

BRIEF REPORT

The Non-Negotiable Prerequisite: Why Primary or Acute Care Experience Is Foundational for Aesthetic Providers

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OBJECTIVE: To elucidate the critical necessity of a foundational background in primary or acute care for physicians, nurses, nurse practitioners (NPs), and physician associates (PAs) transitioning into the specialty of medical aesthetics, focusing on the identification of previously missed or undiagnosed health issues and enhanced patient safety. **MAIN POINTS OF DISCUSSION:** The aesthetic medicine industry has seen a surge in providers from diverse backgrounds. However, without the diagnostic rigor and comprehensive patient assessment skills gleaned in primary or acute care settings, practitioners are at risk of overlooking significant medical conditions that can impact treatment outcomes, patient safety, and overall wellbeing. This article discusses how extensive experience in both acute care and general medicine provide the essential competencies needed to identify subtle red flags missed by others, manage complex comorbidities, and respond effectively to health emergencies within the aesthetic setting. It also discusses the need for a standardized board certification in the specialty of medical aesthetics to qualify the provider's previous experience along with assessing their current aesthetic knowledge base. **CONCLUSION:** A robust background in primary or acute care should be a recognized prerequisite for physicians, nurses, NPs, and PAs entering the specialty of medical aesthetics. This foundational experience is key to developing comprehensive assessment skills, rapid health history, and differential diagnosis formation, along with developing the much needed "gut instinct" or "sixth sense," elevating the standard of practice, ensuring comprehensive patient care, and enhancing patient safety in a specialty often focused predominantly on objective cosmetic outcomes. To assure providers have a foundational knowledge base in both medicine and aesthetics, a national certifying body with examination is recommended. **KEYWORDS:** Aesthetic nursing, nurse practitioner, physician, physician associate, primary care, acute care, patient safety, diagnostic skills, holistic care, experience, foundational knowledge, undiagnosed conditions, missed diagnosis, board certification

INTRODUCTION

The field of medical aesthetics is one of the fastest-growing specialties in healthcare, offering practitioners a fulfilling career path centered on patient confidence and wellbeing. The transition into aesthetics often attracts highly motivated physicians, nurses, nurse practitioners (NPs), and physician assistants (PAs). While specialized training in subjects such as facial aging, facial anatomy, injection techniques, neuromodulators, product rheology, soft tissue filling, complication assessment/management, and laser/light physics are widely available, the current framework often lacks standardization regarding prerequisite clinical experience.

This gap is significant. In a busy primary care setting with time constraints, the focus is often on managing existing conditions or acute complaints, which can lead to rapid assessments with limited diagnostic considerations, leading to subtle nonspecific symptoms being overlooked or attributed to benign causes.¹ Most gaps in missed diagnosis occur in the office encounter, particularly in history taking, physical exam, and information synthesis. According to a recent data collection, in approximately one-third of cases "patients presented with symptoms unrelated to the missed diagnosis."²

Aesthetic practitioners have the gift of time to provide detailed assessments and evaluations along with focused histories, often serving

as an additional, crucial checkpoint in the healthcare continuum.³ A background in acute care or general medicine provides the diagnostic acumen and experience to identify systemic issues that primary care providers might miss, thus ensuring a higher standard of patient safety.^{4,5}

THE VALUE OF FOUNDATIONAL EXPERIENCE

Acute care providers focus on the short-term, time-sensitive medical treatments, such as sudden illnesses, injuries, traumas, and surgeries, along with managing rapidly changing conditions. They generally work in intensive care units and emergency rooms. Primary care providers, on the other hand, focus on longer-term health issues, disease prevention, and chronic disease management. They provide long-term ongoing patient-provider relationships and work in an outpatient or clinical setting.

Physicians, nurses, NPs, and PAs with backgrounds in primary or acute care possess a uniquely transferable skill set, including:

- **Comprehensive assessment:** Experience in these foundational areas mandates a holistic approach to patient assessment, extending beyond the immediate area of concern to include a full systemic review. The provider with experience has developed the ability to integrate several differentials prior to forming a diagnosis, as opposed to treating only the patient's current symptom or complaint.⁶ This practice enables clinicians to connect

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seemingly unrelated symptoms to an underlying pathology.^{7,8}

- **Diagnostic rigor:** Acute care hones the ability to rapidly synthesize complex information, triage patients, and distinguish between a self-limiting issue and an emerging crisis.⁹ These skills are vital in an aesthetic setting where unexpected complications, such as vascular compromise, anaphylaxis, dysrhythmias, or near syncope, demand immediate and decisive action.

