COMMENTARY

△ Marketing Clinical Doctorate Programs

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Over the past decade, clinical doctorate programs in health disciplines have proliferated amid both support and controversy among educators, professional organizations, practitioners, administrators, and third-party payers. Supporters argue that the explosion of new knowledge and increasing sophistication of technology have created a need for advanced practice models to enhance patient care and safety and to reduce costs. Critics argue that necessary technological advances can be incorporated into existing programs and believe that clinical doctorates will increase health care costs, not reduce them. Despite the controversy, many health disciplines have advanced the clinical doctorate (the most recent is the doctor of nursing practice in 2004), with some professions mandating the doctorate as the entry-level degree (i.e., psychology, pharmacy, audiology, and so on). One aspect of the introduction of clinical doctoral degrees has been largely overlooked, and that is the marketing aspect. Because of marketing considerations, some clinical doctorates have been more successfully implemented and accepted than others. Marketing is composed of variables commonly known as "the four Ps of marketing": product, price, promotion, and place. This report explores these four Ps within the context of clinical doctorates in the health disciplines. J Allied Health 2007; 36:107-112.

IN RECENT YEARS, there has been an increasing interest in professional doctoral programs in different disciplines and at numerous universities, both nationally and internationally.1 These emerging doctoral degrees are not limited to health programs and seem to have developed a niche market. For example, the doctor of education (EdD) has been an American standard for many decades but was only introduced in Australia in the early 1990s. Now, almost all of the Australian universities offer this degree.2 The Council of Deans and Directors of Graduate Studies of Australia define professional doctorates as "a program of research and advanced study which provides students the enablement to make a significant contribution to knowledge and practice in their professional context." Further, the advanced student or graduate may also contribute more generally to scholarship within a discipline or field of study (Council of Deans and Directors of Graduate Studies, unpublished manuscript, 1998).

The professional doctorate usually differs from the doctor of philosophy (PhD) degree in that the PhD degree is devoted to and focused on basic research.3,4 In some instances, however, a clinical doctorate may be incorporated into a traditional PhD. For example, differentiation between an EdD and a PhD in education still initiates debate in academia. While there is abundant literature to explain the value of a PhD in health disciplines, Cartwright and Reed also explain the policy issues that must be addressed by the educational institutions offering doctorates and the careful planning to ensure students are well prepared for the future.5 This report focuses on one important and sometimes misunderstood issue, the marketing of the professional doctorate within the health disciplines.

Consider that the practice environment in health care delivery, broadly defined, is virtually the same for all health professionals. For instance, the Institute of Medicine (IOM) has identified the high and inexusable error rate that compromises patient safety to be caused by the fragmented nature of the health care delivery system and the context in which health care is financed.6 This fragmented nature affects physicians in the same way that it affects other health care professions. It is no wonder the IOM recently advocated that "all health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches and informatics in order to improve patient care delivery quality."7 This confirms that all health care professions are affected by the same environmental factors, albeit in differing ways. Therefore, the development of professional doctorates in any health care field will follow similar pathways and require related skills as well as discipline-specific skills. These doctorates will also all require incorporation of standard mar-

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keting theory to be successfully implemented and to positively impact patient care.

**Background**

There are several efforts that are attempting to address the IOM initiatives while also generating significant debate. The emerging doctor in nursing practice (DNP) degree, for example, has ignited an ongoing debate both in favor of and against the degree. Proponents of this degree believe that the DNP offers a new and exciting opportunity to meet the health care demands of the future and address the IOM initiative. Further, they argue that the resulting higher level of clinical skill and knowledge will advance clinical practice and meet the demands for clinical leadership. These leaders will strengthen health care delivery across the board. In addition, the DNP will provide the flexibility to provide the balance necessary for enhanced patient care, nursing leadership, and other aspects of professional nursing that are the focus of the DNP. On the other hand, the opponents of the DNP argue that it could compete against the PhD for scarce institutional resources, including students. The consequence of this competition, as argued by opponents, will be to reduce the number of nurse scientists and lead to a decrease in evidence-based practices desperately needed in the field. However, there is information from a nursing accrediting body indicating that student enrollments in these programs are up significantly (personal communication with Jennifer Butlin, Director of the Commission on Collegiate Nursing Education, January 2006).

