

Society of Urologic Nurses and Associates Medical Assistants Task Force Position Statement

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Issue/Scope of Problem

Medical Assistants (MAs) working in urology practices are prevalent throughout the United States, and each plays an active role in the care of the urologic patient.

In May 2022, 752,460 MAs were reportedly employed in the United States, up from approximately 429,000 in 2012 (U.S. Bureau of Labor Statistics [BLS], 2024). This number is expected to grow another 14% between 2022 and 2032. Of the currently employed MAs, 427,730 work in physician offices, 107,450 in general medical and surgical hospitals, and 70,580 in outpatient care centers (BLS, 2024). In comparison, there are 208,760 Registered Nurses (RN) and 79,130 Licensed Practical Nurses/Licensed Vocational Nurses (LPN/LVN) currently working in physician offices, or half the number of MAs (BLS, 2024). Given that there are currently twice as many MAs as nurses working in clinics, and that number is projected to grow, we can extrapolate that the role of the MA in urology is also growing. By the year 2030, it is projected that 42 states in the United States will experience shortages of nurses (Hoover, 2024). MAs are uniquely positioned to help fill these open positions and ensure patients receive competent and safe medical care. This Task Force seeks to offer guidance for the role of the MA in urology and propose standards for training MAs entering the urology field and maintaining competency.

The scope of practice laws for MAs often varies by state. MAs are not mentioned by name in the laws of some states; rather, MAs may be classified as “unlicensed personnel” or “unlicensed professionals” in the laws of some states (American Association of Medical Assistants [AAMA], 2017). This Task Force recognizes there are certified MAs, as well as non-certified MAs, and does not denounce the tremendous value they bring to urologic practices. For further information regarding a specific state’s scope of practice; a link has been provided in the Additional Resources section.

Due to this, the Society of Urologic Nurses and Associates (SUNA) has developed a Task Force whose goal was to create a position statement to establish minimal evidence-based clinical competencies and guidelines for the urologic MA.

SUNA’s Mission/Guiding Beliefs

We are a leading authority on education which empowers health care professionals to improve the quality of life of urology patients, establish standards to increase patient safety, and provide high-quality education/guidance for urology professionals.

Definition of Key Terms

This position statement serves as the recommended guideline for MAs working in outpatient urology clinical environments.

The Task Force has identified the following areas: cystoscopy assistance, intravesical therapy administration, safety/sterilization, catheter placement/exchange, and urodynamic studies (UDS).

Target Audience

The target audience includes but is not limited to, physicians, advanced practice providers, nurses (RN/LPN/LVN), medical assistants, non-clinical personnel, and administrative personnel on all levels involved in urologic practice.

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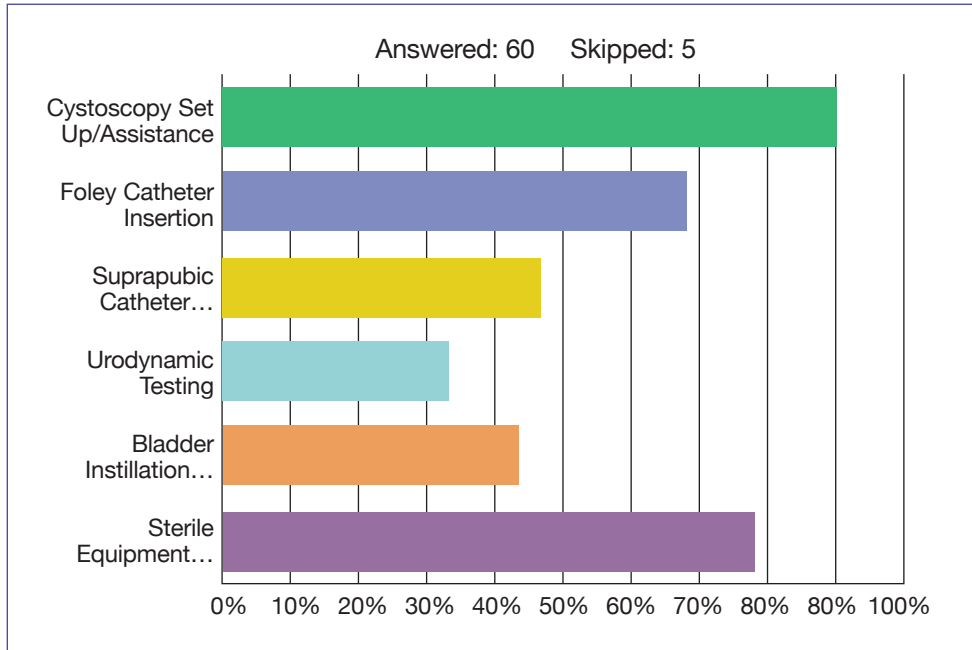
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Table 1.
Q3 Roles/Tasks You (If An MA) Or Your Medical Assistants Performs
in The Clinic Setting – Check All That Apply