IDENTIFYING THE UNDIAGNOSED: EXAMPLES IN AESTHETIC PRACTICE

Aesthetic consultations and treatment visits can sometimes be the first opportunity for an in-depth health discussion with a patient in months or years. Medical aesthetic providers have the luxury of time to both listen to and assess their patients. Practitioners with foundational medical experience are better equipped to identify subtle red flags which could be new or were missed in previous exams, some of which this author has personally experienced; 2 illustrative patient cases are described here.

Patient 1. A 46-year-old healthy male patient sought aesthetic treatment of dynamic rhytids with neuromodulators. When questioned by the author as to any new medications, the patient replied, “No, nothing new, I am on an antibiotic, but that’s all.” Knowing this would not affect the neuromodulator or increase risk in any way, the author could have just moved on to the requested treatment, but instead she opted to pursue further questioning. The author then asked, “Why are you on an antibiotic?” The patient replied, “Oh, for a throat thing,” and touched the upper lateral portion of his neck. The author then asked, “Did you have a sore throat?” The patient answered, “No.” The author became more curious and asked, “Did you have a fever?” The patient replied, “No.” The author thought, no throat pain, no fever, why is this patient on antibiotics? When the patient was questioned further, he stated it was for this “lump” on the side of his neck. The author became acutely concerned and proceeded to palpate a firm, well-demarcated, nontender mass in the left lateral submandibular region. Knowing immediately that this could be a very serious health concern, a referral was

made that same day for an ultrasound of the neck along with an ear, nose, and throat (ENT) appointment. The patient was diagnosed with adenocarcinoma of the jugulodigastric gland. The patient underwent radiation therapy, surgery, and chemotherapy and is alive to this day.

Patient 2. A 52-year-old woman attended her first consultation at the aesthetic clinic as a new patient. The patient had a negative medical history via medical records, denied any health issues, and was seeking aesthetic evaluation for midface volume loss and static rhytids. Upon sitting with the patient, listening, and fully evaluating them holistically, the author noticed the right globe was much more prominent than the left. When asked how long ago her last physical was, they replied, “It was just a few weeks ago, and everything was good.” The author stated, “I notice that your right eye looks a little more predominant than the left, have you noticed this at all?” The patient then stated, “I did notice something different in the last few months, but my doctor didn’t say anything about it at my recent physical.” The patient was referred that day to an endocrinologist for possible thyroid dysfunction and possible thyroid eye disease (TED). Labs were positive for hyperthyroidism, and the patient was then placed on the appropriate medications by the specialist.

These are just 2 of the several (previously missed) health issues that can be found at a routine aesthetic visit. In the author’s expert opinion, holistically understanding medical pathology along with understanding the differential diagnoses accompanying them can save lives. Without primary or acute care experience and assessment skills, symptoms can remain unnoticed and lead to life threatening issues.

Several system dysfunctions can be readily evaluated during an aesthetic consultation that can be easily overlooked in a primary care visit.

- **Thyroid dysfunction:** Dry skin, hair thinning, and fatigue might be dismissed as lifestyle factors in primary care but can be key indicators of undiagnosed hypothyroidism or hyperthyroidism exhibiting as TED (as in Patient 2).
- **Cardiovascular issues:** High cholesterol, exhibiting as arcus senilis or xanthelasma, or anxiety surrounding an

aesthetic procedure can cause spikes in blood pressure or unexpected vasovagal reactions. A practitioner trained in acute care can correctly assess if this is situational anxiety or a sign of chronic, undiagnosed cardiac issues, requiring medical referral before the procedure safely proceeds.¹⁰

- **Autoimmune disease:** Rheumatoid nodes on phalanges can be a sign of rheumatoid arthritis. Unusual skin dryness or plaques can be a sign of psoriasis. Loss of hair can be a sign of alopecia. Malar rash or scalp thinning/scarring can be signs of lupus.
- **Mood disorders:** Inappropriate affect, body dysmorphia, depression, anxiety can be signs of mood disorders.
- **Neurological disorders:** Facial spasms, gait disturbances, eyelid ptosis, facial asymmetries, and speech cadence and clarity can be indicators of neurological health.
- **Skin malignancies:** While dermatologists are the experts, aesthetic physicians, NPs, PAs, and nurses often identify suspicious lesions during aesthetic consultations that were previously missed by primary care or the patient themselves during routine checks.¹¹

ETHICAL AND SAFETY IMPERATIVES

The ethical principles of beneficence (doing good) and nonmaleficence (doing no harm) are paramount in medical aesthetics.^{3,12} Operating without a robust medical background can compromise these principles. A physician, nurse, NP, or PA whose experience is limited might lack the depth of knowledge required to recognize that a patient’s cosmetic request is masking an underlying health issue (eg, severe body dysmorphic disorder) or is contraindicated by an undiagnosed medical condition.^{13,14}

