

Medical Aesthetics Training: Shifting to Collective Competence

Iris Epstein, PhD, RN
Eva Peisachovich, PhD, RN
Celina Da Silva, PhD, RN
Charlotte Lee, PhD, RN
Philip Solomon, MD, FRCSC

With increased demands for medical aesthetics procedures and the sudden profusion of newly licensed, and unlicensed, providers who are performing these medical aesthetics procedures also comes the responsibility to shift to collective competence. Collective competence refers to what occurs among professionals in action, emphasizing the sharing of experiences, knowledge, and perceptions among those who are providing services to the medical aesthetics client. Registered nurses and medical students are not taught to perform cosmetic procedures in basic nursing or medical programs and thus require a post-entry-level education to validate their competency. The current medical aesthetics apprenticeship training

approach of *see one, do one, and teach one* focuses on teaching technical skills and thus does not sufficiently address the ever-changing health care context and the ambiguity in practitioner role. Recent scholars highlight that when health care failed or an error has been identified, it is rarely adduced to an individual's competence but rather is more likely to be a failure of the collective team. In this article, we are advocating for a change in how medical aesthetics practitioners are trained. In particular, it advocates creating opportunities within the curricula to train practitioners as a collective body, as opposed to providing training that focuses on the individual's competence and technical skills alone.

According to the American Society of Plastic Surgeons (ASPS) and the American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS), which includes Canadian doctors, 2.4 million soft-tissue filler procedures were performed

in 2015, up 6% from 2014, and a staggering 274% since 2000 (AAFPRS, 2014; ASPS, 2015). Although adverse reactions are rare, a potential severe filler complication is blindness and, currently, 98 cases around the world have been reported (Carruthers, Fagien, Rohrich,

Iris Epstein, PhD, RN, is Assistant Professor at the School of Nursing, Faculty of Health, York University. Iris research focuses on the links between health, technology, and place and how technology (e.g., E-learning, simulation) used in different places (home, classroom, laboratory, online) affects people's experiences. Iris is currently collaborating with George Brown College Engineering and School of Design in building and evaluating a simulated haptic partial task trainer to teach palpation skills from a multidisciplinary perspective and bring practitioner's "touch" back to the curricular and health care.

Eva Peisachovich, PhD, RN, is Assistant Professor at the School of Nursing, Faculty of Health, York University. Her research involves developing capacity and expertise about innovative educational strategies to foster students' success and enhance students' experiences and transition to the workforce. Transformative education and reflective practice guide her philosophy of teaching and learning to create and explore innovative pedagogy practices that range from classroom to workplace environment.

Celina Da Silva, PhD, RN, completed her dissertation at the Lawrence S. Bloomberg, Faculty of Nursing, University of Toronto, titled "A Phase 1 Study of a Kolb-Influenced, High-Fidelity Simulation Intervention Implemented to Improve Nursing Students' Use of a Conflict Resolution Skill." Some of the research studies that Celina is participating in relate to innovations in interprofessional education. She was the Principal Investigator of a study, titled "Simulated Practice Center Program Evaluation, George Brown College (GBC), Health Sciences Center." This research study generated qualitative data related to the Health Sciences Simulation program at GBC in order to better support the future development of simulation education for health professions students. Presently, she

is conducting a research study that involves designing, refining, and testing a virtual simulation (Body Interact) modality geared to teach interprofessional students decision-making skills related to a deteriorating patient care case. As well, she is part of a research team that recently was awarded an SSHRC grant and developed the mentorship site for postsecondary students with disabilities across Ontario who are partnered with other professionals.

Charlotte Lee, PhD, RN, research focuses on health services evaluation and interprofessional teams. She is particularly interested in understanding how collaborative relationships affect teamwork processes and outcomes in health care. Dr. Lee's current work aims to identify the antecedents and teamwork outcomes associated with collaborative relationships.