A large body of literature reports health-related professions moving, or having moved, toward the doctorate, especially nursing as noted, but also pharmacy, physical therapy, and occupational therapy. Many of these efforts predate the DNP. The history of a general doctorate for nursing dates back to 1979, when the nursing doctorate degree was introduced at Case Western Reserve University. This nursing doctorate degree was to provide the highest level of preparation for specialization in nursing practice. Since then, other forms of professional doctorates in nursing have been introduced; they include Doctor of Nursing Science (DNSc), Nursing Doctorate (ND), Doctor of Science in Nursing (DSN), and now DNP. However, recent reviews of these programs have revealed insignificant differences between these degrees and the research-based PhD program. The present corps of doctoral prepared nurses do not spend the majority of time in direct patient care but instead serve as faculty or conduct nursing research. Furthermore, given other challenging roles that they are involved in, these doctorally prepared nurses cannot be expected to maintain expert levels of clinical competence required to teach advanced practice nursing students. Therefore, nursing is introducing a new doctorate with a strong clinical focus not found in the currently available nursing doctorate programs. The DNP is intended to focus on enhancing clinical skills and to be completely operational by 2015.

Another factor in the move toward patient-centered care is the evolution toward including expanded access points for disease prevention, intervention, and treatment, among others. Results of laboratory testing are increasingly important factors in health care. Diagnostics, health monitoring, and early disease detection are common practices in several health care disciplines at this time and require an interdisciplinary approach. Clinical laboratory scientists are also addressing the IOM initiatives and are planning for an advanced practice doctorate for the profession. They posit that there are a number of factors transforming health care that impact the laboratory. These include an explosion of new knowledge of the scientific basis of laboratory diagnosis, informatics citing that health care (especially in the laboratory) has become a highly technological and information-driven industry, increased sophistication of diagnostics, multiple points of access, and the need for improved quality and patient safety. Another factor significantly affecting the argument for a clinical doctorate (DCLS) is that diagnostics comprise only 2%–5% of total hospital and third-party reimbursement costs, yet they influence between 60% and 70% of the medical record and objective medical decisions. Proponents of the clinical doctorate in clinical laboratory sciences also note that the primary care physician or public health nurses are no longer the conventional points of access and the numbers of clinical pathologists, historically the major communication link with clinicians, are dwindling rapidly.

Within the pharmacy profession, when the PharmD degree was conceptualized, it experienced proponents and critics as well. Many of the same arguments evoked in other professions were heard at the time of its introduction. The University of California at San Francisco was the first school to adopt the new program, and in a relatively short time most other schools followed until the licensure of the profession mandated that the PharmD be the entry-level degree for the profession.

**Drivers of the Professional Doctorate**

There are many and significant environmental forces behind the movement for adoption of clinical doctorate degrees. In important studies related to nursing, Marion et al.

**Changing Practice Environment**

Many health care disciplines such as audiology, dentistry, medicine, pharmacy, podiatry, and psychology have already established the professional doctorate degree as the entry standard for practice. Thus, it may behoove other disciplines that have not established clinical doctorates to examine the need given the plethora of new information.
available and the specific role of a profession in a changing practice environment.

**KNOWLEDGE**

We have entered the information age whereby specialized knowledge that was once controlled by groups such as religious orders and government agencies has now become accessible to almost everyone. The meaning of effective and satisfactory care continues to be redefined. In this and in the coming era, ever more knowledgeable clinicians will be needed to deliver care. Short-term training programs with extended apprenticeships, as seen in the early nurse practitioner programs and still in some health-related programs, no longer meet the needs and expectations of other health care providers or patients for whom health care must be delivered in an evidence-based manner. Only carefully crafted formal education programs, such as the clinical doctorate, will be able to satisfy the ever-increasing knowledge base of clinical disciplines.

