



e-ISSN 3041-2498

Public Management and Policy

<https://www.eu-scientists.com/index.php/pmap>


Cross-Industry Knowledge Transfer: Applying Luxury Retail Management Frameworks to Medical Aesthetics Operations

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ARTICLE INFO

ABSTRACT

Research Article**DOI:**
[10.70651/3041-2498/2026.5.16](https://doi.org/10.70651/3041-2498/2026.5.16)
Received:

6 April 2026

Accepted:

8 May 2026

Published online:

10 May 2026

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This article describes how management practices developed in the luxury retail sector can be applied to the operational context of medical aesthetics clinics. The study was conducted at the Arviv Medical Aesthetics clinic network (Miami, Florida, USA) between 2024 and 2026. The author, who has nearly six years of experience as a General Retail Manager at LVMH / Starboard Cruise Services retail chain and heads a clinic without a medical background, systematically implemented four management systems: an inventory tracking and control system; a staff performance measurement and accountability framework; an employee training and development program; and a structured patient service quality standard. The numerical indicators were obtained from reports of the medical information system over three years: the pre-intervention year (March 2023 to February 2024), the first post-implementation year (March 2024 to February 2025), and the second post-implementation year (March 2025 to February 2026). Annual revenue increased from \$1,656,894 to \$2,034,435 – and was sustained at this level in the third year (\$2,034,769) despite a deteriorating external environment. Average revenue per patient visit increased from \$347.01 to \$463.62. Expenses for goods and supplies decreased by 22 percent. Staff turnover decreased. The percentage of patients making repeat appointments rose markedly. The article separately examines which retail practices can be transferred without modification, which require significant adaptation, and which are simply impossible to apply in a medical setting. It also describes the cultural resistance of medical staff and the specific measures that helped overcome it. The study formalizes these practices into the Cross-Industry Clinical Operations Adaptation Model (CICOA) – a four-system framework that classifies each transferred practice by its transferability and integrates a behavioral component for managing staff resistance – and demonstrates its reproducibility through independent replication at four clinics, with results sustained independently of the author's on-site presence. The model applies beyond medical aesthetics to dental clinics, beauty salons, medical centers, and other highly personalized service organizations.

**KEYWORDS**

transfer of management experience, medical aesthetics, luxury retail, inventory management, service standards, staff development, performance measurement, cross-industry transfer framework, operational adaptation model, reproducibility and scalability.



Міжгалузева передача знань: застосування методів управління роздрібною торгівлею предметами розкоші до операцій у медичній естетиці

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СТАТТЯ

АНОТАЦІЯ

Дослідницька

DOI:

[10.70651/3041-2498/2026.5.16](https://doi.org/10.70651/3041-2498/2026.5.16)

Отримана:

06.04.2026 р.

Прийнята:

08.05.2026 р.

Опублікована:

10.05.2026 р.

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У цій статті описується, як управлінські практики, розроблені в секторі роздрібною торгівлі предметами розкоші, можуть бути застосовані в операційному контексті клінік медичної естетики. Дослідження проводилося в мережі клінік Argv Medical Aesthetics (Маямі, Флорида, США) між 2024 і 2026 роками. Автор, який має майже шість років досвіду роботи генеральним менеджером з роздрібною торгівлею в роздрібній мережі LVMH / Starboard Cruise Services та очолює клініку без медичної освіти, систематично впровадив чотири системи управління: систему відстеження та контролю запасів; систему вимірювання ефективності роботи персоналу та підзвітності; програму навчання та розвитку співробітників; та структурований стандарт якості обслуговування пацієнтів. Числові показники були отримані зі звітів медичної інформаційної системи за три роки: рік до втручання (березень 2023 – лютий 2024), перший рік після впровадження (березень 2024 – лютий 2025) та другий рік після впровадження (березень 2025 – лютий 2026). Річний дохід зріс з 1 656 894 доларів США до 2 034 435 доларів США – і підтримувався на цьому рівні протягом третього року (2 034 769 доларів США), незважаючи на погіршення зовнішнього середовища. Середній дохід на одне відвідування пацієнта зріс з 347,01 до 463,62 доларів США. Витрати на товари та витратні матеріали зменшилися на 22 %. Плинність кадрів зменшилася. Відсоток пацієнтів, які звертаються повторно, значно зріс. У статті окремо розглядається, які роздрібні практики можна перенести без модифікацій, які потребують значної адаптації, а які просто неможливо застосувати в медичних умовах. Також описується культурний опір медичного персоналу та конкретні заходи, які допомогли його подолати. Дослідження формалізує ці практики в Міжгалузову модель адаптації клінічних операцій (CICOA) – чотирисистемну структуру, яка класифікує кожну передану практику за її придатністю до перенесення та інтегрує поведінковий компонент для управління опором персоналу – і демонструє її відтворюваність шляхом незалежного повторення в чотирьох клініках, при цьому результати підтримуються незалежно від присутності автора на місці. Модель застосовується не лише в медичній естетиці, а й у стоматологічних клініках, салонах краси, медичних центрах та інших високоперсоналізованих сервісних організаціях.



