MEDICAL SPA AND ELECTIVE PROCEDURE LITIGATION

It Felt Like a Spa. It Was Medicine

Litigating Injuries from Aesthetic and Wellness Procedures

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Walk into most medical spas and you'd never guess you were in a medical practice. Soft lighting, a booking app, a menu of services with prices next to them. But the filler going into someone's face is a prescription device. The IV bag is a prescription drug. The laser can burn through skin. When one of these procedures goes wrong, the case looks a lot like any other medical case, except the records are often thinner and the lines of supervision are often blurrier.

Regulators have noticed. Three states now have laws aimed squarely at medical spas:

- **Rhode Island** (effective June 30, 2025) requires a physician or certified nurse practitioner medical director with real training, not just a vendor's course, and licenses med spas as health care facilities.
- **Texas** (effective September 1, 2025) put rules around elective IV hydration: who can order it, who can give it, and what supervision is required.
- **Indiana** (effective July 1, 2026) requires registration with the medical licensing board and a named "responsible practitioner," restricts compounding, and fines unregistered operators.

Other states have acted through guidance. Georgia's medical board went after what it called "matchmaker" arrangements, in which a physician gets paid to sign on as medical director without actually supervising anything. New York's Department of State investigated more than 200 med spas and issued 87 citations, mostly for unlicensed medical procedures and oversight problems.

On the federal side, FDA took semaglutide and tirzepatide off its shortage list in 2025, which removed the legal footing for mass compounding. In June 2026 it sent a batch of warning letters to telehealth companies marketing compounded GLP-1s as equivalent to the approved drugs. In April 2026, FDA sent what appears to be its first Drug Supply Chain Security Act warning letter to

a dispensing facility, a Texas med spa, over product it couldn't account for. And in 2024 the CDC investigated a multistate cluster of botulism-like illness tied to counterfeit or mishandled botulinum toxin, much of it injected by unlicensed or untrained people in non-medical settings.

State scope-of-practice and supervision rules differ widely, and whether a particular arrangement was legal is a question for counsel. What follows is about the clinical side.

A FICTIONAL CASE

She's 39 and books a "non-surgical nose job," hyaluronic acid filler to smooth the bridge of her nose. A registered nurse does the injection. The medical director is a physician who isn't on site. Partway through, she feels a sharp pain and sees her skin go white and blotchy. The nurse puts on a warm compress and tells her it's bruising. By that night the skin is dusky. She goes back the next day and gets referred to a dermatologist. She ends up with tissue loss and needs reconstruction.

WHO WAS ALLOWED TO DO THIS?

That's the first question in almost every med spa case, and the answer depends on the state. In many states, a registered nurse can inject prescription products only on an order from a physician or advanced practice provider, after that prescriber has actually evaluated the patient. Some states require the evaluation to be in person. Some allow standing orders under set conditions. Some require the supervising physician to be on site or within a certain distance.

Get the supervision or delegation agreement, the protocols and standing orders, and whatever documents who examined her and who authorized the treatment. Was there a real evaluation by someone with prescribing authority? Did the nurse have documented training in filler, and in the nose specifically? Was the medical director doing anything, or was it a name on a contract?

That last question isn't just about liability. A supervising clinician who is present and paying attention is far more likely to recognize a complication early and know what to do about it.

WHAT WAS SHE TOLD?

Consent carries extra weight with elective procedures, because nobody needed this for their health. She chose it, and she was entitled to know what could go wrong.

The serious known risk with filler is vascular occlusion: product gets into or presses on a blood vessel and cuts off blood supply to the skin. That can cause tissue death. Rarely, when filler travels into the vessels that feed the eye, it can cause blindness. The nose and the area between the eyebrows are generally considered higher-risk sites. Did her consent form mention occlusion at all? Did it mention the nose specifically? Was there a conversation, and is it written down anywhere?

DID ANYONE RECOGNIZE WHAT WAS HAPPENING?

This is usually the heart of the case.