Philip Solomon, MD, FRCSC, completed his medical school training at the University of Toronto, followed by a 5-year residency training program in Otolaryngology Head and Neck Surgery at the University of Toronto. Dr. Solomon's training focused on head and neck cancer surgery, reconstructive facial surgery, and facial cosmetic plastic surgery including rhinoplasty, facelift, blepharoplasty, and otoplasty surgery.

The authors report no conflicts of interest.

Address correspondence to Iris Epstein, PhD, RN, School of Nursing, Faculty of Health, York University, Room # HNES349, 4700 Keele St, Toronto, ON M3J 1P3, Canada (e-mail: iepstein@yorku.ca).

Copyright © 2017 International Society of Plastic and Aesthetic Nurses. All rights reserved.

DOI: 10.1097/PSN.000000000000196

Weinkle, & Carruthers, 2014). Many experts agree that prevention, prompt interventions, and continuity of care are paramount in reducing and eliminating adverse reactions (Carruthers et al., 2014; Lafaille & Benedetto, 2010; Persaud et al., 2013). However, recently, with the increase demand for medical aesthetics procedures and the sudden profusion of newly licensed, and unlicensed, providers who are performing these medical aesthetics procedures, patient safety outcomes remain a top priority (AAFP, 2014; ASPS, 2011; Kirkey, 2016; Physicians Coalition for Injectable Safety, 2013). The purpose of this article is to open for discussion and advocate for a shift to collective competence training approaches as a way to support patients' safety outcomes and support teamwork. Collective competence refers to what occurs among professionals in action (Lingard, 2009, 2014; Lingard, as cited in Hodges & Lingard, 2013), emphasizing the sharing of experiences, knowledge, and perceptions among those who are providing services to the medical aesthetics client. We suggest that licensed health care practitioners lead the way in creating better opportunities to collaborate and communicate during medical aesthetics apprenticeship training. We first discuss the meaning of collective competence and highlight the current focus on individual competence in nursing and medical aesthetics training. Then we discuss the current social and political contexts that affect nurses' roles and require a shift to collective competence. Finally, we discuss strategies to support collective competence in medical aesthetics apprenticeship training.

BACKGROUND

Collective competence has been viewed as invaluable (Lingard, 2009; Lingard as cited in Hodges & Lingard, 2013). Lingard (2014) in her keynote presentation to medical educators argued that when health care failed or an error has been identified, it is rarely adduced to an individual's competence but rather is more likely to be a failure of the collective team. In fact, according to a report from the Institute of Medicine (IOM), as many as 98,000 hospitalized patients die each year as a result of medical errors and none of these errors have been attributed to an individual licensed practitioner but rather to the system and infrastructures (Horns & Loper, 2002). Lingard (2014) advocated for a change in how health care practitioners are trained, in particular creating opportunities within the curricula to train practitioners as a collective body, as opposed to providing training that focuses on the individual's competence at any point in time. A collectively competent team can still be competent even if one member is incompetent (Kitto, McMillan, Marshall, & Wilson, 2014; Lingard, 2009; Melkonian & Picq, 2010; Weick & Roberts, 1993).

Focusing on the individual's competency, and teaching to the technical skills and their knowledge discourse (Hodges & Lingard, 2013), without considering the social (historical) and physical factors affecting client care, omits the complex context that prevails in the patient care delivery realm (Higgs & Titchen, 2001). Thus, mastering injection skills is only a part of being a competent medical aesthetics practitioner. Physicians and other health care providers need collaborative training on how to delegate, negotiate, and better communicate the handover of assignments and skills previously their's alone. Shinnars and Franqueiro (2017), nurse researchers and educators, also called for a shift in nursing education from focusing on individual competence to building the competence of a team to meet the increasing needs of the current health care environment. Thus, individual competence, together with collective competence during the training of medical aesthetics nurses and physicians, has the potential to support patients' safety in the ever-changing context.