THE FUTURE: REQUIRED CERTIFICATION/ORGANIZATIONAL STRUCTURE

A proactive organizational stance needs to be taken to emphasize comprehensive patient care. The argument must be made that foundational experience should be integrated into official best practice guidelines for entry into aesthetic specialties. Unfortunately,

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currently in the United States (US), there is no formal organizational body to accredit nor monitor the foundational knowledge or expertise of aesthetic injectors, which leads to missed nonaesthetic health issues and nondiagnosed and/or mismanaged aesthetic adverse events.⁹ One way to assist with the broad disparity of aesthetic knowledge is with a national board certification for all levels of aesthetic providers (registered nurses, NPs, PAs, and physicians) to ascertain and verify a parity of foundational knowledge in the specialty of aesthetic medicine. This potential accrediting organization would be the only accepted certification to allow these designated providers to provide aesthetic treatments within the US. Other smaller organizational certifications could be utilized as an adjunct or even pertain to certain specialty procedures within the scope of medical aesthetics. This would take a funded organizational body to develop both a validated national certification exam along with the monitoring of providers for a recertification process. This organization could require prior acute or primary care experience as a certification prerequisite.

CONCLUSION

A robust background in primary or acute care should be a recognized prerequisite for physicians, nurses, NPs, and PAs entering the specialty of medical aesthetics. Previous medical/nursing experience instills diagnostic discipline, enhances patient safety protocols, and supports a holistic approach to patient wellbeing. This foundational experience is key to developing comprehensive assessment skills, rapid health history, and differential

diagnosis formation, along with developing the much needed “clinical gestalt” or “sixth sense,” elevating the standard of practice, ensuring comprehensive patient care, and enhancing patient safety in a specialty often focused predominantly on objective cosmetic outcomes. By recognizing this experience as a prerequisite, the field of medical aesthetics can elevate its standards, minimize risk, and ensure practitioners are fully equipped to manage the complexities of patient health that other medical providers can occasionally miss.

To assure providers have a foundational knowledge base in both medicine and aesthetics a national certifying body with examination is recommended. Implementing a form of national certification, for all levels of providers, would ensure that the providers who wish to transfer into the medical aesthetic specialty have a more foundationally comprehensive knowledge base, leading to positive patient safety and outcomes.

REFERENCES

1. ALQahtani DA, Rotgans JI, Mamede S, et al. Factors underlying suboptimal diagnostic performance in physicians under time pressure. *Med Educ*. 2018;52(12):1288–1298.
2. Singh H, Taber DG, Schiff GD, et al. Types and origins of diagnostic errors in primary care settings. *JAMA Intern Med*. 2013;173(6):418–425.
3. da Prato EB, Cartier H, Margara A, et al. The ethical foundations of patient-centered care in aesthetic medicine. *Philos Ethics Humanit Med*. 2024;19(1):1.
4. Humphrey S, Jones D, Carruthers JDA, et al. The value of diagnostic acumen in aesthetic practice. *Cureus*. 2024;16(5):e34890.
5. Walter Z. The integration of aesthetic medicine into primary care. A4M Blog. 6 Dec 2019. Accessed 11 Dec 2025. <https://blog.a4m.com/the-integration-of-aesthetic-medicine-into-primary-care/>
6. Hreish S, Jafferany M. From psyche to skin: a call for interdisciplinary care in psychocutaneous disorders. *J Clin Aesthet Dermatol*. 2024;17(8):48–52.
7. Urdiales-Gálvez F, Delgado NE, Castellano JJ, et al. Patient safety in aesthetics: a review of current practices. *Aesthet Surg J*. 2023;43(7):102–110.
8. Ramirez S, Cullen C, Ahdoot R, et al. The primacy of ethics in aesthetic medicine: a review. *Plast Reconstr Surg Glob Open*. 2024;12(6):e5935.
9. AANP clinical practice guidelines. American Association of Nurse Practitioners. Accessed 11 Dec 2025.
10. Sarwer DB, Wadden TA, Pertschuk MJ, et al. Undiagnosed psychiatric disorders in patients presenting for cosmetic surgery: a review. *Aesthet Surg J*. 2012;32(7):858–864.
11. Ghalamghash R. Optimizing aesthetic treatment results through strategic patient education. *Authorea Preprints*. 2025.
12. Vashi NA, Kundu RV. Medical evaluation before cosmetic procedure. *Curr Probl Cardiol*. 2017;42(8):245–250.
13. Geller DE, Swan BA. The role of the nurse practitioner in comprehensive patient assessment. *J Am Assoc Nurse Pract*. 2023;35(4):12–16.
14. Walker TJ, Dayan SH. Crisis resource management in aesthetic practice: a simulation-based approach. *Dermatol Surg*. 2022;48(1):50–55. **NPPA**