КЛЮЧОВІ СЛОВА

передача управлінського досвіду, медична естетика, роздрібна торгівля предметами розкоші, управління запасами, стандарти обслуговування, розвиток персоналу, вимірювання ефективності, структура міжгалузевої передачі, модель операційної адаптації, відтворюваність та масштабованість.

1. Introduction

The market for medical spas and aesthetic clinics is growing rapidly. According to Grand View Research, its value exceeded \$21 billion in 2023, and it is growing by approximately 15.6 percent annually [8]. In the U.S., the number of active facilities in the industry is growing by 8–10 percent annually, and total revenue exceeds \$5 billion [1]. At the same time, the American Med Spa Association notes that most of these facilities do not fully utilize their potential and lose up to 30 percent of potential revenue [1].

In most of these establishments, no one systematically tracks whether patients return. Supplies are ordered without clear inventory tracking. New employees figure out the work on their own. Doctors have no idea how effective their practice is compared to their colleagues. The luxury retail sector has developed proven tools for addressing each of these issues [1]. Scientific research confirms that management experience from one industry can be transferred to another. The main danger lies in the fact that an organization copies the outward appearance of someone else's practices but does not adapt them to its own conditions, and then the result is worse than if they had not borrowed anything at all [6; 14]. This is particularly challenging in healthcare organizations, as the culture and values of the staff differ significantly from those of the commercial environment [3; 12].

There is no documented example in the scientific literature of how luxury retail management systems have been systematically transferred to medical aesthetics clinics and what specific results this has yielded. This article fills that gap. Beyond documenting a single case, this article proposes a generalizable model – the Cross-Industry Clinical Operations Adaptation Model (CICOA) – for systematically transferring and adapting operational management systems between structurally dissimilar service industries.

Research Objective – to describe and quantitatively assess the results of implementing four management systems transferred from luxury retail to a network of medical aesthetics clinics in 2024–2026, and to analyze how staff resistance was overcome during these changes. The study examines: what the institution was like before the changes; what exactly was transferred and how it was adapted; what numerical indicators were obtained before and after; what the cultural resistance was like and how it was addressed; and where the line is drawn between what can and cannot be borrowed from retail in the medical field. Finally, the study formalizes the intervention into a reproducible and scalable framework applicable to other healthcare service organizations.

2. Literature Review

2.1. *How Management Experience Is Transferred Across Industries*

Argote and Fahrenkopf, studying knowledge transfer between organizations, showed that success depends on four factors: the people who possess this experience, the tasks in which it is applied, the technological tools, and the relationships among all participants in the process [2]. Szulanski and Jensen introduced the concept of “superficial adaptation” – a situation where an organization adopts the outward appearance of another's practice but does not adapt it to its own conditions. According to their data, this approach yields worse results than not adopting the practice at all [14]. Easterby-Smith and her co-authors found that when transferring practices between different organizations, the greatest obstacle is the difference in how people in these organizations understand their work and their roles [6]. This gap is particularly pronounced between luxury retail and a medical clinic: a salesperson in a boutique and a doctor understand their work and their responsibilities differently.

2.2. *Management Systems in Luxury Service*

Kapferer argues that companies in the luxury segment are capable of reproducing the same quality in every customer interaction regardless of the specific employee, and operational systems are the primary tool for this [10]. Forbes standards cover over 900 specific criteria – from staff appearance to how to respond to a dissatisfied customer [7]. Heskett, Sasser, and Schlesinger demonstrated that staff satisfaction and competence are the drivers of quality service, and that service quality directly influences customer loyalty and financial performance. This relationship is confirmed across various service industries [9].