Financial/Social Impact

From a financial standpoint, guidelines serving to address core tasks the MA can perform may alleviate the impacts of improper performance (waste of products) and adherence to safe practices. In turn, this can decrease costs to patients and the practice setting. From a financial *and* social standpoint, set guidelines may give the MA a sense of belonging and confidence, which may reduce MA turnover. Decreased turnover can positively impact the practice in a financial and social aspect.

Regulatory Impact

Our Task Force did an extensive search using the following search engines: Google, Agency for Healthcare Research & Quality (AHRQ), PubMed, CINAHL, Joanna Briggs Institute (JBI), The Cochrane Library, and other sites to query specific literature regarding MAs in clinical practice.

We found only one website belonging to Specialty Certified Medical Assistant, which concentrates on the MA in urologic practice and certification. A Task Force member reached out to this certification organization but was unsuccessful in gathering additional information due to not being an active member.

Review of Literature/Background

The literature search utilizing the above resources resulted in information and guidance for the registered nurse but nothing specific to the MA. Therefore, very little literature on MAs was found across EBP/scholarly platforms.

Due to this lack of available information, the MA Task Force sent a survey to all SUNA members in Fall 2023, specifically asking what tasks the MAs perform. We had a total of 62 respondents. Of these respondents, 20 are APRNs, 24 are RNs, 6 are LPNs, and 12 are MAs. Respondent settings included inpatient (1), outpatient/ambulatory (38), and private practice (23). Figure 1 shows the high percentage of MAs performing tasks. It is assumed, if skipped, MAs are not employed in the respondent's practice.

Regarding training of MAs to perform cystoscopy assistance, catheterization, sterilization, and bladder instillation, most reported on-the-job training, with less than 15% of respondents receiving formal course training on these procedures. However, it was noted that with urodynamic training, 52% of respondents received on-the-job training, while 48% received formal course training.

When asked the number of competencies check-offs required, 45% of respondents stated the MA is considered competent after 1 to 3 times, 36% reported 4 to 6 times, 16% reported 7 to 8 times, while only 3%

Table 2.
Examples of Intravesical Agents Used in the Urological Setting

| Chemotherapy Agents | Immunotherapy Agents | Non-Oncological Agents |
|--|---|--|
| <ul style="list-style-type: none"> • Mitomycin C • Epirubicin • Gemcitabine | <ul style="list-style-type: none"> • Bacillus Calmette-Guerin (BCG) • Astiladrin® • Anktiva® | <ul style="list-style-type: none"> • Antibiotics • Dimethyl sulfoxide (DMSO) |

reported 11 or more. However, the limitation of this survey question is that it did not specify which procedure (cystoscopy, catheterization, sterilization, installation, UDS) required checkoff.

Conversely, survey respondents were questioned about bladder instillation of Bacillus Calmette-Guerin (BCG) and chemotherapy agents (mitomycin, gemcitabine, docetaxel). Regarding MAs, 18% of them reported performing BCG installations, while 15% performed BCG and other chemotherapy agents. Regarding chemotherapy certification, only 3% responded that they were certified.

