Academic Physicians' Attitudes Toward Implementation of Multidisciplinary Cosmetic Centers and the Challenges of Subspecialties Working Together

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A multidisciplinary cosmetic center (MCC) consists of multiple specialties providing a wide array of elective cosmetic procedures to patients. Academic centers have begun creating MCCs in response to increasing public demand for these services. Our goal was to assess the level of interest in MCCs among physicians in specialties that would typically be involved at an academic hospital. A pilot study was performed in which 6 academic physicians from the departments of dermatology, dermatologic surgery, plastic surgery, otolaryngology, and ophthalmology were surveyed on their attitudes toward MCCs and other physicians in specialties providing cosmetic services. The survey included both open-ended questions and multiple-choice opinion statements to assess opinions on MCCs and the collaboration between disciplines. Among survey respondents, the overall opinion on MCCs was positive. Perceived benefits included improved patient care, shared resources, increased opportunity for multidisciplinary research, improved resident education training, and increased cross-referrals. Concerns included potential friction and increased competition among providers with the implementation of a multidisciplinary approach to cosmetic services. This survey was a pilot study, thus the data are limited by a small sample size. Academic physicians were interested in participating in an MCC. This survey helped reveal the potential pitfalls of an MCC, which may be an important step toward constructing a practice model that will minimize conflict among specialists, maximize cooperation and collaboration, and ultimately lead to optimized patient care and outcomes.

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Cosmetic medicine is a booming industry in the United States. It is estimated that Americans spend $12 billion annually on cosmetic procedures.[1] This growth has attracted an increasing number of healthcare providers to offer these cosmetic services.[2-4] Many specialists, including dermatologists, plastic surgeons, ophthalmologists, and otolaryngologists, are expanding their practices to meet the increasing public demand for these services and to buffer the economic effects of lower third-party reimbursements.[5,6] In the academic setting, offering cosmetic services has the potential to bolster a department's income and supplement funding for resident education, care of indigent patients, facility improvements, clinical research, and community outreach.[7]

To better cater to their patients' desire for cosmetic procedures, major academic centers across the nation, including Johns Hopkins and Duke universities, have opened multidisciplinary cosmetic centers (MCCs) to make these increasingly desired cosmetic services more accessible to patients. These centers allow collaboration among physicians and optimize patient care.[7,8] Physicians and patients benefit from providing comprehensive cosmetic services in one centralized facility. However, there is concern that this type of environment in which different specialists offer the same cosmetic procedure may contribute to competition and antagonism among specialists.[1,9] It also is uncertain if adequate interest in MCCs exists among academic physicians, as opinions are mixed regarding the value of offering such services.[7,10,11]

Information on the practicality, efficiency, and role of MCCs at large academic hospitals currently is scarce in the medical literature. We set out to gauge physicians' interest level in MCCs by surveying dermatologists, dermatologic surgeons, plastic surgeons, ophthalmologists, and otolaryngologists at our home institution, Wake Forest Baptist Medical Center (WFBMC), Winston-Salem, North Carolina. We also hope to elucidate attitudes of these specialists in an attempt to break down barriers to cooperative care in the future.

METHODS

A survey was created to assess physicians' attitudes toward MCCs and other specialists in cosmetic medicine. This survey was intended as a preliminary step to gauge physicians' interest in implementing a center at WFBMC. It was administered in person to faculty members from departments that might be involved in an MCC, such as dermatology, dermatologic surgery, plastic surgery, ophthalmology, and otolaryngology. Participation in the survey was voluntary. The names of the participating physicians were removed from collected data.

The survey included 15 open-ended questions and 7 multiple-choice opinion statements. The open-ended questions allowed respondents to share their perspectives on the advantages and disadvantages of an MCC; respondents also were able to express their thoughts on which specialties should be involved in an MCC. Respondents' answers to opinion statements 1, 2, and 3 were averaged to generate the multidisciplinary cosmetic score, and responses to opinion statements 6 and 7 were averaged to generate the collaboration score between specialties. For questions 1 through 5, the answer of strongly agree was assigned a value of 2, agree a value of 1, no opinion a value of 0, disagree a value of −1, and strongly disagree a value of −2. For questions 6 and 7, the scale was reversed, with strongly agree assigned a value of −2 and strongly disagree a value of 2, so that a higher value always correlated with a positive opinion. In addition to generating opinion scores on MCCs and on collaboration, an overall opinion score was calculated combining the multidisciplinary and collaboration opinion scores to determine overall attitude toward working in a multidisciplinary setting.