Individual competence has the status of a "God term" in many health care disciplines (Hodges & Lingard, 2013, p. 1). Registered nurses and medical students are not taught to perform cosmetic procedures in basic nursing or medical programs and thus require a post-entry-level education to validate their competency (College of Nurses of Ontario [CNO], 2013, 2016; College of Registered Nurses of Nova Scotia, 2013). Becoming a competent nurse focuses on the nurse's knowledge and skills to perform a procedure in a safe way (CNO, 2013). Benner, a pioneer nurse researcher and educator, argued that nurses' competence involves a step-by-step progression from novice (a beginner who has no experience, lacks confidence to demonstrate safe practice, and requires continual verbal and physical cues) to expert (one who has mastered the skills) (Benner, Tanner, & Chesla, 1997). However, Benner's concept of competence has been challenged, as a practitioner can be both a novice and an expert simultaneously (Gobet & Chassy, 2008). For example, many nurses working in medical aesthetics might be expert medical, surgical, or pediatric nurses who have decided to learn a new skill. Thus, one can be a novice and an expert (Smith, 2012). Teaching and training to enhance medical aesthetics practitioners' competence must integrate the social, physical, and political contexts of the individual and collectively.

Individual competence is the focus in medical aesthetics training. The training curriculum centers on isolated and measurable skills. Typically, these aesthetics training programs occur over a weekend. The education involves several components: (1) reading material about the anatomy and physiology of the head and neck and potential complications related to injecting fillers; (2) passively observing videos and participating in lectures with experts demonstrating their unique injection techniques; and (3) sometimes a brief supervised hands-on practice session.

Many of these training programs are led by physicians or nurses. They would have been excellent opportunities for collaboration, as both physicians and nurses attended. Unfortunately, the focus is not on collaborating and learning from each other but on isolated technical skills that could be observed and measured.

The aging population, advances in technology, and the health care restructuring are some of the social (relationship), physical (accessing services), and political (power differences) contexts affecting the role and responsibilities of health care providers. Thus, training health care providers with the dogma of *see one, do one, and teach one* has been criticized as an unsafe practice, as it is believed to omit these social, physical, and political contexts (Kotsis & Chung, 2013; Mason & Strike 2003; Rohrich, 2006; Smith et al., 2004; Vozenilek, Huff, Reznek, & Gordon, 2004). These social, physical, and political contexts also contribute to the current role ambiguity challenges medical aesthetics practitioners' experience. In Canada, a physician and a nurse can inject fillers; however, a nurse injects "under the direction of a physician" (College of Physicians and Surgeons of British Columbia, 2014; CNO, 2017, p. 2). Yet, having a *physician's direction* is open to many interpretations: Can a physician's assessment and direction to the nurse be completed virtually or be delegated? Should a physician's order to inject the fillers be in a written, verbal (face-to-face or telephone), or Web-based format. Duchscher and Myrick (2008) discussed how the advances in technology, the aging population, and the restructuring of health care during the last few decades have resulted in role ambiguity for nurses. For example, the reliance of nurses and doctors on e-health technology to assess, diagnose, and even treat patients who have limited access to health care is increasing (American Society for Quality, 2013). A current prediction is that technology will replace the need for nurses' and physicians' physical presence so as to provide care to diverse populations in different places and to increase continuity of care and access to services (British Broadcasting Corporation, 2013). We see an increase of videoconferencing technology such as Skype and e-counselling as a strategy to support accessibility of health services. Thus, the need to clarify and communicate is paramount.

Another factor leading to role ambiguity is how some of the direct care work that traditionally constituted the domain of nursing has also been shifted to others, for example, to technicians, registered practical nurses, personal support workers, and family (Duchscher & Myrick, 2008). This rapid role shift has clashed with a physician-dominated health care culture and contributed to challenges in collaboration for nurses, physicians, and other health care teams because of poor communication, power relation issues, scope of practice limitations, and role ambiguity (Rainford, Wood, McMullen,

& Philipsen, 2015; Stankovic, 2016). Curtis, Vries, and Fintan (2011) described how the historical factors that shape each profession's roles, responsibilities, and power relationships are accentuated during conflict and disagreement. Thus, the need to increase patients' access to services and support continuity of care has also increased instances of role overlap between and among practitioners; yet, limited training is given on how to communicate delegation of tasks and responsibilities (DiCenso et al., 2010).

