Dual MBA/Medical Degrees For Doctors

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ABSTRACT

With the dramatic changes ushered in by managed care with the promise of even more change with new policies and medical budget pressures, medical schools face the challenge of adapting curricula to prepare physicians for the new demands of health care delivery. Medical students have different tolerances for learning management skills, but medical schools are finding persistent demand for dual degree programs which deliver such skills from a core of students - in some schools amounting to as much as 10% of the medical school students. Over the last two decades, the number of medical schools offering a dual medical/MBA program has expanded from less than 10% to nearly 50% of U.S. medical schools, both for Allopathic and Osteopathic medicine. Schools which had already offered dual medical/MPH programs were particularly likely to add the dual medical/MBA degrees. While schools are learning how to realize the advantages for the few students who undertake dual degrees, they still face a monumental task to reach the rest of the students.

Keywords: Dual Degree; MBA; Medical Degrees; Diffusion; Doctor Education

INTRODUCTION

Managed care forever changed the relationship between physicians and the managers of health care organizations. With managed care, physicians found that their medical judgments could be called into question by managers of health care organizations.

Subsequent research has shown that physicians and managers are likely to make different judgments about health care choices (Farber et al., 1986). In the 1980's, experiments attempted to train physicians who were studying for their medical degrees with managers who were studying for their MBAs, which demonstrated the limits of exposing MBAs to clinical training (Getzen, Eisenstaedt, Uris, & Lowe, 1985).

By the 1990's, physicians were beginning to recognize that they would not have the luxury of leaving management issues to managers who had no clinical experience. In increasing numbers, physicians were admitted to Executive MBA (EMBA) programs (Lazarus, 1997; Seaman, 2004; and Desai, et. al. 2009). However, such programs were available only for a limited number because they were difficult to afford in both time and money for most physicians. General MBA programs - particularly the night programs - were often too long, were difficult for physicians to attend, and required mastery of material not directly relevant to a doctor whose primary responsibility was to professional - not management - responsibilities. Fundamentally, after seven years or more of training, physicians found that their time was valuable and the expense of an MBA - both in tuition and time - was too great.

As a result of such pressures, there have been substantial pressures to change medical education. The pressures to modify physician education came from many different sources and marked a continuum of change (Papa & Harasym, 1999). Experts in medical education observed that the medical education system had generally not kept pace with advances in scientific knowledge and did not adequately prepare physicians for practice in the health care delivery environment. Notably, the Accreditation Council for Graduate Medical Education (ACGME) Outcome Project 2000 identified six general competencies for residents that were beyond the biomedical sciences and clinical training normally provided during medical education. Among these competencies were "Interpersonal and Communication Skills that result in effective information exchange and teaming with patients, their families, and other health professionals" as well as "Systems-Based Practice, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on

system resources to provide care that is of optimal value." Designing a curriculum to impart the value of "information exchange", "teaming", and "optimal value" could not simply be placed into an existing medical school curriculum. A few universities had already ventured into creating a market for physician managers. Notably, the Tufts Managed Care Institute took on a major role in defining some of the competencies necessary for physicians in a managed care world, which they published in their curriculum framework (Halpern et al., 2000).

There was no single model to follow when redesigning the curriculum and there was no standardization in the direction that medical schools were taking. While there were major experiments in the delivery of management education for physicians, the sudden interest in dual degree programs was not characterized by a single standardized model. The programs initially set up were marked by no standardization with respect to the timing of the education, the length of education, the degree of integration between medical school and management training, admission procedures, or the tailoring of leadership education for the specific needs of physicians (see Larson et al., 2003, p. 339).

By 1993, MBA programs were being set up as dual degrees primarily for medical students, and not physicians. Larson, Chandler, and Forman (2003) reported that dual degree programs were being offered by 26.4% of the allopathic medical schools (33 programs) by 2002, up from six medical schools in 1993 (see Figure 1). Similarly, the osteopathic medical schools created new programs. For the 2001-2002 academic year, Barzansky (2002) estimated that a total of 36 medical schools offered dual medical-MBA degree programs. Since then, there has been a steady increase (Freudenheim, 2011) in programs, as shown in Figure 1.

If this steady increase continues, then most medical schools will eventually be offering the dual medical/MBA degree in some form. In Figure 1, a logistic curve, which is used to estimate the diffusion of new technologies, is fitted to the data on expanding programs by medical schools[1]. At this rate, nearly all of the medical schools would offer such programs by the year 2020.