RESULTS

The survey was administered to 6 faculty members at WFBMC: 1 each from the departments of otolaryngology, ophthalmology, general dermatology, and dermatologic surgery, and 2 from plastic surgery. Five of 6 physicians indicated that they currently perform cosmetic procedures. When asked how much of their own practice is currently cosmetic, the answers varied from 0% to 50% for the dermatologic surgeon and otolaryngologist, respectively, with an average of 25%. Two participants, the otolaryngologist and general dermatologist, desired a larger percentage of their practice devoted to cosmetic procedures. The other physicians were satisfied with the amount of cosmetic procedures they perform.

Average scores for the 7 opinion statements regarding issues relevant to MCCs were neutral to positive (Table 1). Respondents on average agreed with the following statements: "Patients would benefit from a MCC involving dermatology, plastic surgery and otolaryngology personnel" (score, 0.8); "I would be willing to work at a MCC" (score, 0.5); and "My professional participation in a MCC would likely be a wise investment" (score, 0.7). Respondents disagreed with the statement, "Market competition among providers of cosmetic services fosters an attitude of competition and contempt among them" (score, −0.7), and felt neutral toward the statement, "The professional relationship amongst dermatologists, plastic surgeons, and otolaryngologists is contentious" (score, 0.3). Respondents had stronger opinions regarding procedures, strongly agreeing that "Certain procedures

Table 1

Average Responses to Opinion Statements From Survey[a]

Opinion Statement	Average Response
Patients would benefit from a MCC involving dermatology, plastic surgery and otolaryngology personnel.	0.8 (agree)
I would be willing to work at a MCC.	0.5 (agree)
My professional participation in a MCC would likely be a wise investment.	0.7 (agree)
Certain procedures should only be performed by board-certified members of my subspecialty.	1.6 (strongly agree)
Only specialists that develop certain procedures should be licensed to perform them.	−1.6 (strongly disagree)
The professional relationship amongst dermatologists, plastic surgeons, and otolaryngologists is contentious.	0.3 (no opinion)
Market competition among providers of cosmetic services fosters an attitude of competition and contempt among them.	−0.7 (agree)

Abbreviation: MCC, multidisciplinary cosmetic center.
[a]The individual responses to the questions were averaged to generate the average response. The average response represents the consensus answer to that specific question. The possible answer choices were strongly disagree, disagree, no opinion, agree, or strongly agree. These responses were assigned values between −2 and 2. The closest answer response to the average value is provided in parentheses next to the score. The value of −2 corresponded to strongly disagree and 2 corresponded to strongly agree in questions 1 through 5. For questions 6 and 7, the scale was reversed with −2 corresponding to strongly agree and 2 corresponding to strongly disagree, so that a higher value corresponded to a positive opinion on collaboration and competition.

should only be performed by board-certified members of my subspecialty" (score, 1.6). However, on average, they strongly disagreed that "Only specialists that develop certain procedures should be licensed to perform them" (score, −1.6).

The average multidisciplinary cosmetic score was positive (score, 0.7)(Table 2). The average collaboration score was neutral (score, −0.2). The average overall score among respondents, which reflected the 2 average scores, also was neutral (score, 0.2).

The responses to the open-ended questions were diverse (Table 3). The respondents described many benefits that could come with opening an MCC. They also all noted that increased competition between specialties and questions about who does what procedure would be one of the greatest drawbacks. When expressing their thoughts on opening an MCC at their institution, the 2 plastic surgeons expressed the most reservations. Both plastic surgeons expressed concern about conflict between the departments involved in the cosmetic centers. Regarding disadvantages, all of the physicians, except the ophthalmologist, expressed concern about increased competition and conflict between the departments for overlapping procedures. One plastic surgeon worried about "working with people who don't work at the same level/achieve same results" or having their "reputation linked." The dermatologists considered the centers a good idea and thought they could bring "expanded opportunities for all disciplines within such a center." The otolaryngologist and ophthalmologist were in favor of the center and hoped to participate in one at their institution. Some of the perceived benefits included improved patient care, shared resources, increased opportunity for multidisciplinary research, improved resident education training, and increased cross-referrals.