2.3. Management Characteristics in Medical Aesthetics Clinics

A medical aesthetics clinic is both a medical facility and a commercial enterprise. Brandão and Ribeiro, in their study of this specific type of facility, found that the quality of clinical work and the quality of patient care are equally important in determining whether a patient will return. A technically flawless procedure paired with poor service does not retain patients [4]. Moons, Waeyenbergh, and Pintelon, based on a review of the scientific literature, found that poor inventory management in medical facilities is one of the main causes of unnecessary costs [11]. Collings, Mellahi, and Cascio, analyzing large international companies, demonstrated that systematic identification of high-potential employees and structured training are crucial for staff retention and performance in any service industry [5].

2.4. Challenges in Implementing New Practices in the Healthcare Setting

Nilsen, summarizing the scientific literature on change implementation in healthcare organizations, identified staff cultural readiness as a decisive factor in whether new approaches will take root [12]. Braithwaite and his co-authors demonstrated that in complex healthcare organizations, no management idea is implemented on its own – even if it is technically sound – without persistent work to overcome resistance from people and the organizational culture [3].

3. Problem Statement

This study introduces:

- a structured methodology for transferring luxury retail management systems into medical aesthetics clinics;
- a four-system operational adaptation framework that classifies each practice by its transferability (direct transfer / metric substitution / clinical redesign / non-transferable);
- a behavioral integration model for reducing staff resistance during organizational transformation;
- empirical evidence of reproducibility and scalability, demonstrated by independent replication across four clinics and by sustained results decoupled from the author's personal presence.

4. Methods and Materials

4.1. Research Approach and Data Sources

The study is structured as a detailed analysis of a single specific case, comparing indicators before and after the changes. This approach is standard practice when studying complex management interventions in real-world settings where a controlled experiment is not feasible [3; 12]. The primary site was the Arviv Medical Aesthetics clinic in Miami. Clinics in Tampa and Ocala were involved to verify whether the developed systems could be replicated in other settings. The fourth clinic in Coconut Creek was in the process of implementation at the time of writing.

The numerical indicators were taken from automatically generated reports from the Zenoti medical information system, which integrates medical records, appointment scheduling, billing, inventory tracking, and reporting. Since the data is generated automatically by the system rather than collected manually in retrospect, it is accurate and can be verified by an independent auditor. Staff performance of daily tasks was tracked via the Prosp app, allowing the director to monitor the status of each clinic in the network without being physically present there. Three consecutive years were selected for comparison: the year before the changes – from March 2023 to February 2024; the first year after implementation – from March 2024 to February 2025; and the second year – from March 2025 to February 2026.

4.2. The Author of the Study and the Context

The author of the study served as General Retail Manager at a retail network at LVMH / Starboard Cruise Services, leading a multi-specialist boutique team in which several members were subsequently promoted into leadership roles under her management. The fact that the author has no medical training is significant for this study: the changes could not have occurred due to clinical experience, which she lacked, so they can be confidently attributed specifically to the management systems she implemented.

4.3. The State of the Clinics Before the Changes Began

When the author assumed the Facility Director role in March 2024, none of the four systems described in this article had yet been formally implemented at the facility. Inventory tracking relied on manually maintained spreadsheets without defined reorder thresholds, and periodic physical counts frequently showed discrepancies against recorded balances. Individual provider performance was not tracked against defined monthly targets, and no structured daily team meeting cadence was in place. New employee onboarding consisted of a single day of informal shadowing, without standardized training materials, assigned mentorship, documented competency standards, or a formal evaluation at the end of the probationary period. No written patient service standards had yet been established. Structured post-appointment follow-up and proactive outreach to lapsed patients were not part of the standard operational workflow at that time.

4.4. The Four-System Operational Framework (Core of the CICOA Model)

The intervention is structured as four interacting operational systems. Within the CICOA model, each system is classified by its transferability and linked to the others through shared data (the medical information system) and shared accountability (provider-level metrics), forming a single operational architecture rather than four isolated tools.

The first system is inventory tracking and control. The logic of retail inventory control has been adapted for the medical information system so that material usage is linked to specific procedures and specific doctors. This makes it possible to accurately calculate the cost of each treatment and identify which doctors are using materials excessively. Orders are placed automatically as soon as the stock level drops below five units. Two independent individuals cross-check each other's work, and the director conducts random spot checks. The expiration dates of clinical supplies are tracked separately: there is nothing like this in retail, but for medical work, it is a mandatory requirement for patient safety. In the retail environment, this level of discipline resulted in a level of unexplained losses of 0.19 percent, compared to an industry benchmark of 0.6 percent.