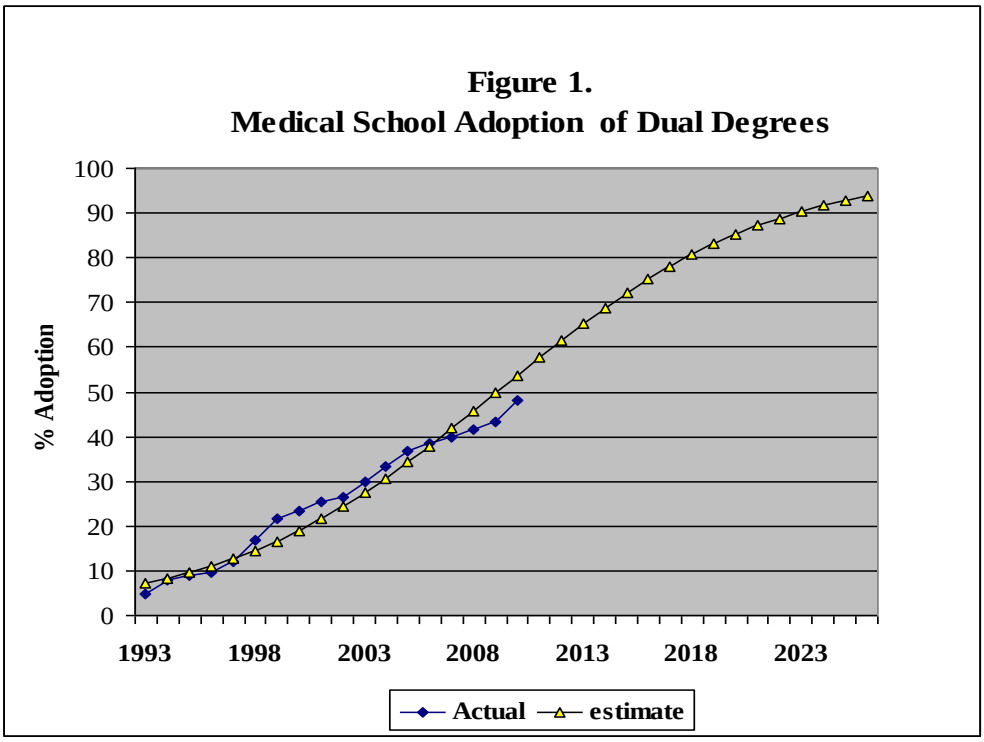
However, even if such a rapid rate were attainable, the number of physician leaders and managers who would be trained in such programs would be small and expensive. At present, the median number of enrolled students per program is 8 with an average number of 4 graduates per year. Most programs are too small to allow the majority of courses to be tailored to the needs of future physicians. For example, in 2002 only five programs out of 33 reported the ability to tailor some courses specifically for the MD/MBA students (Larson et al., 2003, p. 337). As a result, a great deal of creativity by administrators of such programs as well as faculty must go into guiding student schedules to fit the availability of existing curricula - often across different schools and programs. Designing an entire physician leadership program from scratch is generally not an option.

It is not surprising then to find that 62 out of the 72 medical schools who have (or are contemplating having) the medical/MBA dual degree already have another medical management dual degree program. Table 1 shows a cross tabulation of 154 Allopathic and Osteopathic medical schools with respect to their dual degree offerings.

A large variety of management degrees are available to match with an MD or DO medical degree. Most popular is the Master of Public Health, but the Master of Public Health and Administration (MPHA) and Master of Public Administration (MPA) are also available in some schools. Analysis of the curricula of the MBA and MPH programs typically uncovers many courses in common.

We may be seeing evidence in Table 1 of the economies of scope available by having multiple programs that have the potential to help fill courses. A competing hypothesis is that larger institutions are the ones that can afford to make a wide variety of small programs available. Certainly, perusal of the list of 62 schools that have (or will soon have both) leads to the conclusion that big public universities are the ones most likely to have both kinds of dual degrees.

[1] The estimated equation explains the log (Ladopt) of the ratio of the percentage of adopters to non-adopters as a function of the year (Year) and is given by the formula Ladopt=-322.1+.1603*Year (see Hall, 2004). The R-square is .94 and with an F-statistic of 198 with 12 degrees of freedom.



Data source: Larson et al. through 2003 with more recent data from directories on graduate school dual, joint, and combined degree offerings, as well as Freudenheim (2011). In assembling the recent data, we found many schools claim they have dual degree programs or are about to institute them - 72 programs in all! However, using the Larson criterion that the programs must show design features that allow the student seamlessly to take both degrees simultaneously, rather than sequentially, we believe there are only 60 dual degree medical/MBA programs that currently (2010) exist for Allopathic medical schools.

Table 1: Management Dual Degree Offerings by Medical Schools

	MPH, MPA, MPHA Dual Degree		
Medical/MBA Dual Degree	**NO**	**Yes**	**Grand Total**
NO	40	42	82
Yes	10	62	72
Grand Total	50	104	154

As the availability of management training standardizes, standardization of curriculum among different programs simply doesn't exist. While 15 medical schools must go outside of the university in order to find the MBA programs with which to create a dual degree, the rest are able to find schools within their universities that have the necessary skill sets and capabilities. Working with these schools internally to make the necessary compromises to produce a well-thought out curriculum that does not compromise the integrity of either the medical or MBA degree is difficult. While there is a great deal of experimentation in how to integrate two distinct programs from two distinct schools, it is likely to be a long time before any standardization occurs in how this is to be done.

The availability of resources within a university does provide the potential to produce curriculum changes in the medical school curricula to provide all students with the management training they need and that they are ready to learn. Tapping resources in externally provided MBA programs is generally more difficult because of location, organization, and jurisdiction problems. However, coordination with other schools within a university often involves a political process that limits the flexibility and compromise necessary to coordinate two very different kinds of learning. Simply being able to transfer resources among schools to provide support for curricular changes within a medical curriculum can be very difficult, not to mention coordinating everyone on the same page. At best, the spread of management education to all medical students will take a long time to accomplish.

CONCLUSION

With the dramatic changes ushered in by managed care, with the promise of even more change with new policies and medical budget pressures, medical schools face the challenge of adapting curricula to prepare physicians for the new demands of health care delivery. Medical students have different tolerances for learning management skills, but medical schools are finding persistent demand for dual degree programs which deliver such skills from a core of students - in some schools amounting to as much as 10% of the medical school students. Over the last two decades, the number of medical schools offering a dual medical/MBA program has expanded from less than 10% to nearly 50% of U.S. medical schools, both for Allopathic and Osteopathic medicine. Schools which had already offered dual medical/MPH programs were particularly likely to add the dual medical/MBA degrees. While schools are learning how to realize the advantages for the few students who undertake dual degrees, they still face a monumental task to reach the rest of the students.

AUTHOR INFORMATION

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