COMMENT

Our pilot survey results suggest that academic physicians at WFBMC would be interested in participating in an MCC. Four of 6 physicians interviewed were willing to work in an MCC, and the overall opinion on MCCs was positive. Of the physicians who did not want to work in

Table 2

Opinion Scores for Multidisciplinary Cosmetic Centers and for Collaboration Including the Overall Scores by Respondent[a]

	ENT	D	DS	O	PS1	PS2	Average Score
Multidisciplinary cosmetic score	1.7 (strongly agree)	1.7 (strongly agree)	−0.3 (no opinion)	0.7 (agree)	0.7 (agree)	−0.3 (no opinion)	0.7 (agree)
Collaboration score	−1.0 (agree)	0.0 (no opinion)	−1.0 (agree)	0.5 (disagree)	1.0 (disagree)	−0.5 (agree)	−0.2 (no opinion)
Overall score	0.6 (agree)	1.0 (agree)	−0.6 (disagree)	0.6 (agree)	0.8 (agree)	−0.4 (no opinion)	0.3 (no opinion)

Abbreviations: ENT, otolaryngologist; D, dermatologist; DS, dermatologic surgeon; O, ophthalmologist; PS, plastic surgeon.

[a]The multidisciplinary cosmetic score was calculated using questions 1, 2, and 3 of the survey, which were questions aimed at the willingness of respondents to work in a multidisciplinary setting. The collaboration score was based on questions 6 and 7 of the survey, which were designed to determine the level of conflict and competition that might arise in a multidisciplinary setting. Because questions 6 and 7 expressed negative thoughts on collaboration between specialties, disagreeing was set as positive and agreeing with the statements was defined as negative. The overall score included questions 1, 2, 3, 6, and 7, and calculated the overall opinion of the respondents on the idea of opening and working within a multidisciplinary cosmetic center at their institution.

an MCC, one was the dermatologic surgeon who does not perform cosmetic procedures and the other was a plastic surgeon who expressed strong concerns about collaborating with other specialties. Although opinions were mixed, the survey responses overall suggest that the benefits of a multidisciplinary approach to cosmetic services outweigh the risks, with most respondents feeling that an MCC would be personally and professionally beneficial.

Perceived benefits of a multidisciplinary approach include increased opportunities for research and improved resident education. Further research and experience are needed to determine how MCCs can advance the goals of academic medicine. The centers may provide revenue to allow for more resident education and interdepartmentally funded research. According to Alam,[7] cosmetic surgery could easily be used as a revenue engine for academic dermatology departments, allowing them more finances for their nonsurgical programs. Resident cosmetic experience within the centers would provide a complement to the academic medicine traditionally taught in residency programs. Results of a retrospective outcome analysis of a resident-run plastic surgery cosmetic clinic at WFBMC from 2000 to 2007 found the clinic to be safe for patients. In addition, the clinic provided patients with desirable results and allowed residents a unique opportunity to learn how to provide elective cosmetic services.[12]

Although the present survey revealed many positive opinions, several concerns also were raised. One physician mentioned fear of competition, jealousy, and ego as disadvantages of MCCs. Another physician discussed how the plastic surgery field is self-reliant—"can do anything that other specialties can" without needing to collaborate—and that other specialties do not bring anything to the table aside from more patients. Several physicians mentioned that it would be difficult to agree on the scope of practice for each specialty in areas where procedures could be performed by multiple disciplines. These attitudes could certainly impede cooperative care across disciplines. Two physicians felt the professional relationship between disciplines is contentious, and most felt that the competition for overlapping procedures could lead to feelings of contempt across disciplines.

Drawing attention to the potential negative perceptions some physicians hold of other disciplines is an important step toward finding strategies to minimize negativity as well as help institutions to construct practice models that alleviate conflict among specialists, maximize cooperation and collaboration, and ultimately lead to optimized patient care and outcomes.

