton, BAUN President). These programs have been in place in the U.K. for over 10 years, and both research and literature-based evidence clearly attests to their efficacy (Fagerberg & Nostell, 2005; Gidlow et al., 2000; Radhakrishnan et al., 2006). To this end, SUNA is currently in the initial phases of developing guidelines and competencies for cystoscopy. These guidelines are meant to be applicable for both NPs and PAs. The American Urological Association is currently divided in its opinions regarding NPs and PAs performing cystoscopy, and has been uncommitted to collaborating in the creation of these guidelines and competencies despite an open invitation from SUNA.

In the U.S., a recommended training program with protocols that NP or PA cystoscopists can take back to their own institution and implement needs to be established. There should be a formal didactic training portion with basic introduction to cystoscopy, similar to the advanced practice workshops offered at the SUNA Annual Symposia in 2010 and 2011. In addition, a practical, “hands-on” teaching component would also be necessary and likely be achieved through one’s home institution or practice. The future could see the development of regional “centers of excellence,” where NPs or PAs could participate in programs to learn the specifics of cystoscopy and build their competency through live clinical experience.

Didactic and practical training could be supplemented with a Web-based training program to allow for distance education for the didactic portion. This content could be used for follow-up refresher training. It would also provide education to NPs and PAs not able to attend conferences due to budgetary or logistical issues, which are often cited as roadblocks by NPs and PAs in rural communities across the country. This online content could be based on videos recorded and packaged as part of the live courses that are already taking place at SUNA and conferences every year.

Finally, it would be beneficial for NP/PA cystoscopy training to be modeled after our international colleagues to allow for research and clinical outcome comparisons. This will ensure the best quality of care for patients with appropriate training, competence, and accountability by adapting guidelines already successful overseas. Underlying each educational objective is the development of a consistent and well-devised curriculum to achieve clinical competency for the NP and PA to perform screening, surveillance, and diagnostic cystoscopy. Such a curriculum will be an essential component to provide the necessary medical care our growing patient population will require for many years to come.
References

Additional Readings