Severe pain during the injection, blanching, and a mottled or lacy pattern on the skin are textbook signs of vascular occlusion. Expert consensus guidance on hyaluronic acid filler complications treats occlusion as a time-sensitive emergency, and the usual treatment is hyaluronidase, an enzyme that dissolves the filler, often in large and repeated doses. Many experienced injectors won't inject HA filler at all without hyaluronidase in the room and a written protocol for using it.

So: Did the nurse recognize the signs? Was hyaluronidase on site? Was the medical director called? How much time passed before real treatment started? An occlusion caught and treated in the chair may leave little behind. The same occlusion called "bruising" and sent home overnight can leave permanent damage. The gap between those two outcomes is often the whole case.

If there were any vision symptoms, the situation becomes an emergency needing an ophthalmologist immediately. Check whether anyone asked about her vision.

SAME QUESTIONS, DIFFERENT PROCEDURES

- **Lasers:** device and settings, her skin type, whether a test spot was done, operator training, and how burns or pigment changes were handled afterward.
- **IV hydration and vitamin drips:** whether a qualified prescriber screened her, whether anyone reviewed her history for heart or kidney problems, vital signs before and during, and whether staff could recognize and handle a reaction. Texas wrote its 2025 law around exactly these gaps.
- **GLP-1 weight-loss drugs:** who prescribed, what was actually dispensed (brand or compounded, and from which pharmacy), how the dose was escalated, and whether anyone followed up on side effects.
- **Neurotoxins:** where the product came from, how it was stored, the dose, and whether anyone recognized spread, such as trouble swallowing, breathing, or speaking.

WHO OWNS THE PLACE, AND WHAT DID THE MEDICAL DIRECTOR DO?

Many states limit who can own a business that practices medicine. Non-physician-owned med spas often use a management company paired with a physician-owned practice. Whether that structure complies with state law is for counsel. Clinically, what matters is how it worked day to day. How often was the medical director there? Did they review charts, approve protocols, train staff, answer the phone when something went wrong? Is any of that documented? Texts and calls between staff and the medical director on the day of the injury can be the most revealing evidence you'll find.

CAUSATION AND DAMAGES

The core causation question here is whether prompt recognition and hyaluronidase would probably have prevented or reduced the tissue loss. That needs a dermatologist or plastic surgeon who manages filler complications. On damages, document all of it: the scarring, the reconstructive procedures and what's still ahead, the psychological effect of a visible facial injury, and what it has done to her work and her life.

RECORDS TO REQUEST

- The full treatment record: intake form, medical history, consent, treatment note with product, lot number, volume, and injection sites
- Before, during, and after photographs, which spas often take as a matter of routine
- Texts, emails, DMs, and app messages between the spa and the patient
- Product purchase and inventory records (source and chain of custody)
- Supervision or delegation agreements, standing orders, and protocols, including any complication protocol
- Staff licenses, training certificates, and competency records
- Medical director agreement and evidence of actual oversight
- All follow-up care: dermatology, plastic surgery, ophthalmology, ER

SOURCES AND REFERENCES

- Holland & Knight, "Medical Spa Compliance Under the Microscope" (Aug. 2026)
- Rhode Island, Indiana, and Texas medical spa and elective IV therapy legislation (2025–2026)
- FDA, removal of semaglutide and tirzepatide from the drug shortage list (2025); FDA warning letters to compounded GLP-1 marketers (June 2026)
- CDC, *Notes from the Field: Illnesses Associated with Counterfeit or Mishandled Botulinum Toxin Injections* (2024)
- Expert consensus guidance on the prevention and management of hyaluronic acid filler vascular complications (published aesthetic and dermatologic literature)

This newsletter is educational and doesn't constitute medical or legal advice. The case is fictional. Scope-of-practice rules vary significantly by state.

ABOUT LEXCURA CLINICAL INTELLIGENCE

Lexcura Clinical Intelligence provides integrated clinical and regulatory analysis for attorneys handling healthcare litigation. If you're evaluating an injury from an aesthetic or wellness procedure and want the supervision, consent, and complication response measured against the standard of care, we'd welcome the conversation.

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