Table 3

Written Responses of the Respondents That Provide Insight Into the Attitudes and Outlook of the Physicians on MCCs and Working With Other Medical Specialties

Question	Positive Responses (Specialty of Respondent)	Negative Responses (Specialty of Respondent)
How would you feel about a MCC?	I think it is important for major institutions like this one to offer programs such as that. I look forward to it here. (ENT)	Not in love with the idea. Have to clearly define who does what and have people that really get along with one another. (PS)
	There could be interesting possibilities for teaching patient care and expanded opportunities for all disciplines within such a center if properly managed. (DS)	It depends on the vision and implementation- who it includes, how it includes them. (PS)
	I'm for it. (O)	
In your opinion, what would be the advantages/ disadvantages of such a center?	We each provide services that complement each other. It would be beneficial to patients overall. (ENT)	Ego, jealousy, fear of competition, use of resources, sharing of expenses, referral patterns, information given. (ENT)
	Cross referrals. (O)	Increasing competition for a defined group of pts. No other specialty is bringing anything to the table- other than more pts than we already have. (PS)
	(1) Increased patient care possibilities with high reward cosmetic procedure, (2) resident teaching, (3) properly constructed ethical delivery of advice to patients interested in purchasing a nonmedically necessary service. (D)	(1) Protection of patients in procedures that overlap (Botox, fillers) departments, (2) location suitable to all, (3) price agreement, (4) fair distribution of profits based on cases and referrals. (D)
Do you have any concerns about working with other specialists in this setting?	Nope. (O)	Plastic surgery can do anything that other specialists can provide--> self-reliant. Working with people who don't work at the same level/ achieve same results; reputation linked; had to watch subpar standards. (PS)
		Potential conflict regarding who does what. (DS)

Abbreviations: MCC, multidisciplinary cosmetic center; ENT, otolaryngologist; DS, dermatologic surgeon; O, ophthalmologist; PS, plastic surgeon; D, dermatologist; pts, patients.

This pilot survey was created to gauge the interest level of various specialists who might be affected by the creation of an MCC at their institution. The sample size was small, limiting the generalizability of our results; however, given the overall positive opinions of survey respondents, the potential benefit to patients, and the success of other similar centers, we believe the multidisciplinary approach to cosmetic medicine warrants further consideration.

Employing a multidisciplinary approach has proven to be effective in other aspects of medicine. According to Rodin,[13] the University of Pennsylvania Health System, Philadelphia, has been successful creating incentives for collaboration and a culture that "stresses the success of the program, the team, and the institution, over that of the more traditional department." The multidisciplinary approach has been effective in the treatment of chronic disease. Successful disease interventions typically involve a multidisciplinary care team. In treating chronic disease, using medical specialists in consultative roles may lead to better outcomes. Teams that utilize multiple physician specialties facilitate optimal care for patients, though this approach occasionally occurs at a cost, resulting in administrative and communication challenges between involved specialties.[14] This multidisciplinary approach to patient care has been successfully implemented in the management of cancer whereby comprehensive cancer centers employ surgeons, oncologists, and interventional radiologists. Children with multisystem disease benefit from attending multidisciplinary health clinics, which have been shown to decrease the length of stay at hospitals and improve utilization of surgical services.[15] Another example of success is in the treatment of drug addiction. Patients who receive multidisciplinary treatment with medical management as part of their addiction treatment program have been found to remain abstinent longer.[16]

Further research is needed to ensure that the presence of an MCC at academic institutions is not at the expense of the larger mission of the organization. A potential danger of implementing MCCs in the academic setting is the possibility of fostering financial competition between departments and shifting the focus from education and service to profit.[17] Although revenue-producing ventures should not overshadow education, research, and most importantly quality patient care, it seems unlikely they would, as experience thus far suggests these centers could enhance rather than detract from these aspects of an academic medical center.

CONCLUSION

The multidisciplinary approach has been implemented successfully for cosmetic medicine as well as other aspects of medicine in several academic centers in the United States already. We believe a multidisciplinary approach could be implemented in a way to avoid potential pitfalls and improve cosmetic medicine delivery to maximize patient care. Further research and experience are necessary to determine how best to structure MCCs that would be tailored to meet individual institutional needs.

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