It is not realistic to expect a physician to acquire all the known medical information in four years and a residency. This has been especially well documented for laboratory services. The explosion of medical advancements makes it impossible for any one person to master this expansive knowledge base.

**CHANGING DEMOGRAPHY**

Today, people are living longer than ever before while coexisting with the morbidities associated with chronic illnesses. The management of these chronic illnesses has placed an enormous burden on the health system. Thus, the demand for quality, cost-effective, and better management of chronic illnesses will increase as people continue to live longer. Further, the knowledge, skill, and caring required to ensure a comfortable and dignified end-of-life experience will also increase. In addition, culturally competent care will become very important as cultural and ethnic diversity among consumers increases. This is coupled with the sharp reality of related health disparities.

**HEALTH CARE CONSUMERS AND SELF-CARE OF THE FUTURE**

As the cost of delivering health care in America continues to increase, many people will indulge in self-care as a means of containing their ever-increasing health care costs. This situation is complicated by the growth and demand for multispecialty care that has resulted in severe discontinuous and uncoordinated health care that is not cost-effective. All these forces will expand self-care beyond the abilities of ordinary consumers. Therefore, to remedy this situation, consumers will increasingly need individualized self-care support and interventions with culturally appropriate undertones, as well as comanagement of complex care across settings and specialties.

**IMPROVING THE QUALITY OF HEALTH CARE SYSTEMS**

Despite the huge advances in technology and procedures, the U.S. health care system has not lived up to its potential. The major challenges facing quality of care delivery include medical errors, workforce shortages, slowness of information technology transfer from bench to bedside, and the lack of well-prepared leaders and managers. Several issues, including rapid growth in knowledge, technology, and demand for services from diverse consumers, have resulted in this ever-widening divide between knowledge and practice. Thus, the panacea for ensuring a culture of quality that encompasses safe, effective, patient-centered, timely, and equitable care delivery may be achieved only when all health care disciplines improve and expand their clinical training to meet the needs of their society.

**SHORTAGE OF PRIMARY CARE PHYSICIANS**

There is a growing shortage of primary care physicians, especially in rural areas. This is because many physicians prefer specialized medicine, where reimbursement for care is much higher. The DNP and other clinical doctorates may be a way of increasing primary care providers who could work in rural areas and medically underserved areas. Similarly, the increasing shortage of pathologists and physicians calls for advanced practice in the laboratory. These shortages will increase the importance of the cost-effective argument for clinical doctorates.

These forces that Marion et al. have identified show how varied factors from within and outside the profession influence development of the nursing clinical doctorate and influence other doctorates as well. What is interesting is that the factors are interdisciplinary in nature and are cause for some overlap between disciplines.

The rationale for and the forces driving clinical doctorates are well understood within each discipline, and in most cases there is ample evidence to support the development of the doctorate. What has not been equally clear in each discipline is an understanding of a marketing strategy required to gain acceptance and understanding by not only the profession itself but by the rest of the health care team. For example, the pharmacy approach was to clearly define what the clinical doctorate was by slowly testing it in a practice setting and refining it. The results were presented to other members of the profession and to universities at professional meetings and through publications. In time, schools saw the advantages of the degree in attracting students and followed suit. As more and more colleges and universities followed the model, the licensing authority saw that acceptance was occurring nationwide and adopted the degree as the entry-level degree. Contrast that to the physical therapy profession, where it was decided that a graduate-level degree was needed for entry level and each institution could decide if it wanted to offer a master's degree or a doctorate to satisfy the requirement. For occupational
therapy, it was decided to move to graduate entry level for accreditation but with a postprofessional doctorate option that would not be accredited. Thus, the marketing strategies differed from profession to profession with no common relationship to classic marketing theory.

The public and third-party payers must also understand what the clinical doctorate has to offer over an undergraduate or other graduate degree. An understanding of marketing concepts is essential to develop this understanding, recognizing that an appropriate marketing plan for a specific profession is necessary and that no two marketing plans will be alike. A review of marketing concepts necessary to develop a successful marketing plan is described in the following text.

