British Association of Cosmetic Nurses

The BACN response to the DHSC consultation

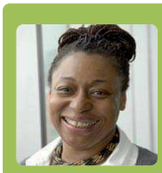
BACN members Sharron Brown and Constance Campion-Awwad discuss the implications of the DHSC consultation on aesthetic nurses and their patients

AdobeStock/artiemedvedev

When Professor Sir Bruce Keogh's Review of the Regulation of Cosmetic Interventions 2013 highlighted concerns about the aesthetics sector, the two authors of BACN's response Constance Campion-Awwad and Emma Davies, set out a comprehensive, evidence-based document on behalf of nurses which made several key points. The strongest statement was that there was an existing framework of standards that nurses and doctors were mandated to deliver in their treatment and care of patients, and there could be no deviation from that standard due to the law. Secondly, it was pointed out that only nurses and doctors can meet the legal standard of patient care, defined in law as 'the reasonable standard of care'. What had emitted in the wider aesthetics industry however, was that due to the historic fact that incursions by non-registered specialists, had already over-taken specialist accredited plastic surgeons in the sector, this led to the commercialisation of cosmetic surgery as we have never seen before, but under the blind-eye of the Department of Health. The Government had shown no appetite for regulation and neither did the regulator, the General Medical Council, and as a result, commercial cosmetic surgery established itself in its own free market zone. As non-surgical medical aesthetics is far less risky than surgery and it is a lot more lucrative an area of work than aesthetic surgery; a widening selection of practitioners from a vast army of providers, including allied healthcare workers, entered the 'aesthetics industry' that took shape and outnumbered the medical sector, including non-medics.

By the time Professor Sir Bruce Keogh's recommendations were published, standards had already fallen well below the threshold of the reasonable standard of care. The regulatory standards that are in place in other areas of medicine and nursing should have been the standard of professionally competent doctors and nurses, if they are compliant with the General Medical Council (GMC) fitness to practise regulations. The Code was not seen as the benchmark to build practice.

In Britain's medical aesthetics sector today, there is a well evidenced and documented invasion led by lay injectors and therapists who masquerade as trained and qualified. This has overwhelmed the sector, whilst commercialising and sabotaging medical and nursing standards of treatment and care. This has left vulnerable groups of patients, physically injured, mentally abused and harmed.



SHARRON BROWN
Management Comittee Member and Secretary, BACN
E: sbrown@bacn.org.uk

CONSTANCE CAMPION-AWWAD
Consultant Nurse Practitioner
E: info@constancecampion.com

The position Britain's specialist nurses have maintained (since it was they who initially assisted the dawning of medical aesthetics within the specialism of specialist plastic surgery in the mid 1980s) is that whenever a patient seeks an aesthetic treatment from a nurse or a doctor, medical treatment and nursing care must always be carried out in accordance with the parameters of a regulatory mandated framework, in which sits a duty of care. A 'duty of care' refers to the obligations placed on people to act towards others in a certain way, in accordance with certain standards. The term can have a different meaning depending on the legal context in which it is being used. Generally, the law imposes a duty of care on a health care practitioner in situations where it is 'reasonably foreseeable' that the practitioner might cause harm to patients through their actions or omissions. This is the case regardless of whether that practitioner is a nurse, midwife, nursing associate, healthcare assistant or assistant. A newly qualified nurse would be expected to deliver safe care in the same way as an experienced nurse performing the same task. The standards to be expected are not generally affected by any personal attributes, such as level of experience.

» The Code does not place restrictions or limits on tasks, treatments or the practices of nurses. Therefore, any person who seeks information from a registered nurse, whether they embark on treatment or not, would fall within statutory regulatory law as being 'patients' «

The Code does not place restrictions or limits on tasks, treatments or the practices of nurses. Therefore, any person who seeks information from a registered nurse, whether they embark on treatment or not, would fall within statutory regulatory law as being 'patients'. Thus, not only does regulatory law place nurses in a position of trust, but equally, as the regulatory law and two other areas of law converge (civil and criminal law) it is the law that holds nurses to account and holds them to a higher standard.

Given what has been absent and overlooked in terms of standards in the provision of medical aesthetics 'professional manpower' in the UK, and the fact that patients are being affected, the BACN welcomed the long overdue consultation announced by the government in September 2023. The BACN then set itself

AdobeStock/Gabriel

AdobeStock/ William Richardson

the task of gathering a consensus group of nursing experts from within the ranks of its membership, to respond to the consultation. This included the two authors of this article, as well as Sharon Bennett, Anna Baker, Sharon King, and our esteemed colleague, Cheryl Barton, who acted as an external nursing expert for reflective thinking input.

