SKIN CONFIDENT

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Dear Medical Spa Work Group,

This letter is an advisory opinion related to Medical Director roles in aesthetic medicine practices in the state of Alaska. My name is Whitney Carlson, MSN, FNP-C. I have specialized in aesthetic medicine for 15 years. As a Registered Nurse, I began my career assisting in surgery and providing aesthetic services such as neurotoxin and filler with two facial plastic surgeons in Anchorage. I then spent 10 years assisting in a dermatology clinic and providing aesthetic services with a Dermatologist who performs MOHS procedures. During this time, I became an autonomous APRN and was able to function as my own medical director and medical director for my employees. I am a national trainer and KOL for both a neurotoxin and filler company and a laser company. I train aesthetic offices around the state of Alaska and nationwide. I am deeply involved in the aesthetic medicine subspecialty of dermatology and plastic surgery. I believe that there needs to be major reform on these policies with clear boundaries. Clear policies will protect businesses, providers, and patients.

RE: Medical Director Definition

1.)To better guide the decisions on this subject, it is best to look to a similar system that already has such organized operational standards in practice. For example, the hospital system. In the hospital, there are clear rules regarding what skills or treatments each employee may perform based on their credentials (RN, PT, RT, etc.), the designation of which may be done by the overseeing MD, PA or NP provider. This must be the same in aesthetic medicine as it is a subspecialty of medicine. In this way, any assessment, diagnosis, and plan of care must be performed by the medical director in charge. In the hospital setting, the nurse may perform delegated duties as IV bag mixing + hanging, medication administration, minor procedures such as wound dressing, etc. These tasks rarely have a requirement for supervision if delegated.

This model should be the same for medical aesthetics. The Medical Director is responsible for the initial exam and assessment and writing orders, then delegating tasks/procedures to the RN or MA as applicable to each scope as defined by the state boards. Supervision of aesthetic procedures is not necessary as long as the performing individual is licensed and has the knowledge and skill to perform the procedure. It is my opinion that as long as the Medical Director is available via electronic communication or in-person, the Medical Director does not need to be physically on site when the procedures are performed. To be clear,

Non-licensed professionals (ex: estheticians) should not be allowed to perform any aesthetic treatment that falls into the medical category just like an esthetician would not be able to draw blood, inject or administer medication or perform any procedure in the hospital. Further education for such licenses is necessary.

2.) As a medical director myself and long-tenured in the aesthetic space, I believe a Medical Director needs to be the same subspecialty or at the very least, a similar specialty. I know RN injectors who have an OB for their medical director. This OB has nothing to do with aesthetics and would have no idea how to fix something if it went wrong. I see if no different than if an Ophthalmologist was going be the Medical Director for an Orthopedic Surgery Center. The Ophthalmologist would not have any idea how to properly manage post-op ortho patients because that is not his specialty. Medical Aesthetic Directors should be actively practicing aesthetics, derm or plastics and should have a specific requirement for aesthetic CEU's (in addition to the regular licensing CEU requirements). Safety data, indications and complication research has drastically changed over the last several years and advancements continue to be made at a rapid rate. A Medical Director should know not only how to perform the services but also how to manage complications. I also recommend Medical Directors should only be allowed to be a Medical Director if aesthetics is in their scope. For example, a PMHNP should not be allowed to be a medical director as aesthetics is out of their scope. This particular recommendation is held by multiple states.

I thank you for considering these thoughts. I am available for any questions or concerns. I hope to continue to be a part of this discussion and I thank you for the work you are doing.

Fondly,
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Susanne Schmaling, LME
CEO/Founder

RE: Advisory Opinion on Medical Director Roles in Aesthetic Medicine

Dear Medical Spa Work Group,

We appreciate the opportunity to engage in thoughtful dialogue around the evolving landscape of aesthetic medicine and the roles of various licensed professionals within it. However, we feel compelled to address several assumptions and recommendations made in the recent advisory letter regarding the role of estheticians and Medical Directors in aesthetic practice.

1. Estheticians and Supervision in Aesthetic Medicine

Licensed estheticians have been working alongside medical professionals in the aesthetic medicine space for well over 25 years, delivering safe and effective care under appropriate supervision frameworks. The assertion that estheticians cannot be supervised to perform certain services — even those deemed "medical" — fails to acknowledge both the current reality in many states and the depth of training that estheticians can and do receive. In fact, with robust protocols and clearly delineated scope, supervision of estheticians is working successfully without increased adverse events in numerous states.

This is not a new or experimental model. Supervision structures — where a medical director provides oversight, writes protocols, and delegates non-invasive, non-prescriptive services — have been legally and ethically functional for decades. Attempting to redefine this long-standing, functional partnership as unsafe or inappropriate is a disservice to an entire professional group that has contributed significantly to the growth and success of the aesthetic industry.

2. Misclassification of Non-Invasive Services

Many services estheticians perform under supervision — such as medium depth chemical peels, light-based therapies, and energy-based skin treatments — are non-invasive and do not rise to the level of medical diagnosis or treatment. Labeling every aspect of aesthetic care as “the practice of medicine” is not only inaccurate but represents a scope grab that restricts access to safe services, stifles innovation, and sidelines a licensed, trained, and regulated workforce.

Furthermore, it is worth noting that the definition of "medical" varies widely between states and continues to evolve. To claim a universal standard without recognizing state variability undermines the nuanced regulatory framework we currently operate within.

3. Aesthetic Medicine Is Not Part of Core Medical Training

It's important to recognize that "aesthetic medicine" is not a standardized component of traditional medical, nursing, or advanced practice education. It is a post-licensure specialty, often learned through independent continuing education, industry-sponsored training, and hands-on experience. In this regard, estheticians who seek additional certifications and advanced education are no different than their nursing or medical counterparts. Competency in aesthetics does not inherently stem from one's license type — it stems from training, experience, and ongoing education.

4. Safety and Specialty-Specific Oversight

While we agree that having a medical director with relevant experience in aesthetics, dermatology, or plastics is ideal, the notion that only someone from these specialties can manage an aesthetic team ignores real-world dynamics. Many excellent medical directors come from varied specialties but seek advanced training in aesthetics, just as injectors and estheticians do. The focus should be on demonstrated competency, not on limiting participation based on a narrow interpretation of "scope."

Lastly, the claim that non-licensed professionals should never be involved in "medical" aesthetics ignores the legal classification of estheticians as licensed professionals. Estheticians are not laypeople — they are licensed providers regulated by state boards and held accountable for the services they perform. With appropriate training and supervision, they are more than capable of operating within safe parameters.

Conclusion

A collaborative, inclusive model that honors the existing expertise of estheticians and recognizes the evolving interdisciplinary nature of aesthetic care is key to advancing safety, access, and professional integrity.

Labeling non-invasive aesthetic procedures as strictly "medical" — when they do not involve diagnosis, prescription, or invasive techniques — creates unnecessary barriers to access, especially for clients seeking affordable, routine skin wellness services. It inflates costs, reduces provider availability, and drives up demand for services that may be safely provided under supervision by well-trained estheticians. This over-medicalization does not protect the public; rather, it limits access to care, inflates consumer costs, and harms small businesses — many of which are owned and operated by licensed estheticians.

Sweeping restrictions that eliminate estheticians from the equation do not promote public safety — they promote professional gatekeeping. We respectfully urge the Work Group to consider evidence-based, inclusive models that allow licensed estheticians to continue contributing to high-quality, supervised aesthetic care in a way that benefits both the industry and the public.

Sincerely,

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