Figure 1. Interaction of Four Operational Systems within the CICOA Framework

Source: Compiled by the author.

The second system is the measurement of staff performance. At the facility-wide level, the following are tracked monthly: total revenue (\$205,000 target), revenue from the premium membership program (\$25,000), revenue from comprehensive treatment courses costing \$2,950–\$3,850 (\$65,000), sales of skincare products (\$5,000), sales of gift certificates (\$7,500), the percentage of patients who book follow-up appointments (70 percent), and the number of new Google reviews (20 per month). Each provider is assigned an individual monthly production target ranging from \$15,000 to \$85,000, calibrated to the scope of their practice, their clinical specialization, and their proficiency across the facility's treatment offerings. In addition to metrics similar to those in retail, specific medical metrics are tracked: the percentage of consultations that result in a treatment appointment; patient conversion to premium membership; and compliance with the requirement to photograph the patient

before and after each procedure. The structure of meetings remains unchanged: in the morning, everyone receives a plan for the day; in the evening, results are reviewed; and the weekly review combines performance analysis, training, and recognition of achievements.

The third system is staff training and development. Instead of a single “shadowing” day, a four-week protocol has been introduced. In the first week, a new employee gets acquainted with the facility, the team, and clinical protocols and is assigned a mentor from among experienced colleagues. In the second week, they perform duties independently under supervision. In the third week, supervision is gradually reduced. The fourth week concludes with an evaluation: an interview, a written test of protocol knowledge, and role-playing exercises involving complex patient scenarios. Every 90 days, the director independently evaluates performance across five categories, then compares the results and sets goals for the next quarter. Commission rates on retail and treatment package revenue increase on a tiered basis as monthly volume rises, but eligibility for each higher tier requires that the provider also meet defined patient satisfaction and treatment-plan-quality thresholds – specifically a minimum patient satisfaction score and documented confirmation that recommended treatments are consistent with each patient's stated goals and clinical needs. As a result, a provider's personal income reflects not only their commercial contribution but their consistency in delivering treatment plans aligned with documented patient need and satisfaction, rather than sales volume alone. Achievements are recognized publicly during team meetings: the top-performing provider is selected each month based on a composite of production, patient satisfaction, and rebooking metrics, and the provider demonstrating the greatest quarterly improvement across these combined measures is recognized separately.

The fourth system is patient service standards. Patients are greeted by name within eight seconds of entering, offered a drink, and personally escorted to the waiting area – these standards have been adopted from retail without modification. A significant structural change: the patient coordinator introduces the new patient to the premium membership program before the patient meets with the provider for the first time. This allows the provider to enter the office solely in the role of a clinical specialist. Before the appointment, the provider receives a brief summary of the patient's information, so the patient does not have to repeat their story. The next appointment is scheduled right in the office, without leaving the room. Within 24 hours after the procedure, the patient receives a phone call to check on their condition. Two weeks later, they come in for a follow-up visit. The practice management system automatically flags patients who have not returned within a defined interval, and a personalized re-engagement message referencing their prior treatment history is sent inviting them to schedule a follow-up visit.

5. Results and Discussion

5.1. Financial Results

In the year before the changes, the Miami clinic's annual revenue was \$1,656,894. After implementing the four systems, it rose to \$2,034,435 – an increase of 22.8 percent. In the second year following the changes, revenue was \$2,034,769 – virtually the same, even though external economic conditions had deteriorated. The highest monthly revenue in the clinic's history was recorded in May 2025: \$205,151. Average revenue per visit rose from \$347.01 to \$463.62 – an increase of 33.6.

Patients began purchasing comprehensive treatment packages more frequently, upgrading to premium memberships, and adding procedures during a single visit. Expenses for goods and consumables decreased by 22 percent: thanks to automated inventory control, excess orders were eliminated; thanks to tracking expiration dates, losses from expired products stopped; and after linking expenses to specific providers, it became clear where materials were being overused.