COLLECTIVE COMPETENCE: PARTICIPATING IN AUTHENTIC SITUATIONS

Lingard (2009) proposes key approaches to promote collective competence. She argues that collective competence can be achieved through *authentic situations*. There is evidence to support the thesis that when a multidisciplinary team comprising physicians and nurses trains together, there is an increase in successful patient outcomes. Neily et al. (2010) reported an 18% decrease in the mortality rate when an operating room multidisciplinary team had trained together. Using integrated simulation can facilitate practitioners' participation in authentic situations and increase good patients' outcomes ((Gomoll, O'Toole; Czamecki & Warner, 2007; Grechenig, Fellingner, Frankhauser & Weiglein, 1999) Phipps et al., 2012; Riley et al., 2011).

We advocate for the use of more *integrated simulation* during medical aesthetics training, which can support moving the focus in training from parts and isolated technical skills (individual competence) to a collective competence that includes those issues of social and political contexts that prevail within medical aesthetics practice. Integrated simulation is defined as *activities* (e.g., simulated persons, case scenario, interactive gaming) and/or *devices* (task trainers) that mimic the reality of a clinical environment and that have been designed for use in demonstrating procedures and promoting team decision making and critical thinking (Jeffries, 2005; Low-Beer et al., 2011; Xu, Fung, Glicksman, Brandt, & Campbell, 2012). In the IOM report, *To Err Is Human: Building a Safer Health Care System*, simulation training is recommended as one strategy that can be used to prevent errors and increase collaboration in the clinical setting in a safe environment (Kohn, Corrigan, & Donaldson, 2000).

For Dall'Alba and Sandberg (1996), collective competence occurs through enriching participants' lived experience of their practice. This means creating an aesthetics medical scenario where participants do not simply acquire new injection knowledge, nor where old injection knowledge is replaced by new; instead, learning opportunities involve the participants' ways of experiencing aspects of the medical aesthetics practice with each other in a simulation

scenario. Dall'Alba and Sandberg (1996) suggested first exploring with prospective students what they, the students, considered central to a medical aesthetics practice. For example, simulation can be used to enact problem-solving scenarios calling for prompt team management in a case of an artery occlusion. Medical aesthetics training could include a simulation scenario that lays out the problem-solving algorithms for each professional's role.

Whereas individual competence focuses on objective and measurable testing, collective competence training can use group assessment and feedback during a simulation scenario in different contexts (Boreham, 2004). Using ongoing peer assessment and providing feedback are linked to building professional collective competence (Van der Vleuten & Schuwirth, 2005). For example, assessing prospective students' existing knowledge of anatomy and physiology and then using simulation with a multidisciplinary team to test skills in context. Investing in ongoing assessment and evaluation, and creating a group of experts as resources after the completion of the training, also enhances collective competence.

Dall'Alba and Sandberg (1996) also suggested shifting the focus in training from parts and isolated skills to connect to the whole dimension of medical aesthetics practice. If the majority of the training focuses on the anatomy of the face and avoiding unwanted outcomes while achieving aesthetics goals, it leaves the most difficult task of integrating the parts into a coherent way of experiencing the medical aesthetics practice context to the students. Thus, the whole is often missing in practitioners' attempt to learn the parts. However, when educators use simulation to lead a process that includes an ongoing interplay between the isolated skill parts and the significance of the practice in context, the learning process becomes one of collective competence development for both practitioners and educators.