Bladder Instillation

One of the many responsibilities that fall upon the MA in the urology outpatient setting is the instillation of intravesical therapies. It is important to note the term ‘intravesical therapy’ refers to all medications instilled directly into the bladder. The number of therapies constantly evolves, including medications used for oncological and non-oncological treatments. Treatments for non-muscle invasive bladder cancer (NMIBC) comprise cytotoxic (interchangeable here with ‘chemotherapy’) and immunotherapy agents. Examples of cytotoxic intravesical therapies include mitomycin C, epirubicin, and gemcitabine (American Urological Association [AUA] & SUNA, 2020). BCG is the most common intravesical immunotherapy for treating early-stage bladder cancer (American Cancer Society, 2024).

Simply put, immunotherapy promotes one’s immune system to assist in attacking the cancer cells. Newer immunotherapy agents also include nadofaragene firadenovec (Astiladrin®) and nogapendekin alfa inbakicept (Anktiva®). Intravesical therapies are also used to treat a variety of non-oncological conditions, such as interstitial cystitis (IC), bladder pain syndrome (BPS), and chronic urinary tract infections (UTI). Examples of each type of agent are listed in Table 1.

Several publications establish the guidelines for this crucial practice. As has been the ongoing theme, what appears to be lacking are guidelines specific to the MA.

In 2015, the AUA and SUNA collaborated to develop a standard operating procedure for the use of intravesical therapeutic agents. Per this position statement, “Healthcare personnel (MD, NP, PA, RN, LPN, or MA) performing intravesical therapy must be educated, demonstrate competency, and understand the implications of non-muscle invasive bladder cancer. Scope of

practice for health care personnel listed may vary based on state or institution” (AUA & SUNA, 2020). At a minimum, these professional organizations recommend that each institution or office practice setting implement an established, annual competency program to review safety work practices and guidelines (AUA & SUNA, 2020).

A review of the literature found that other authors agree. According to Hensley (2016), health care personnel performing intravesical therapy must be educated, demonstrate competency, and understand the implications of NMIBC, including treatment options. As AUA and SUNA recommended, Hensley also endorses retraining and competency testing be done on an annual basis.

Again, as summarized in the literature review, recommended strategies for the training of administering intravesical therapy were given. Because these are not specific to the MA, it is SUNA’s goal to present such guidelines that ensure the successful, safe, and competent practice of intravesical instillations by the MA in the urology setting. Whether being administered by an RN or MA, SUNA strongly encourages all personnel administering intravesical chemotherapy agents to obtain formal training and, if available, certification. However, a review of the literature has shown that chemotherapy certification for the MA does not exist. If and/or when such certification becomes available, SUNA recommends that becoming certified be the standard.

Appropriate training will emphasize the importance of safe handling precautions. This is crucial, as potential exposures to such hazardous drugs in the clinic setting can occur during preparation, administration, and disposal (Hensley, 2016). Safe handling precautions include the use of safety equipment (e.g., using a zip-top bag labeled as ‘chemotherapy’), safe work practices, and proper personal protective equipment (PPE) (e.g., chemotherapy gloves, disposable gown, surgical mask, protective eyewear). When all three are used consistently, these precautions can reduce hazardous drug exposures (Hensley, 2016). In addition to the above, appropriate disposal is an equally important step that should be included during the preliminary education.

Before practicing bladder instillation, the MA must have a general understanding of the anatomy and physiology of the urinary tract. Patient-specific information is helpful to know prior to a catheterization attempt is key (i.e., a history of a stricture, enlarged prostate, perineal

urethroscopy). Because each institution will have its own policy, the MA should be able to perform catheterization per unit protocol. Following the procedure steps established by our colleagues in the past position statement (AUA, 2020), the MA will safely and successfully administer the intravesical medication by gentle push instillation.