The Marketing Aspect

The American Marketing Association\(^1\) defines marketing as "the process of planning and executing the conception, pricing, promotion, and distribution of ideas, goods, and services to create exchanges that satisfy individual and organizational objectives." To best satisfy this classic definition, four prerequisites must occur before the marketing effort: (1) unsatisfied needs of two or more parties must be present, (2) the desire or ability of another party to meet the needs of the unsatisfied party must be present, (3) the parties must have something to exchange, and (4) there must be a mechanism to communicate between the parties.

The core of marketing is the development of a response to the needs of the marketplace. This is accomplished by defining the variables contained within what is referred to as the "marketing mix." The variables are the four P's of marketing: product, price, promotion, and place. These are all relevant variables and apply to the marketing of any clinical doctorate.

PRODUCT

Product, in the context of a clinical doctorate, may be defined as the goods, services, or ideas offered by a profession. This definition includes traditional concepts such as medical procedures, medical devices, diagnostics, counseling, and prescription drugs. It also includes products and services offered by third-party payers, preventive health services, and disease management. The product mix includes the entire range of services offered by a profession and must also clearly define the breadth of the product, which can best be described as the listing of related services offered by the profession. The depth of the product mix must also be well defined and include a detailed description of the number of products contained in each group listed in the breadth. Most professions assume responsibility for multiple product lines. With the rapid advancement of health care knowledge, professions must keep in mind the life cycle of their services and will find that periodically they must reposition their product to reflect current need. In the clinical laboratory, it has been found that having a laboratory professional on rounds with other health care providers provides for consultation services and avoids inappropriate laboratory tests.

PRICE

Price, in the context of a clinical doctorate, is defined as the reimbursement that professionals demand for their services. This typically equates to the economic value that the patient provides to the health professional for his or her services. In setting the price for a service, one consideration must be to set a price that corresponds to the consumers' perceived value of the service provided. Another consideration is the positioning value for the service. A higher price may imply better quality. However, one must also consider the effect price has on consumer demand and competitor response. For example, if two professions offer the same service, one may increase its market share by offering a lower price for the same service.

Setting a price for a service is accomplished in six steps: (1) identify the pricing policy limitations; (2) identify objectives; (3) forecast the demand and revenue for the service; (4) resolve the cost, volume, and profit relationships; (5) secure a pricing strategy; and (6) consider the positioning effect in establishing the final price.

Price variations are frequently tied to the life cycle of the service provided. The newer the life cycle, the lower the price. During the infancy of the life cycle, when awareness is minimal, prices will be lower in an effort to get consumers to try the service. However, as the service experiences growth and awareness, the price will increase. The PharmD is a good example of this observation. When the PharmD was first introduced, the average annual salary was approximately $55,000. Today, the average salary for the PharmD is approaching $100,000.

PROMOTION

Promotion addresses the mechanism that professions use to communicate their messages to the marketplace. There are four parts to the mechanism: advertising, personal selling, publicity, and sales promotion.

Advertising

Advertising may be viewed as any directly paid form of nonpersonal presentation of the profession. In this part of the marketing mechanism, the advertiser maintains the control of what, when, and how often the message is communicated, as advertising is distinguished from other forms of promotion in that (1) it is paid for and (2) it is nonpersonal. The greatest impact that advertising has is when buyer awareness is minimal and demand is high. Advertising is also effective when service features are not normally observable. In this way, outcomes of a particular service can
be demonstrated. For example, clinical laboratory services are not normally observed by patients or even by health care providers, yet the clinical laboratory outcomes can be readily demonstrated. In this instance, advertising presents a great opportunity for differentiation and can highlight the advantages inherent in the clinical doctorate. A serious limitation to advertising is that it lacks feedback and can easily become "noise" because of the large number of advertisements that consumers encounter every day.