CONCLUSION

With increased demands for medical aesthetics procedures and the sudden profusion of newly licensed, and unlicensed, providers who are performing these medical aesthetics procedures also comes the responsibility to shift to collective competence. The current apprenticeship training approach of *see one, do one, and teach one* that focuses on teaching technical skills for individual competence is not sufficient, particularly in the ever-changing health care context. We advocate for a shift to collective competence, which focuses on the relational and context aspects between the teacher, the student, and the ongoing environment of practice. Some suggested means to enhance collective competence include creating opportunities for future medical aesthetics practitioners to participate in authentic situations. Authentic situations are those situations where both physicians and nurses are trained together using integrated simulations. Although

the medical aesthetics training period is brief, continuing relationships afterward are paramount. We leave you with an analogy:

"The question should not be whether a particular pilot is performing well, but whether or not the system that includes the pilot, co-pilot and the technology of the cockpit is performing optimally to ensure that passengers arrive safely to their destination. (Hutchins & Klausen, 1998, p. 22).

It is the performance of that system, not the technical skills of any individual pilot, that determines the desired outcome.

REFERENCES

- American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS). (2014). *Face of plastic surgery goes younger due to growing social media and reality TV influence on millennials*. Retrieved May 28, 2017, from <https://www.aafprs.org/media/press-release/20160114.html>
- American Society for Quality. (2013). *Japan moving toward nursing robots for elderly*. Retrieved July 26, 2017, from <http://asq.org/qualitynews/qnt/execute/displaySetup?newsID=16207>
- American Society of Plastic Surgeons (ASPS). (2011). *Guiding principles: Supervision of non-physician personnel in medical, spas and physician offices*. Arlington Heights, IL: Author.
- American Society of Plastic Surgeons (ASPS). (2015). *Patient safety report*. Retrieved May 2, 2017, from <https://www.plasticsurgery.org/patient-safety>
- Benner, P., Tanner, C., & Chesla, C. (1997). Becoming an expert. *The American Journal of Nursing*, 97(6), 16BBB, 16DDD.
- Boreham, N. (2004). A theory of collective competence: Challenging the Neo-Liberal individualization of performance at work. *British Journal of Educational Studies*, 52(1), 5–17.
- British Broadcasting Corporation. (2013). *Video interview with Dr. Rosalind Picard titled "Robots Will Have a Role in Health-care"*. Retrieved July 26, 2017, from <http://innovation.uk.msn.com/personal/will-robot-nurses-soon-be-caring-f...>
- Carruthers, J. D., Fagien, S., Rohrich, R. J., Weinkle, S., & Carruthers, A. (2014). Blindness caused by cosmetic filler injection: A review of cause and therapy. *Plastic Reconstruction Surgery*, 134(6), 1197–1201. doi:10.1097/PRS.0000000000000754
- College of Nurses of Ontario (CNO). (2013). *Practice standards*. Retrieved April 27, 2017, from https://www.cno.org/globalassets/docs/prac/41038_strdrnec.pdf
- College of Nurses of Ontario (CNO). (2016). *The standards*. Retrieved May 2, 2017, from <http://www.cno.org/en/learn-about-standards-guidelines/magazines-newsletters/the-standard/november-2016/Administering-Botox>
- College of Physicians and Surgeons of British Columbia. (2014). *Professional standards and guidelines—Injection of Botulinum toxin, dermal fillers and venous sclerotherapy*. Vancouver, BC, Canada: Author.
- College of Registered Nurses of Nova Scotia. (2013). *Policy statement: The role of registered nurses in cosmetic procedures: Botox and dermal fillers*. Halifax, NS, Canada: Author.
- Curtis, E., Vries, J. D., & Fintan, K. (2011). Develop leadership in nursing: Exploring core factors. *British Journal of Nursing*, 20(5), 306–310.
- Dall'Alba, G., & Sandberg, J. (1996). Educating for competence in professional practice. *Instructional Science*, 24, 411–437.
- DiCenso, A., Bourgeault, I., Abelson, J., Martin-Misener, R., Kaasalainen, S., Carter, N., et al. (2010). Utilization of nurse practitioners to increase patient access to primary healthcare in