Therefore, the Task Force recommends the following should be implemented to ensure the MA can independently administer intravesical therapies:

1. Have a dedicated preceptor/educator that is consistently with the MA during the initial training and can then act as a resource afterwards.
2. Have initial training that should include the review of safety work practices and guidelines regarding storage/receiving, handling/transportation, administration, disposal, and handling a spill of hazardous drugs (AUA, 2020).
3. Be able to perform an instillation successfully and correctly on three separate occasions.
4. Complete an annual competency consisting of performing one instillation under the supervision of a clinical nurse specialist or designated preceptor.
5. Complete an annual competency program to review safety work practices and guidelines regarding storage/receiving, handling/transportation, administration, disposal, and handling a spill of hazardous drugs (AUA, 2020).
6. Initial training and annual competencies must be documented, filed, and saved.

Urodynamic Testing

Urologic physician offices perform most urodynamic testing (UDS); some hospitals and/or outpatient care centers also offer UDS. As evidenced by the large number and statistics of MAs working in urology, it is important to clearly define guidelines for the appropriate training of the MA to become proficient in UDS, thus ensuring the patient is receiving quality care.

After reviewing the guidelines of organizations such as the International Continence Society (ICS), Department of Health and Human Services, and SUNA, this Task Force has composed the following recommendations for the MA performing UDS:

1. UDS should only be performed by, or under the direct supervision of, an individual who has been fully trained (AUGS, 2024; Department of Health and Human Services [DHHS], 2016; International Continence Society [ICS], 2023; United Kingdom Continence Society [UKCS], 2009).
2. Trainees should have a basic understanding of the urologic diagnoses pertinent to their area of UDS testing. For example: urogynecology MAs may only need to be familiar with female diagnoses, as they would not be expected to perform UDS on men; or practices not performing pediatric UDS clinician would not necessarily need to be familiar with pediatric considerations (DHHS, 2016; UKCS, 2009).

3. Attendance at a recognized, standardized training course for UDS is the ideal gold standard for training (ICS, 2023; SUNA, 2014).
4. At the time of this publishing, the current entities that provide UDS training courses are SUNA, Laborie, and Prometheus.
5. As an alternative to formal training courses, trainees should be mentored by an experienced clinician (DHHS, 2016; UKCS, 2009).
6. Trainees should observe at least five UDS studies performed by an experienced clinician (DHHS, 2016; UKCS, 2009), including:
 - a. History/diagnosis of patients.
 - b. Explaining the procedure and obtaining informed consent.
 - c. Set up techniques for UDS equipment and prepping patients.
 - d. Including maintaining a clean and safe environment and sterile technique.
 - e. Running of the study.
 - f. Reviewing and charting the study.
 - g. Discussion of the study for Q & A after completion.

After completing a training course or observation of an experienced clinician:

1. Trainees should perform a minimum of 10 studies under the direct supervision of an experienced mentor (DHHS, 2016; UKCS, 2009).
2. These should include a variety of pertinent patient groups (i.e., men, women, incontinence, retention, neurogenic bladder, etc.) (UKCS, 2009).
3. Trainees should be signed off on all aspects of UDS testing by an experienced clinician before performing any UDS independently (ICS, 2023; UKCS, 2009). Competencies should be created for UDS training and should be documented and saved at the practice in an appropriate training file.
4. Trainees should perform UDS independently with an experienced clinician onsite for assistance, if needed, for at least six months (expert opinion, personal experience training).
5. MAs performing UDS should perform at least 30 UDS studies per year to maintain competency (UKCS, 2009).
6. MAs performing UDS should be audited for competency at least yearly (DHHS, 2016; UKCS, 2009). This Task Force would recommend annual competencies include a review of technique, safety, familiarity with relevant diagnoses, and updates to guidelines for UDS. These annual competencies should include observation of the MA performing UDS by an experienced clinician.
7. Competency during the training period and yearly audits must be documented (DHHS, 2016; UKCS, 2009).
8. Copies of certificates of completion for UDS training courses should be filed and saved at the practice location.

9. MAs performing UDS should be encouraged to pursue continuing education to stay updated on current best practices (this may include reviewing studies with a multidisciplinary team, reading articles, attending webinars, SUNA conferences, etc.) (DHHS, 2016; UKCS, 2009).