5.2. Patients and Staff

The percentage of patients booking follow-up appointments rose from 41 percent to 52 percent in the first year after the changes and to 60 percent in the second. The clinic's Google rating improved from 4.7 to 4.8, and the facility consistently received at least 20 new reviews each month. Staff turnover decreased by 52 percent and remained at that level. All providers saw an increase in individual income. Revenue from the premium membership program and treatment courses became a regular source of income. The same documented systems were replicated in the Tampa and Ocala clinics, and a fourth clinic in Coconut Creek was under implementation at the time of writing. Because the systems are encoded in standardized documents rather than residing in the author's personal involvement, the

architecture could be reproduced at each new site without the author being physically present. Six external facilities – two beauty studios and four off-network clinics – are currently implementing these approaches.

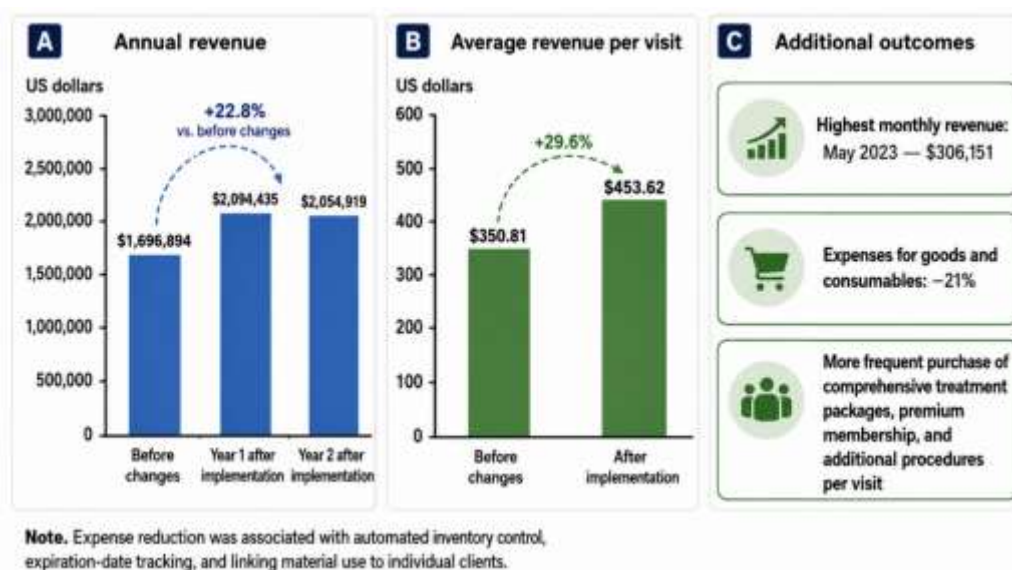


Figure 2. Changes in financial performance indicators after the implementation of four management systems in the Miami clinic

Source: Compiled by the author.

6. Discussion

6.1. What Can Be Transferred from Retail, and What Cannot

The CICOA model classifies every candidate practice into one of four transfer modes: (1) direct transfer – the underlying logic is identical in both environments; (2) metric substitution – the purpose is retained but the specific indicators are clinically reframed; (3) clinical redesign – no retail equivalent exists and the practice must be built from scratch; and (4) non-transferable – the practice cannot be moved without violating clinical ethics or law. This classification is the central decision tool of the framework.

Some practices can be transferred as-is because they work equally well in both environments. Revenue per hour worked, average ticket size, percentage of returning customers, inventory audits, the structure of daily meetings, and mentoring principles – retail and medical clinics handle these the same way, just using different terminology. Some practices retain their purpose, but specific metrics must be replaced: the percentage of visitors who made a purchase becomes the proportion of consultations that resulted in a treatment appointment; sales analysis by product category transforms into analysis of patient enrollment in treatment courses; and service standard evaluations evolve into audits of compliance with clinical protocols. There are practices for which there are no retail equivalents and which had to be developed from scratch: tracking the expiration dates of clinical materials, photographing patients before and after procedures, documenting complaints in accordance with medical confidentiality laws, and escalating clinical complications to the medical director. Uncritical copying is most dangerous in these situations: it can violate legal requirements or compromise patient safety [14].

At the same time, there are aspects of the retail approach that cannot be transferred to medicine. In retail, a salesperson strives to close a deal under any circumstances. In medicine, a provider cannot recommend a procedure that a patient does not clinically need – and no performance metric system can require this. A clinic director who builds an accountability system without understanding this boundary risks harming patients. In retail, regular customers are given individual discounts and deals are made informally; in medicine, such practices violate the law. In a boutique, a customer buys goods anonymously; in a medical clinic, patient identification, a signed informed consent form, and the maintenance of medical records are mandatory for every visit.