**Personal Selling**

Personal selling is a personal, one-on-one form of communication. Its major strength is that it allows for direct feedback from the receiver of the message. Because personal selling involves a person, the message may vary depending on the individual's training, disposition, or style. Unfortunately, the more technologically sophisticated the profession, the greater the need for personal selling. Also, the higher the risk, the more there is a need for personal selling. If numerous people are involved in making a decision about whether or not to engage a clinical doctorate, the personal selling becomes even more important. The major limitation to personal selling is cost because it is a time-and-people-intensive approach, but it has worked in the "rounding" experiences with laboratory professionals.

**Publicity**

Publicity is the most common tool used by health care organizations. For example, the Red Cross has become recognized as the primary respondent to disasters due to the positive publicity it has received. The reason for this is its credibility. Publicity is generated by public relations departments and is typically viewed as unbiased by the consumer. It is the public relations department that encourages media to print or broadcast stories about the accomplishments and contributions of an organization or a profession. Public relations are most useful in dealing with negative information that is presented to the public. When it was discovered that a nurse at a large hospital had been killing patients, publicity about the hospital's strengths, its novel or life-saving programs, following the incident helped neutralize the negative information stemming from the killings. Publicity has limitations in that it lacks control over how, when, or if the message gets across. However, it makes a good supplemental tool to the overall promotional plan.

**Sales Promotion**

Sales promotion involves temporary inducements to buy or to use the product by the consumer. Tools such as coupons, samples, or cash rebates are the most common forms of sales promotion. Use of sales promotions has been limited in health care due to the fear that it would lead to unnecessary use of health care services. This is not to say that it has not been effective in engaging the public in health screening activities. Further, pharmaceutical companies frequently use sales promotions to induce trials of new medications. There are nine identifiable objectives in sales promotion: (1) to encourage the trial use of the product by the consumer, (2) to encourage intermediaries to utilize the product, (3) to encourage clinicians/patients to purchase more than one unit of the product, (4) to encourage intermediaries to devote more effort to selling the product, (5) to acquaint clinicians with service changes, (6) to identify new users of the product, (7) to build clinician loyalty, (8) to encourage clinicians that they become their consultant of choice, and (9) to gain entry into new areas of patient care.

**PLACE**

Place is a basic component of the marketing mix and represents how a product is accessed by the customer. The path that the product takes from the university to the student is referred to as the "channel of distribution." In marketing this degree, the university has several decisions to make regarding how the degree will be accessed by the student. The place component of the marketing mix contains considerations such as how the product will be distributed, who within the university should perform specific functions, how much coverage of the market is needed, and of course how to control this action.

Universities must also decide if other organizations, referred to as intermediaries, are needed to help distribute their product. Indirect channels may have several intermediaries, such as the campuses of other universities (as in a consortium) or the Internet. A direct channel is one where there is no entity between the university and the student.

Other functions of the channel of distribution include time. This utility refers to the notion of providing the product when the student wants it. This may be at the student's convenience, such as a weekend or evening program, or one that is totally student driven, such as distance education via the Internet. Possession is another function and refers to financing. Universities must decide if they will offer financial aid via scholarships, offer employment (i.e., teaching assistants, resident assistants), or make loans available to students. The fourth function is form. This utility provides some customization of the product. The university must decide if it will offer a clinical doctorate that has the same requirements for all students or if it will allow variations of the degree to fit the interests of the students or possibly the needs of the community.

**Conclusions**

While they continue to be planned, developed, and implemented, clinical doctoral programs are facing an ever more competitive marketplace at work and in academia. Scope of practice and marketing strategies must be revised and changed continually to respond to new technologies and
health and medical information. For new clinical doctorates in academia, it must be recognized that the university retains control of what is institutionally acceptable and must market its own programs to potential students using programmatic strengths. 32

Essential to the effective marketing of a clinical doctorate is the ongoing measurement and monitoring of outcomes. As clinical doctorate programs face more difficult resource allocation decisions, they will need to document their capabilities as well as the results of their practice. To effectively accomplish this, they must institute a system to monitor and measure results of their efforts that are understandable to other clinicians, administrators, third-party payers, and patients. It would be helpful to the public if, periodically, each profession would conduct a system-wide review of its contributions to health care and ensure that marketing efforts are appropriately responding to the changing demands of society.

REFERENCES