Cystoscopy

Another way the MA is utilized in the outpatient urology setting is to assist the provider with cystoscopy and associated cystoscopic procedures. This includes, but is not limited to, associated cystoscopic procedures such as bladder biopsies, ureteral stent removals, bladder washes, cystoscopy over guidewire, and Botox® injections in the bladder. Review of the literature showed limited publications that set guidelines for assisting with these types of urologic procedures. As is the common theme that this Task Force has established, there is also a lack of protocols and competencies specific to the MA.

There are, however, several educational and training opportunities exist, including:

- SUNA Medical Assisting Training Guide.
- Uro^{MA}: Essential Urology Training for Medical Assistants through Large Urology Group Practice Association (LUGPA).

Proposed competencies to be included in the education and training of cystoscopy assisting include but are not limited to:

1. Demonstrates knowledge of the anatomy and physiology of the urinary tract.
2. Demonstrates knowledge of equipment/supplies used for cystoscopy and associated cystoscopic procedures.
3. Demonstrates set up for a cystoscopy and related cystoscopic procedures.
4. Demonstrates proper handling of a cystoscope.
5. Recognizes diagnoses and implications for cystoscopy and associated cystoscopic procedures.
6. Demonstrates clean versus aseptic technique.
7. Demonstrates complete reprocessing of cystoscopes.
8. Demonstrates urethral instillation of lidocaine gel.
9. In addition to the above initial training, an annual competency is recommended.
10. Initial training and annual competencies must be documented, filed, and saved.

Catheterization

As mentioned at the beginning of this position statement, the scope of practice laws for MAs may vary by state. Therefore, this Task Force will not address state-specific laws regarding MAs but instead provide recommended guidelines for a commonly delegated task in urology settings where MAs perform urinary catheterization; this includes exchanging suprapubic catheters in the established tract. The newly inserted suprapubic

catheter track is considered established within 4 to 6 weeks (Quallich et al., 2023).

A guiding recommendation from this Task Force, with respect to MAs performing urinary catheterization, a delegating practitioner may delegate to an MA the performance of a task if the delegating practitioner knows the MA possesses the knowledge, skill, and training to perform the task safely and properly. Before performing catheterization, the MA must ensure consultation with the physician or advanced practice provider (APP; usually a nurse practitioner or physician assistant/associate), the patient, and/or caregiver that the decision to catheterize is made for the right clinical reasons.

The MA should then carefully review the order to ensure the proper catheter is used (i.e., size of the catheter, latex versus silicone, Coudé-tip versus straight tip). Next, the MA will prepare the patient and insert the catheter per their facility protocol. It is important for the MA to receive proper training and regular competency validation to ensure proper techniques are being utilized. Male patients are known to have more adverse events with Foley insertion than their female counterparts due to the length of the urethra and the presence of a prostate. Improper catheterization can lead to urethral injury. Trauma can result from misjudged application of pressure during catheter insertion or from inflation of the balloon while still in the urethra. Although seldom life-threatening, iatrogenic urethral injury associated with catheter insertion may have devastating long-term sequelae, including strictures, incontinence, erectile dysfunction, and infertility. Males are more commonly affected due to their longer urethra (Manalo et al., 2011). According to the article *Clinical Practice Procedure: Urinary Catheterization of the Adult Male* (Newman, 2021), difficult transurethral catheterization is defined as failure to insert a catheter after two attempts; if you are not able to pass the catheter because of resistance, stop the procedure, and consider using a Coudé-tip catheter. If still unable to pass with a Coudé-tip catheter, notify the prescribing provider.

Training in catheterization should be universal and designed to include step-by-step instruction in the process, emphasis on history taking, and raising awareness of factors associated with increased risk of urethral injury. Given the risk of serious patient injury, training might best be delivered by urologists (Manalo et al., 2011). A study published in the *Canadian Urological Association Journal* (2021) recommends catheter training should develop to focus on different types of catheters and management strategies for difficult catheter scenarios. Standardizing safe catheter education during undergraduate training and including this as a part of regular annual or bi-annual mandatory training for health care staff involved in dealing with catheters in clinical practice (Bhatt et al., 2021).