6.2. Resistance from Staff and What Helped

Medical staff met individual revenue targets and public provider rankings with resistance. The most common expression of this resistance was: “I’m a doctor, not a salesperson.” Retail terminology – such as “upselling,” “funnel,” and “conversion” – exacerbated the situation, even though the very idea of the system did not generally scare people. Staff perceived the dual inventory control system as an expression of mistrust rather than a management standard.

The author replaced all retail language with the language of clinical values. “Upselling” became a “comprehensive treatment plan,” “conversion” became the “transition from consultation to treatment,” and “production plan” became a “treatment activity plan.” When the team heard those same ideas phrased in terms closer to clinical work, resistance dropped significantly. Then they launched a monthly contest: the provider with the highest monthly revenue received a cosmetic product. The reward was deliberately chosen to be symbolic, not monetary – so that competition would arise in a format that wasn’t oppressive or threatening. When the team saw their own results, they were more convincing than any explanation.

One team member resisted more stubbornly than the others. The author assigned this person the responsibility of developing specific metrics for the system. The person who built the metrics himself eventually became their active advocate. At the same time, the author personally demonstrated service standards in real-life situations. When a new patient came for an appointment and found that the necessary device was temporarily unavailable, he refused to reschedule and headed for the exit. The clinical staff was unable to stop him. The author intervened: she sincerely acknowledged the patient’s dissatisfaction, explained that such things happen, and offered a free procedure instead of making him wait, maintaining a warm, personal connection throughout. The patient stayed, received the scheduled treatment, and signed up for a premium membership by the end of the visit. The team that witnessed this received clear confirmation that service standards from the luxury sector actually work in a clinical setting.

Table 1. Transformation of staff resistance into system adoption

Source of resistance	Initial staff perception	Management response and behavioral result
Revenue targets and provider rankings	Targets and rankings were first read as pressure to sell, not as a clinical management tool. The strongest reaction was: “I’m a doctor, not a salesperson.”	The author replaced sales vocabulary with clinical language: “upselling” became a comprehensive treatment plan, “conversion” became transition from consultation to treatment, and “production plan” became a treatment activity plan. As a result, the same indicators became easier to accept.
Retail and sales terminology	Terms such as “upselling,” “funnel,” and “conversion” made the system feel commercially aggressive.	The vocabulary was reframed around patient care, treatment continuity, and service quality. Resistance decreased because staff no longer perceived the system as contradicting medical ethics.
Dual inventory control	Inventory control was interpreted as mistrust rather than as an operational standard.	Procedures were linked to material use, expiration-date tracking, and provider-level accountability. The system became less personal and more procedural.
Internal competition	Direct financial competition could have created tension inside the team.	A monthly contest was introduced with a symbolic reward, a cosmetic product. This allowed competition to appear in a non-threatening format.
Persistent resistance from one team member	One employee opposed the system more strongly than others.	The author assigned this person responsibility for developing the metrics. Participation changed the employee’s position from critic to advocate.
Doubts about luxury-sector service standards	Staff did not immediately believe that service standards from the luxury sector could work in a clinical setting.	The author demonstrated the approach in a real patient conflict: she acknowledged dissatisfaction, offered a free procedure, and maintained a personal connection. The patient stayed, received treatment, and joined a premium membership.
Risk of losing accumulated experience	Without documentation, the system depended too much on the author’s personal involvement.	A document library was prepared: role guidelines, service standards, scripts, medical information system instructions, inventory procedures, and quarterly evaluation forms. This made replication possible in Tampa and Ocala.

Source: Compiled by the author.

To preserve the accumulated experience, a library of documents was prepared: role guidelines for each staff category, patient service standards, conversation scripts for every touchpoint from the first call to re-engagement, step-by-step instructions for the medical information system, inventory procedures, and forms for quarterly evaluations. This documentation is the main reason the system was successfully replicated in clinics in Tampa and Ocala.

