Should the UK have rigorous aesthetic nursing qualifications like the US?

The introduction of the Certified Aesthetic Nurse Specialist exam in the US has led many practitioners to consider the quality and regulation of training in the UK. However, according to Yvonne Senior, this qualification system is not as progressive as it seems, with many US aesthetic nurses requiring the support of their medical counterparts to administer non-surgical interventions such as injectables.

At the recent Journal of Aesthetic Nursing conference, I was invited to take part in a post-lunch panel discussion addressing the topic ‘Training and qualifications: should the UK be more like the US?’ This was quite a broad matter to fully analyse in the time given, but nonetheless raised some interesting and perhaps unexpected comparisons from the panel members, and challenged my knowledge of the US system. What it did remind me was that aesthetic nursing in the UK is far more unusual in the role it plays within the industry and the responsibilities we bear in comparison to both the US and most parts of Europe.

There remains in the UK a general perception among the public and patients that the US is much more advanced in the aesthetic treatments it offers, and following my trips there patients often asked what new treatments are on the scene. This is for the most part a wide misconception—when I undertook aesthetic training in the US in 1999, the only fillers available were collagen-based, and Restylane, which was fast becoming the most popular filler in the UK, was only available to US practitioners via Canadian pharmacies. This perception of being advanced in the field can also carry through to practitioners, so what is the situation stateside for aesthetic nurses?

Initially, what is perhaps commendable about the North American system is that, for several years, the US has had a recognised and recordable education programme and examination system: the Certified Aesthetic Nurse Specialist (CANS) exam. However, the course title itself is an example of our linguistic disparities in that only a small percentage of the core curriculum is aesthetics as we know it, as this usually refers to non-surgical work in the UK. In fact, the majority of the CANS curriculum is designed to deliver knowledge and skills in plastic surgery nursing. To this end, the curriculum is rigorous, challenging and extensive. It covers in-depth topics, such as cosmetic surgery, wound care, facial cranial surgery, anaesthesia, care of the burns patient, psychosocial considerations, anatomy and pharmacology.

The essential eligibility criteria to access this programme are to possess a license to practise and to be working in collaboration or in a practice with a physician certified in either plastic surgery, ophthalmology, dermatology or ear, nose and throat surgery. Nurses must also have a minimum of 2 years working in one of the these specialties, have spent at least 1000 hours within the core specialty during those years, and need to have a core physician endorse their application.

Following successful completion of the CANS exam, nurses are expected to re-register every 2 years and demonstrate a number of contract hours. This is not so dissimilar to the way we register with the Nursing and Midwifery Council, but is more reliant on a doctor’s approval. Nurses that do chose to pursue the non-surgical avenue in aesthetics in the US often practise under the auspices of a physician using the appointed pharmacy prescribing number that all US physicians have appointed to them to order their botulinum toxin. This feels too much like remote prescribing to me, and the consensus in the UK is that this is not safe practice and is against the advice of the regulatory bodies.

While the concept of a rigorous qualification recognised by the licensing bodies is very attractive and would, in theory, lead to more transparent and easily implemented systems of practice assessment and licensing, the US system certainly does not reflect the position in the UK. British nurses in aesthetics are unique in that the UK sector has been very much led and developed by nurses themselves, so to hand all the power back to doctors would seem a retrograde step. If we were to practise to US standards, many nurses would be tethered to medically-owned and private-run practices, and would rely on physician approval or recommendation to undertake courses like the CANS. As it is in this country, higher education courses are increasingly emerging within aesthetics, as institutions like Northumbria University offer content and modules to allow practitioners to further their knowledge and skill to master’s level. Here, further aesthetics and non-surgical treatments have developed as a specialty separate to plastics and our higher education system merits the experience of the practitioner based on their prior study, qualifications and experience—not who signs them off.

The regulation for non-surgical aesthetics still remains disappointing; however, when reflecting on countries like the US, who discourage independent practice and learning without the backing of physicians, or European countries like Spain, who do not allow nurses to administer botulinum toxin at all, it is a relief that as a profession we have progressed through collective learning and remain masters of our own education and skill.