We engaged firstly in an analysis of the points outlined in the consultation document, before considering the history of the sector as well as all the themes and elements that constituted the subjects matters. This detailed research was required before we could tackle the association's response and so the BACN could produce its own in-depth, cogent, evidenced response. Our principal aim was to produce a response which would not only influence government policy and thinking, but one which would inform others engaged in the independent medical sector.

When the Government released the consultation document in September 2023, many experts found it to be poorly researched, badly written and inaccurate in parts. It was clear that its main focus was directed, unfairly, at assisting the aesthetics industry, as opposed to supporting and strengthening the medical and nursing professions who represent specialist nurses, primary medical carers and specialist doctors alike, who engage in the provision of medical aesthetics services to patients in accordance with the reasonable standard mandated by law. Overall, the consultation can be summed up as reflecting an industry culture, in an industry language and mindset, which demonstrates the face of Britain's uniquely poor industry standards today.

» The WHO defines stewardship as 'the careful and responsible management of the well-being of the population'. This means developing a strategic framework for health policies, building support amongst stakeholders, regulating and monitoring health care systems, and using data to improve «

Therefore, rather than demonstrating that the Government and their policy advisors align themselves with the developed medical and nursing sub-specialism of medical aesthetics (which is the standard of the rank and file of nurses and doctors in the sector) the Government has proved yet again, that when it had to look at 'aesthetics', the consultation was driven by revenues that could be earmarked by The Treasury. The Government consistently demonstrates that it prefers to pander to the hair and beauty industry, rather than the appropriate doctors and nurses in the medical aesthetics sector, who are the legitimate practitioners and stewards of healthcare, medicine and nursing, acting as the advocates of patients.

The World Health Organization defines stewardship as 'the careful and responsible management of the well-being of the population'. This means developing a strategic framework for health policies that reaches all citizens, building support amongst stakeholders, regulating and

monitoring health care systems, and using data to improve. This has not happened in the three decades of medical aesthetics practice in the UK and neither has the Government employed data gathering or any signs of data analysis, save for the possibility that A1 drafted the consultation document. Regardless, the only statistics it could draw from were published by the British Beauty Council, which state that the cosmetic and personal care sector brought a total of £24.5 billion to GDP contribution and tax contributions of £6.8 billion to HM Treasury in 2022 (DHSC, 2023).

The BACN has correctly set out its response to the Government, in which it highlights and links the medical aesthetics sector to its historic medical market that is rooted in the independent healthcare sector. In addition, it has linked it equally to independent services provision in aesthetic surgery and added to this, is the indisputable fact that medical aesthetics is an element of the emerging market that associates it with the wellness-age management fields of practice in longevity regenerative aesthetics.

According to a Barclays Corporate report in 2019, the global health and wellness industry was valued at £3.3 trillion. The UK market for services related to wellness has meanwhile been estimated to be worth £12.4 billion in 2020, with annual growth averaging nearly 4% per annum, occurring since 2015. The UK private healthcare market was forecast to grow from £9.3 billion in 2017 to £10.9 billion by the end of 2023. The UK's cosmetic surgery market is currently worth an estimated £3.6 billion. Non-surgical treatments, such as botulinum toxin and dermal filler injections account for 9 out of 10 procedures, which values the sector in the UK at approximately £2.75 billion although it is generally agreed more accurate estimates placed its value at around £3.6 billion in 2021. McKinsey research data from 2021 estimates that the global injectable market has the potential to increase between 12-14% annually over the next five years. This is thought to be due to the changing attitudes, alongside acceptance and a growing awareness towards wellness and anti-aging. Roberts discusses developing a generational approach as a model of prevention towards the evolving aging patient identifying and reducing the risk factors in detecting early skin disease (Roberts, 2013). Therefore, it is expected that we will see increasing provision and growth in independent dermatology services being provided as part of the overall wellness and focus on skin health which is being met by specialist nurses and doctors. As nurses working in medical aesthetics, we are an established part of the independent healthcare sector and several specialist nurses amongst our ranks have established specialist nursing services over the past two decades, in restorative and regenerative medical aesthetics. They operate in the wellness age-management space as well as in specialist reconstructive and aesthetic fields of practice in plastic surgery. Not only are nurse members in BACN now showing interest in widening their scope of practice in this expanding field, but they are reporting that their patients are driving the agenda, and as a result, nurses see it as the means to deliver a more comprehensive specialist standard of patient care that deliver measurable outcomes. This is the primary justification for why BACN feels that more and more nurses are looking to BACN as they are bringing developed skills with them and see an opportunity