- Canada—Thinking outside the box. *Nursing Leadership*, 23, 239–259. doi:10.12927/cjnl.2010.22281
- Duchscher, J. E., & Myrick, F. (2008). The prevailing winds of oppression: Understanding the new graduate experience in acute care. *Nursing Forum*, 43(1), 191–206.
- Gobet, F., & Chassy, P. (2008). Towards an alternative to Benner's theory of expert intuition in nursing: A discussion paper. *International Journal of Nursing Studies*, 45, 129–139.
- Gomoll, A. H., O'Toole, R. V., Czarnecki, J., & Warner, J. J. (2007). Surgical experience correlates with performance on a virtual reality simulator for shoulder arthroscopy. *American Journal of Sports Medicine*, 35, 883–888. doi:10.1177/0363546506296521
- Grechenig, W., Fellinger, M., Fankhauser, F., & Weiglein, A. H. (1999). The Graz learning and training model for arthroscopic surgery. *Surgical and Radiologic Anatomy*, 21, 347–350. doi:10.1007/BF01631337
- Higgs, J., & Titchen, A. (2001). Framing professional practice: Knowing and doing in context. In J. Higgs, & A. Titchen (Eds.), *Professional practice in health, education and the creative arts* (pp. 3–15). Oxford, England: Blackwell Science Ltd.
- Hodges, B., & Lingard, L. (2013). The Question of competence: Reconsidering medical education in the twenty-first century. Ithaca, NY: ILR Press, an imprint of Cornell University Press.
- Horns, K., & Loper, D. (2002). Medication errors: Analysis not blame. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 31(3), 347–354.
- Hutchins, E., & Klausen, T. (1998). Distributed cognition in an airline cockpit. In Y. Engestrom, & D. Middleton (Eds.), *Cognition and communication at work* (pp. 15–34). New York: Cambridge University Press.
- Jeffries, P. A. (2005). Framework for designing, implementing, and evaluating simulations used as teaching strategies in nursing. *Nurse Education Perspectives*, 26, 96–103.
- Kirkey, S. (2016). Blowfish lips and puffy faces: New study warns of the complications and not-so-pretty side of facial fillers. *National Post Newspaper, Health Section*. Retrieved May 1, 2017, from <http://news.nationalpost.com/health/1020-fillers>
- Kitto, S., McMillan, S., Marshall, S., & Wilson, S. (2014). Rapid response system and collective (in)competence: An exploratory analysis of intraprofessional and interprofessional activation factors. *Journal of Interprofessional Care Early Online*, 4(1), 1–7. doi:10.3109/13561820.2014.984021
- Kohn, L. T., Corrigan, J. M., & Donaldson, M. S. (2000). *To err is human: Building a safer health system. A report of the Committee on Quality of Health Care in America, Institute of Medicine*. Washington, DC: National Academies Press.
- Kotsis, S., & Chung, K. (2013). Application of see one, do one and teach one concept in surgical training. *Plastic Reconstruction Surgery*, 131(5), 1194–1201. doi:10.1097/PRS.0b013e318287a0b3
- Lafaille, P., & Benedetto, A. (2010). Filler: Contradiction, side effects and precautions. *Journal of Cutaneous Aesthetics Surgery*, 3(1), 16–19. doi:10.4103/0974-2077.63222
- Low-Beer, N., Kinnison, N., Baillie, S., Bello, F., Kneebone, F., & Higham, F. (2011). Hidden practice revealed: Using task analysis and novel simulator design to evaluate the teaching of digital rectal examination. *The American Journal of Surgery*, 201, 46–53.
- Lingard, L. (2009). What we see and don't see when we look at "competence": Notes on a god term. *Advances in Health Science Education Theory and Practice*, 14(5), 625–628.
- Lingard, L. (2014). *Collective competence: More than a collection of competent individuals*. Keynote speaker proceeding: International Conference of Residency Education. Retrieved May 2, 2017, from <https://icreblog.royalcollege.ca/2014/06/03/collective-competence-more-than-a-collection-of-competent-individuals>