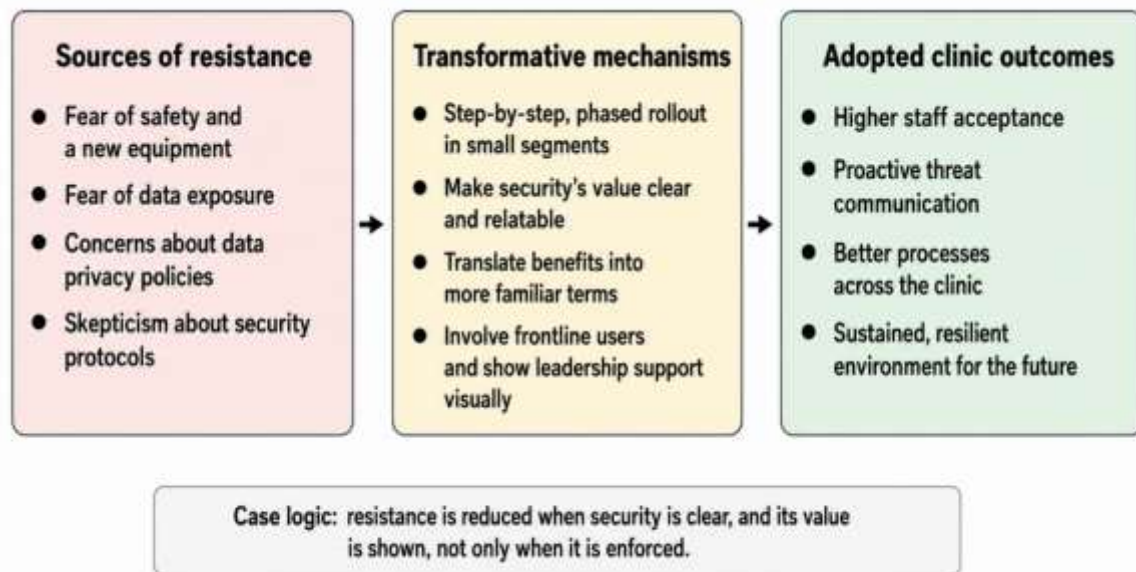


Figure 3. CICOA Resistance Adaptation Model

Source: Compiled by the author.

6.3. Why the results of the third year are more important than those of the first

The fact that revenue remained virtually unchanged in the third year – \$2,034,769 compared to \$2,034,435 the previous year – despite a deteriorating external environment is a more significant indicator of the systems' effectiveness than the growth recorded in the first year. Any management decision can yield a short-term effect. The fact that the effect did not disappear once the novelty wore off and conditions became more challenging indicates that the changes affected not the surface but the essence of the relationship between the facility and its patients. Reichheld and Markey have shown that the proportion of returning customers is a predictor of future revenue [13]: maintaining a high repeat appointment rate and a 4.8 rating in the third year confirms that patients have become attached to the facility.

The reduction in staff turnover is also significant from a purely clinical perspective: in medical aesthetics, patients are often loyal to a specific doctor, and a doctor's departure risks losing their patients. People stayed because the four-week protocol eliminated the main source of stress for a newcomer – uncertainty about what was expected of them. Written guidelines, quarterly evaluations with feedback, and a tiered review committee made the link between effort and outcome tangible and transparent. All of this aligns with what Heskett, Sasser, and Schlesinger described as the chain linking employee satisfaction, service quality, and customer loyalty [9].

6.4. Reproducibility and Scalability

The framework's value lies not in the single-site result but in its reproducibility. Once codified into the document library – role guidelines, service standards, scripts, system instructions, inventory procedures, and quarterly evaluation forms – the system was transferred to the Tampa and Ocala clinics and is currently being implemented in Coconut Creek and in six external facilities. Critically, the sustained third-year performance occurred independently of the author's continuous on-site presence: the daily-task application allowed each clinic to be monitored remotely, and the operational architecture, rather than individual leadership, drove the outcome. This decoupling of results from the originator is the defining property of a transferable, scalable management system. Beyond medical aesthetics, the same architecture applies to dental clinics, multidisciplinary medical centers, and other service organizations characterized by a high degree of service personalization, where clinical or professional expertise must coexist with structured operational management.