The suggested structure for gaining competence in catheterization:

- Gain theoretical knowledge and understanding in aspects of catheterization.
- Observe model/manikin being catheterized.
- Practice catheterization on a model/manikin under supervision until confident.
- Observe catheterization performed by others on actual patients.
- Undertake supervised catheterization on actual patients.
- Be able to catheterize without direct supervision.
- Gain experience and become confident.
- Become a competent mentor for others.
- Have the catheterization technique observed as part of a clinical audit.
- Undergo initial training and annual competency, both of which must be documented, filed, and saved.
- In relation to all aspects of catheter care, it is recommended health care professionals have a formal update at least every five years, and more often if appropriate or required (Royal College of Nursing, 2021).

Extensive literature research yielded no specific timeline recommendations, number of observations, or insertions on manikins/actual patients to achieve competency. This Task Force recommends individualized training for MAs with an experienced mentor, in addition to online learning/video platforms, to achieve safe/competent Foley catheter insertion. Annual competency evaluation by a clinical supervisor is recommended as research has shown.

Sterilization/Safety

Staff training and oversight on the disinfection process are not always readily available to all staff. MAs need to be aware that the complexity of these procedures, lack of resources, and training often create gaps in standards and practice. It is important that ongoing leadership and infection prevention oversight for this highly complex task are required to ensure patient and staff safety, including a process for new hire training and competency. Leaders must ensure all required supplies for reprocessing are made available to staff, policies following manufacturers' recommendations are readily available, and all reprocessing quality control records are kept up to date. Leaders should also oversee staff adhere to all steps in the high-level disinfection (HLD) process by implementing regular audits using a checklist that outlines all the required elements of instrument reprocessing (Montero et al., 2022).

Per the Centers for Disease Control and Prevention (CDC) (2023), recommendations regarding quality control for effective sterilization/safety are to provide comprehensive and intensive training for all staff assigned to reprocess semi-critical and critical medical/surgical instruments to ensure they understand the importance of reprocessing these instruments and to achieve and maintain competency, train each member of the staff regarding reprocessing semi-critical and/or critical instruments as follows:

1. Provide hands-on training per the institutional policy for reprocessing critical and semi-critical devices.
2. Supervise all work until competency is documented for each reprocessing task.
3. Conduct competency testing at the beginning of employment and regularly thereafter (e.g., annually)
4. Review the written reprocessing instructions regularly to ensure they comply with the scientific literature and the manufacturers' instructions.
5. Conduct infection control rounds periodically (e.g., annually) in high-risk reprocessing areas; ensure reprocessing instructions are current and accurate and are correctly implemented. Document all deviations from policy. All stakeholders should identify what corrective actions will be implemented. Periodically review policies and procedures for sterilization (CDC, 2023).

Options for Implementation and Recommendation

In addition to the specific recommendations set forth within each area listed above, this Task Force suggests the following guidelines would apply to all general skills designated to the MA:

- Annual competency.
- Logbook.
- Return demonstration.
- Checklist.
- Lead/designated preceptor.
- Web-based/Leading Authority (SUNA, AUA, etc.).

Summary

Medical Assistants (MAs) are important patient care professionals in urology. In this specialty, they have a very hands-on role, which requires unique skills to accomplish safe and competent care. Our goal is to empower the MA and their respective employers with minimal evidence-based guidelines to support them in their practice. While different states restrict MAs from performing procedures, we encourage stakeholders to advocate for the MA in urology to lift such restrictive rules.

“When given training, medical assistants can play a more vital role as part of the care team and can yield tremendous value to patients and health care providers. We need to deliver care in a new and more efficient way and know that big changes are needed to accomplish that goal.” (Langely, 2016). ▣

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Additional Resources

- LUGPA: Integrated Practices Comprehensive Care. *Uro^{MA}: LUGPA's essential urology training for medical assistants*. <https://www.lugpa.org/uroma>
- Society of Urologic Nurses & Associates. *SUNA medical assistant urology training series – Module 1: Introduction to urology*. https://library.sun.org/store/14/index/86_