(HEE) is reviewing the qualifications required for non-surgical cosmetic procedures. Phase one established a proposed qualifications framework for five treatment modalities including non-surgical treatments. All practitioners will be expected to take part and there will be a range of entry points including accredited prior learning. A range of common themes including consent and ethics[8] will form part of the curriculum ranging from foundation to PhD level. Training will be competence based. The Department of Health will support HEE with legislation as at present non-medical personnel are undertaking these treatments. The legislation will ensure that all consultations for dermal filler treatments are undertaken by a member of the NMC or GMC. The treatment can then be undertaken 'under supervision' by an appropriately qualified practitioner[9]. It is hoped that this more formal model of education will reduce the high level of litigation in this specialty, currently running at 20%.

Avoiding Litigation

While aiming to relieve distress medical treatments can cause iatrogenic harm. Non-surgical treatments are no exception and carry risks as well as benefits.

In this field many clinical negligence cases which come before the courts do so because not enough attention has been paid to the consultation and the consent process. Many patients are vulnerable and can suffer from low self-esteem which adds to the pressure medical practitioners face in wanting to help them. Although these patients self-refer, patient selection is key to a successful cosmetic outcome, and not everyone is suitable for treatment.

Obtaining valid consent is an ethical, clinical and legal requirement. It must be free from coercion and the patient must have the ability to understand the information given. All risks must be explained and recently the importance of patient autonomy in a competent patient was clarified in *Montgomery*[10].

Although ignorance is no excuse in law, many practitioners are ignorant of the legal requirements of the consent process.

Two way communication is key and practitioners have a responsibility to give as much information that patients need to make a decision. The amount of information is a matter for clinical judgement while respecting patient autonomy. Practitioners must also make every reasonable effort to ensure the patient has understood what has been said and it is helpful to give him a written information sheet. The signature on the consent form records the patient's decision and that a discussion has taken place. It is not proof that consent is valid, neither does it take away legal liability if all aspects of the consent process are not covered. Finally it is advisable to check the medical history and obtain fresh consent before each treatment episode.

Conclusion

For nearly a quarter of a century nurses have led the way in the use of non-surgical procedures with a group of pioneering nurses being responsible for raising the profile of education and setting standards.

Many factors have contributed to the medicalisation of the ageing process including those which directly impact on ageing and the way we approach it. These in turn have made people more aware of their appearance and the way others regard them.

The way in which education is undertaken is changing. Training will be competence based and legislation will ensure all consultations are undertaken by medical or nursing staff.

Finally, in order to reduce the incidence of litigation, those who are responsible for consultations and the consent process must be mindful of the legal requirements.