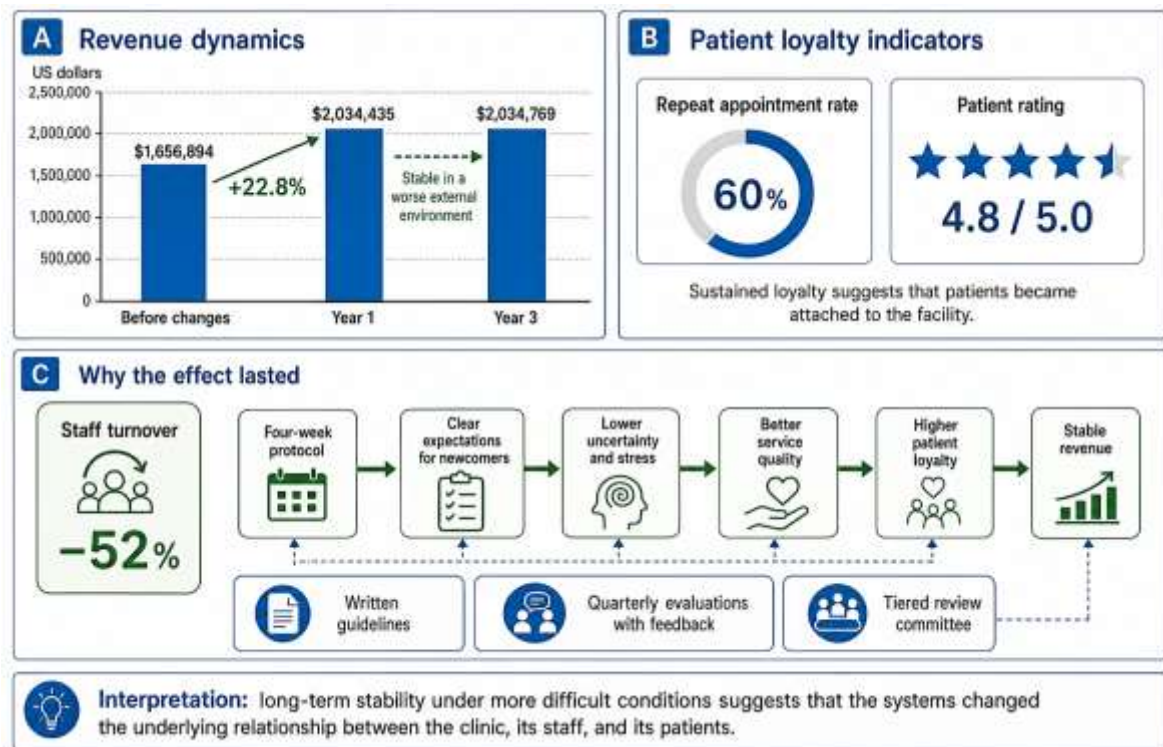


Figure 4. Long-term stability of clinic performance after implementation of the management systems

Source: Compiled by the author.

7. Conclusions

Luxury retail management systems can be successfully adapted to medical aesthetics clinics if approached thoughtfully, rather than simply copying the outward form. The implementation of four systems within the Arviv Medical Aesthetics network yielded the following results: revenue increased by 22.8 percent and remained at this new level during the challenging third year; average revenue per visit increased by 33.6 percent; material costs decreased by 22 percent; staff turnover decreased by 52 percent; the percentage of patients making repeat appointments rose from 41 to 60 percent.

For a clinic director who wants to borrow management experience from another industry, it is important to understand that different practices behave differently. Some work without changes because the principle of solving the problem is the same in both environments. Others retain their logic, but specific metrics need to be replaced. Still others must be redesigned from scratch, as medical work imposes requirements that do not exist in retail at all. If the director understands in advance which group a specific practice belongs to, they do not waste energy trying to transfer what cannot be transferred.

The main complication turned out to be a cultural barrier: providers view their role fundamentally differently than salespeople in a boutique. Rewording retail concepts in the language of clinical values, demonstrating standards through personal example in real-life situations, involving the most critical team member in developing the systems themselves, and a short one-month pilot as a first safe step – all of this together helped overcome this barrier.

It remains to be seen how well these same systems will work in institutions of a different profile or in other countries. It is also worth investigating whether structured management systems influence clinical treatment outcomes alongside financial ones. A standard tool for assessing the management maturity of medical aesthetics clinics – similar to those existing in healthcare quality systems – also needs to be developed.

The principal contribution of this work is not the documented financial result but the Cross-Industry Clinical Operations Adaptation Model itself: a structured, reproducible, and scalable methodology for transferring and adapting operational management systems between dissimilar service industries, with empirically confirmed results.

The model reframes the intervention from a successful managerial case into a transferable framework available for systematic application and further validation. In doing so, it establishes a structured approach to adapting management systems across industries, where no such formalized procedure previously existed.

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