AdobeStock/JackF

British Association of Cosmetic Nurses

» The BACN are recommending to members that they should have a current enhanced DBS in place, as the BACN is taking safeguarding vulnerable patients very seriously «

to incorporate wellness and regenerative medicine into their practices. The BACN takes the stance that only regulated doctors and nurses can deliver the clinical standards and practises necessitated within the widening scope of what originated as medical aesthetics.

Consumers who are patients require what the authors of our BACN response articulate as 'an optimal level of clinical standards which registered nurses and doctors must deliver, in concert with the highest standards of patient care'. The BACN consistently holds out that its members, being registered nurses, are experts in patient care and have statutory responsibility for their patients' physical and psychological needs. The history of nursing in the aesthetic fields of plastic surgery and non-surgical medical aesthetics attests to the facts that patients often display a level of vulnerability, which can be identified in patients seeking a surgical or a non-surgical medical aesthetic treatment. The worrying trend to align non-surgical aesthetic treatments with the beauty sector can mean that safeguarding is overlooked. This factor was first noted in the sector by BACN's expert consensus nurses' group, when Cheryl Barton drew our attention to the fact that a gaping safeguarding loophole existed amongst the UK's unregulated operators, that there was a complete absence of checks and balances in place and this was not even mentioned in the government's consultation. This contrasts with the case of nurses who must have an enhanced DBS, especially when working with vulnerable adults, young people and children. The BACN are recommending to members that they should have a current enhanced DBS in place, as the BACN is taking safeguarding vulnerable patients very seriously. Moreover, the BACN is looking into registering with the DBS organisation as an umbrella group, so that our members can access a DBS check as employers through a BACN DBS Scheme, that it is hoped will be established. The general opinion of nurses and doctors has to matter when it comes to safeguarding and advocating for all patients.

What gives patients and the public confidence is the knowledge and skills required by regulated healthcare professionals (doctors and nurses) is mandated to a set of quality standards which cannot be comported to the non-regulated, because nonesuch exist. Therefore, despite what the aesthetics industry would have us believe, and the overarching theme of our nursing experts, is that there cannot be two standards of patient care. As regulated, registered nurses, we have a legal standard, which is the reasonable standard of patient care as defined by Fitness to Practice for doctors and The Code (2015) for registered nurses. The reasonable standard for care in medical aesthetics requires a level of professional competence demonstrated by the criteria designated by statutory regulatory bodies and this encompasses standards on education, core training, practice, continuing professional development and revalidation. The BACN cannot accept a lesser standard of care for patients which contravenes the benchmark in the standards for which they and doctors are already mandated to deliver, no matter what attempts are made by lays and the spokespeople who claim to control the narrative. It is the BACN who speak for the largest group of registered nurses in the independent medical sector and in the medical aesthetics sector, and they have continuously reminded the Government

AdobeStock/Pixel-Shot

» As regulated, registered nurses, we have a legal standard, which is the reasonable standard of patient care as defined by Fitness to Practice for doctors and The Code (2015) for registered nurses «

and will continue to hold out the legal standard of care. Amongst several factors the BACN is in agreement with however, is bringing high risk procedures in medical aesthetics into the scope of the Care Quality Commission (CQC). This is in alignment with The Nuffield Council on Bioethics, which in 2017 produced a report on non-surgical procedures. They recommended that the Department of Health should extend the remit of the CQC to all premises that perform invasive treatments (Nuffield 2017). The Kings Fund 2010 stated that there is evidence that a good-quality therapeutic relationship improves both patient satisfaction and professional fulfilment, saves time, and increases compliance. Yet the subtle and intangible elements that underpin a strong therapeutic relationship are difficult to define and measure. The BACN would regard this standard as the gold standard that our nurse members should always strive to attain and practice. The factors that motivate our patients in seeking anti-ageing or wellness related treatments can be nuanced. It not just about the aesthetic result. Patients may be influenced by social media, poor body image, be coerced into having a procedure and think they need to look a certain way to reflect a particular fashion or standard. Some feel they need treatments for a wide variety of reasons, for example; recovery from an illness such as cancer, trauma, injury, or diseases. Even a relationship break-up, or just wanting to improve how they look due to a milestone birthday brings patients to us. Being cognisant and aware of co-morbidities, polypharmacy and psychosocial issues when consulting, screening or assessing patients helps to mitigate negative outcomes. This is not the cosmetic or beauty standard of care, but forms an elegy in the compassionate elements of the collaborative professional relationship in extending medical and nursing care (Krebs et al, 2017), (McDonald et al, 2022).