- Mason, W. T., & Strike, P. W. (2003). See one, do one, teach one—Is this still how it works? A comparison of the medical and nursing professions in the teaching of practical procedures. *Medical Teacher*, 25, 664–666.
- Melkonian, T., & Picq, T. (2010). Opening the "black box" of collective competence in extreme projects: Lessons from the French Special Forces. *Project Management Journal*, 41(3), 79–90. doi:<http://dx.doi.org/10.1002/pmj.20181>
- Neily, J., Mills, P. D., Young-Xu, Y., Carney, B. T., West, P., Berger, D. H., et al. (2010). Association between implementation of medical team training program and surgical mortality. *JAMA*, 304(15), 1693–1700. doi:10.1001/jama.2010.1506
- Persaud, R., Garas, G., Silva, S., Stamatoglou, C., Chtrath, P., & Patel, K. (2013). An evidence based review of botulinum toxin (Botox) applications in non-cosmetics head and neck conditions. *JRSM Short Reports*, 4(2), 10. doi:10.1177/2042533312472115
- Phipps, M. G., Lindquist, D. G., McConaughy, E., O'Brien, J. A., Raker, C. A., & Paglia, M. J. (2012). Outcomes from a labor and delivery team training program with simulation component. *American Journal of Obstetric and Gynecology*, 206(1), 3–9. doi:10.1016/j.ajog.2011.06.046
- Physicians Coalition for Injectible Safety. (2013). *Injection safety*. Retrieved May 22, 2017, from www.injectablesafety.org
- Rainford, W., Wood, S., McMullen, P., & Philippsen, N. (2015). The disruptive force of lateral violence in the health care setting. *The Journal for Nurse Practitioners*, 11(2), 157–164.
- Riley, W., Davis, S., Miller, K., Hansen, H., Sainfort, H., & Sweet, R. (2011). Didactic and simulation nontechnical skills team training to improve perinatal patient outcomes in a community hospital. *The Joint Commission Journal on Quality and Patient Safety*, 37, 8. Retrieved May 22, 2017, from http://www.saferpatients.com/wp-content/uploads/2014/03/Joint-Commisson-Journal_Improving-Perinatal-Outcomes-with-Team-Training.pdf
- Rohrich, R. J. (2006). "See one, do one, teach one": An old adage with a new twist. *Plastic and Reconstructive Surgery*, 118, 257–258.
- Shinners, J., & Franqueiro, T. (2017). Individual and collective competence. *Journal of Continued Education Nursing*, 48(4), 148–150. doi:10.3928/00220124-20160321-02
- Smith, C. C., Gordon, C. E., Feller-Kopman, D., Huang, G. C., Weingart, S. N., Davis, R. B., et al. (2004). Creation of an innovative inpatient medical procedure service and a method to evaluate house staff competency. *Journal of General Internal Medicine*, 19, 510–513.
- Smith, S. (2012). Nurse competence: A concept analysis. *International Journal of Nursing Knowledge*, 23(3), 172–182.
- Stankovic, L. (2016). *Barriers and facilitators for successful integration of nurse practitioners into interdisciplinary collaboration*. Unpublished manuscript, School of Nursing, MCPHS University, Worcester, MA.
- Van der Vleuten, C. P., & Schuwirth, L. W. (2005). Assessing professional competence: From method to programmes. *Medical Education*, 39(3), 309–317.
- Vozenilek, J., Huff, J. S., Reznick, M., & Gordon, J. A. (2004). See one, do one, teach one: Advanced technology in medical education. *Academic Emergency Medicine*, 11, 1149–1154.
- Weick, K. E., & Roberts, K. H. (1993). Collective mind in organizations: Heedful interrelating on flight decks. *Administrative Science Quarterly*, 38, 357–381. doi:<http://dx.doi.org/10.2307/2393372>
- Xu, J. J., Fung, K., Glicksman, J. D., Brandt, M. G., & Campbell, G. (2012). Development of a tissue-mimicking neck model for medical education. *Journal of Otolaryngology-Head & Neck Surgery*, 41(2), 145–151.

