Editorial

Frivolous lawsuit, unmanageable debt

Most members of AΩA have benefited from the National Resident Matching Program (NRMP). Between 1953 and 2004 you filled out your match list and sent it off to NRMP with the assurance that, even though hospitals were filling out their own lists, your preferences would be honored before those of the hospitals. If you ranked a given hospital first while that hospital ranked you number 56, if there was still an opening there when number 56 came up, you would match there even if your second choice had ranked you number one. In 2003, more than 21,000 students were matched to residencies in the "main match," and over 2,000 to specialty positions. It has been a reliable, effective program. Sponsored by the American Board of Medical Specialties, the American Hospital Association, the AMA, the Association of Medical Colleges (AAMC) and the Council of Medical Specialty Societies, the NRMP has been uncontroversial . . . until recently.

The NRMP is now one of 30 defendants in the lawsuit *Jung et al.* v. *AAMC et al.*, pending in U.S. District Court in the District of Columbia. What's going on? The lawsuit, filed by three physicians, claims that the NRMP and other defendants have conspired to depress compensation for medical residents. In fact, however, NRMP's sole mission is to operate the match and it does not mandate, oversee, or review any terms of residency programs, including compensation.

In a related story, an AAMC national survey of 13,764 graduating U.S. medical students in 2003 found that their average individual debt from attending medical school was $109,457. Those graduating from public medical school had an average debt of $97,275, and graduates of private medical colleges carry an average debt of $129,392. It is not surprising that the AAMC describes these numbers as "unmanageable," or that the high debt discourages graduates from pursuing careers in primary care or academic medicine, turning them instead to more lucrative specialties, or that disadvantaged minorities are deterred from medicine by the daunting costs.

We can only hope that a rational court system throws out the suit against *AAMC, et al.*, but there is every reason to conclude that, were the plaintiffs not part of a system generating huge debt for medical students, the suit might never have been filed. Excessive debt could well be the root cause driving students' desires to make more money as residents, as well as in practice. What is to be done?

Every general and specialty society is concerned about these debt numbers, and each advocates varying forms of relief. The American College of Physicians, for example, urges its members to lobby Congress for support of two specific bills: (1) The College Loan Assistance Act of 2003 (H.R. 2505), which would allow physicians with medical student debt to refinance student consolidation loans without being locked into a certain interest rate when a lower interest rate becomes available; and (2) the Higher Education Affordability and Equity Act of 2003 (H.R. 3412), to expand the tax deductibility of student loan interest and increase the income eligibility level for receiving these deductions by excluding scholarship, grant, or fellowship funding for higher education from taxable income. In addition, the ACP urges Congress to continue and extend plans for pay-back of debt in return for service in underprivileged and underserved areas. These are band-aids, not strong solutions.

As ACP governor for northern California, I trekked to Capitol Hill recently to talk with my senators and congressional representatives. I enjoyed the experience, but heard a recurrent theme: Doctors are self-serving. You want relief of medical student debt, but what you want more is better reimbursement from Medicare and caps on payments in malpractice suits.

They have a point, and it needs answering. While thinking about a strategic response, I kept coming back to Dr. Robert Moser's paper in *The Pharos* in which he pointed out the need for the peripheral health economy to contribute to, as well as profit from, sickness ("Mene, Mene, Tekel, Upharsin Comes to Medicine," Fall 1999, pp. 15–19). By "peripheral health economy" he means every corporation that makes money in the health care sector. This includes big and little drug houses, of course, but also device manufacturers, uniform producers, hospital supply houses, and insurance companies (exempting the not-for-profit ones). Dr. Moser proposed that the peripheral health economy should contribute a portion of its earnings to help the financial stress upon academic medical centers (and their students' debt).

But what about the core health economy: the doctors, nurses, and hospitals? We could not expect nurses to contribute, and only for-profit hospitals would be taxed. But consider what moral leverage we could exert if, linked with a tax on the peripheral health economy, physicians paid a 1 percent tax on every dollar over a net $200,000 annual income, to be earmarked for academic medical centers to reduce student debt. No longer could the "self-serving" image stick. Both sides of the aisle in Congress would have motivation to levy such a tax. Those in the peripheral economy would lobby hard to defeat any such legislation, of course, and such a bill might be years away, but in the interval the word would be out: Doctors are willing to look at their profession as a "guild" and help their apprentices. Perhaps they do deserve better reimbursement and tort reform!

The prime beneficiaries, our medical students, could make postgraduate choices based on a good fit for their interests and capabilities rather than on the need to make as much money as possible as soon as possible to pay off medical school debt. And the NRMP would be left alone to do its usual effective job.

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Editor