There is a growing number of adverse events, some very complex, in respect to the increased application of dermal fillers. This has led to an increase in a range of symptoms, within a widening range of medical aesthetics. The problems patients are experiencing are relating to a wide number of causes from overfilling, dynamic distortion, chronic inflammation, oedema, infection, compression, vascular compromise and filler displacement. This can result in patients suffering. A larger proportion has been reported have to sought specialist care from the NHS due to the need for specialist and expert treatment. For example, complex wound management, which requires investigations from an immunology, pathology, microbiology and imaging perspective. In their response to the consultation, the BACN recognises that in accordance with the Care Standards Act 2008, any soft tissue injury following an injectable procedure must be carried out in a CQC registered establishment for the regulated activity of Treatment of Disease Disorder and Injury (TDDI). We have to remember that all procedures have a level of risk and require categorisation as part of a traffic system of red, amber and green. This was at variance with the medical and scientific standards which underpin risk analysis, and could potentially trivialise the level of associated risk in determining outcomes. The BACN's expert consensus group was very clear to the Government when they pointed this out in their response.

We therefore hope our contribution will be recognised by the Government and the

aesthetics industry, because our concerns further question how the enforcement of any new legislation, safeguarding, relevant oversight, clinical supervision, management of medical emergencies and complications will be carried out in patients' best interests. This includes data collection and data analysis to establish and ensure a quality framework is in place to annually review the facts. JAN

References

DHSC. The licensing of non-surgical cosmetic procedures in England. 2023. https://www.gov.uk/government/consultations/licensing-of-non-surgical-cosmetic-procedures/the-licensing-of-non-surgical-cosmetic-procedures-in-england.

GMC UK. Good medical practice. 2024. https://www.gmc-uk.org/ethical-guidance/good-medical-practice-2024

Greenhalgh, T., & Heath, I. Measuring quality in the therapeutic relationship--part 1: objective approaches. Quality & safety in health care, 19(6), 475–478. 2010. https://doi.org/10.1136/qshc.2010.043364

Keogh, S.B. Review of the Regulation of Cosmetic Interventions Final Report. p.6. 2013. https://assets.publishing.service.gov.uk/media/5a7a25dee5274a319e77831c/Review_of_the_Regulation_of_Cosmetic_Interventions.pdf

Krebs, G., Fernández de la Cruz, L., & Mataix-Cols, D. Recent advances in understanding and managing body dysmorphic disorder. Evidence-based mental health, 20(3), 71–75. 2017.https://doi.org/10.1136/eb-2017-102702

McDonald, C.B., Hart, S., Liew, S. et al. The importance of patient mindset: cosmetic injectable patient experience exploratory study—part 1. Aesthetic Surgery Journal Open Forum, volume 4. 2022, https://doi.org/10.1093/asjof/ojac043

Leclerc, O., Peters, N., Scaglione, A. et al. From extreme to mainstream: The future of aesthetics injectables. McKinsey. 2021. https://www.mckinsey.com/industries/life-sciences/our-insights/from-extreme-to-mainstream-the-future-of-aesthetics-injectables.

Nuffield Council on Bioethics. Cosmetic procedures: ethical issues. 2017. https://www.nuffieldbioethics.org/publications/cosmetic-procedures.

Roberts, W.E. Generational dermatology: model for prevention and multi decade approach toward the evolving, aging patient. JDDonline - Journal of Drugs in Dermatology. 2013. https://jddonline.com/articles/generational-dermatology-model-for-prevention-and-multi-decade-approach-toward-the-evolving-aging-pa-S1545961613P1396X.

Nursing and Midwifery Council (NMC). The code professional standards of practice and behaviour for nurses and midwives. 2018. https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf.

Saltman, R. B., & Ferroussier-Davis, O. The concept of stewardship in health policy. Bulletin of the World Health Organization. 2000. 78(6), 732–739.