For more than 100 additional continuing education articles related to professional development topics, go to NursingCenter.com/CE.

Instructions:

- Read the article on page 103.
- The test for this CE activity is to be **taken online** at www.NursingCenter.com/CE/PSN. Find the test under the article title. Tests can no longer be mailed or faxed.
- You will need to create and login to your personal CE Planner account before taking online tests. Your planner will keep track of all your Lippincott Professional Development online CE activities for you.
- There is only one correct answer for each question. A passing score for this test is 10 correct answers. If you pass, you can print your certificate of earned contact hours and access the answer key. If you fail, you have the option of taking the test again at no additional cost.

- For questions, contact Lippincott Professional Development: 1-800-787-8985.

Registration Deadline: September 30, 2019

Disclosure Statement: The authors and planners have disclosed that they have no financial relationships related to this article.

Provider Accreditation:

Lippincott Professional Development will award 1.0 contact hours for this continuing nursing education activity.

Lippincott Professional Development is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity is also provider approved by the California Board of Registered Nursing, Provider Number CEP 11749 for 1.0 contact hours. Lippincott Professional Development is also an approved provider of continuing nursing education by the District of Columbia, Georgia, and Florida, CE Broker #50-1223.

Payment:

- The registration fee for this test is \$12.95.

DOI: 10.1097/PSN.0000000000000199

Call for Papers for *Plastic Surgical Nursing*

Plastic Surgical Nursing (PSN), the official journal of the American Society of Plastic Surgical Nurses, is currently soliciting manuscripts. *PSN*, published by Lippincott Williams & Wilkins (LWW), is a quarterly journal that has been published continuously since 1980. *PSN* presents the latest advances in plastic and reconstructive surgical as well as nonsurgical nursing practice. Written by and for plastic surgical nurses, *PSN* features clinical manuscripts covering a wide variety of surgical and nonsurgical procedures. Patient education techniques and research findings are also included, as well as manuscripts discussing the ethical issues and trends in this expanding clinical nursing specialty. The journal also contains continuing education for the entire scope of plastic surgical nursing practice. *PSN* is interested in receiving manuscripts on a variety of topics that would be of interest to the readership but not limited to plastic surgery topics. Our readers pride themselves in having broad nursing knowledge, so general interest topics are welcome as well. Authors from other health care professions also are encouraged to submit manuscripts. Easily submit and review manuscripts online with LWW's Editorial Manager. This automated, Web-based tool simplifies the manuscript submission and review processes and enables users to submit electronically, review, and track manuscripts and artwork online in a few easy steps. The journal invites contributors to use the Editorial Manager interface at <https://www.editorialmanager.com/psn>.

PSN journal staff are willing to work with novice writers and walk them through the writing process. All you have to do is ask. The most important thing is that you share your knowledge with other nurses.

Some Suggested CE Article Topics

Aesthetic Surgical Procedures
 Anesthesia Techniques
 Evidence-Based Practice
 Intraoperative Considerations
 Nonsurgical Treatment Options
 Nursing Research
 Pain Management
 Patient Education
 Patient Safety Considerations
 Pediatrics
 Pharmacology
 Reconstructive Surgical Procedures

Department Discussions

Aesthetic
 Management
 Skin Care
 Reconstruction
 Wound Care
 Pediatrics

Please feel free to e-mail me at tracey@hotta.ca

Tracey Hotta, RN, BScN, CPSN, CANS

Editor-in-Chief

500 Cummings Center, Suite 4550

Beverly, MA 01915

1-978-927-8330