Rising Medical Education Debt a Mounting Concern ......Page 14

2012 Officer and Council nominees
Page 8

The debt crisis in medical education
Page 4

Dr. William Beaumont: Gastroenterology pioneer
Page 12
Cover Feature

Rising Medical Education Debt a Mounting Concern
Graduates also face less favorable repayment terms, shortage of training positions
By Timothy P. Craft, MD, and Joseph A. Craft III, MD, FACC

Area Medical Schools Address Debt Issue

Features

Election Set for 2012 Officers and Councilors
Voting takes place online between November 1 and 25

Dr. William Beaumont: Founding Father of Gastroenterology
Early SLMMS president also was outspoken critic of false expert witness testimony
By Arthur Gale, MD

Columns

SCAM-O: Richard J. Gimpelson, MD
Bundling Will Save Us All

President’s Page: Thomas A. Applewhite, MD
The Debt Crisis in Medical Education

Executive Vice President: Thomas A. Watters
The Value-Added Organization

Departments

Harry’s Homilies
Newsmakers
Alliance
Obituaries
Calendar

Minutes of the SLMMS Council
Birthdays
Welcome New Members
In this issue of St. Louis Metropolitan Medicine, we examine the increasingly onerous problem of educational debt for our young colleagues in the medical profession. Drs. Timothy and Joseph Craft present an excellent and up-to-date analysis of the debt situation and its implications.

Education has long been the vehicle of upward social mobility and the gateway to the professions in the United States. As a consequence, educational institutions have had virtual carte blanche to charge what the traffic will bear in tuition and fees despite low to non-existent inflation. The situation has been exacerbated by a decade of market volatility causing reductions in anticipated endowment income. This affects all levels of higher education, but is most acutely seen in medical studies because of the inherent cost, complexity and length of the educational process.

The most recent American Medical Association figures estimate the average indebtedness of the class of 2010 at $157,944. Seventy-eight percent of graduates have at least $100,000 in debt. When the cost of undergraduate education and living expenses during school are considered, debt burdens of $200,000 or even $300,000 are not uncommon. This does not even include the opportunity costs of wages which could have been earned during the educational process. In the words of a recent private medical school graduate, “You spend the first 10 years of your career just trying to break even.”

At least medical graduates will have a job – a situation not shared by some other professional school graduates. Retiring baby boomers will create the greatest demand for health care ever seen. But, there is a catch: governmental mandates threaten eventual income potential even as tuition increases remain unregulated. Recent graduates face the potential dilemma of high debts on the front end of their career and reduced government-dictated income when they eventually enter practice.

What does this mean for the medical profession? In a society clamoring for primary care providers, American medical graduates commonly eschew primary care and focus on higher paying specialties. Rural and underserved areas become untenable practice venues for those with high debt to repay. Physician diversity may be negatively impacted, because high tuition discourages low income and minority applicants. Young physician quality of life suffers. As a result, the risk of depression and career burnout increases.

Left unaddressed, the market will eventually control the situation. The brightest and most ambitious students will seek other careers. Physician extenders will replace doctors in many settings. The profession will change.

If we do not want this to happen, organizations such as SLMMS need to become involved. There is no easy answer. Resources are finite and financial outlooks are guarded. Interest reforms to keep passive increases in debt burden as small as possible would be welcomed. Creative incentives sponsored by states or counties to encourage rural practice after graduation should be encouraged. Federal-level advocacy to tie any reductions in reimbursement structure to educational financial support should be promoted.

It should be an interesting next few years in American medicine. The economic implications are only part of the total picture. We owe it to our new doctors to advocate on their behalf and to leave our profession to them as an attractive way to live their lives and serve others.
An unavoidable topic at most leadership meetings of membership societies is membership growth. Your medical society is no exception. Almost always, the discussion winds and turns, but eventually someone asks the inevitable question: “How do we add value to our membership?”

It’s a good question, and one that deserves an answer. I believe there are several parts to the answer. First, the question should be: “Are we providing value?” Assuming the answer is yes, then the next question should be “Are we doing a good job of telling our members about the value they receive by being a member?” We’re not unlike other businesses. A car dealer could have the best inventory in town, but if they don’t advertise it, and no one knows about it, they might not make many sales.

There is no doubt SLMMS provides value. Here are some services that are available ONLY to members:

• Free subscription to *St. Louis Metropolitan Medicine*
• Electronic updates and newsletters
• Peer review process to handle patient complaints
• Grievance process to deal with third party complaints (insurance)
• Patient referrals
• Special “one person” group health insurance
• Access to Society membership directory
• Unique networking and leadership opportunities
• Advocacy on a local level – your only true local watchdog
• Special rates on investment opportunities with Mason Road Wealth Advisors
• Discounted rates on Medjet Assist memberships

Still, the question remains, can we do more? Of course. Keeping pace with technology alone is an ongoing challenge, and perhaps, one of our biggest opportunities. The SLMMS website will soon be getting a facelift, moving us into a new era of electronic communication with our members. But what else?

Organizations that survive into the future will need to be constantly challenging their existing premises, and postulating new ones. In their recent book, *Race For Relevance*, Harrison Coerver and Mary Byers state the following:

...the traditional model for associations doesn’t work well in today’s environment, and its efficacy will diminish in the future because of rapid changes and the continually shifting landscape. While most professional societies are not in immediate danger, they will struggle if they cling to conventional approaches and structures. They will survive but they won’t grow. They will function but without vitality. They will have members but market share will decrease. They will exist but their influence will decline.

Today’s association is in a race for relevance. The track is fast and associations are at risk of falling seriously behind ... (some) to drop out of contention altogether.

As part of the leadership team at SLMMS, I sense that the team is ready to reach out for radical change, as opposed to settling for incremental improvements on an old plan. This can be an exciting time. As we stage our own “Race for Relevance,” here are some important questions we need to ask.

• Can we add an important service that isn’t readily available elsewhere?
• Do we have service areas that are outdated?
• Do we spend too much on any services that only impact a small percentage of our membership?
• Are we doing too much of what we know how to do as opposed to what we should be doing?
• Is there something we’re doing that could be done differently or better?
• Are our members ahead of us in using technology? How and where?
• Are our traditional delivery vehicles not allowing us to add meaningful value?

I like to believe that every member of an association is part of the leadership. That’s one of the things that makes working for an association exciting. I would love to hear responses from our members to some of the questions posted above. New ideas are the seeds from which we grow. Email me at twatters@slmms.org.
To commemorate the 175th anniversary of the St. Louis Metropolitan Medical Society, we remember the world’s first great experimental gastroenterologist, Dr. William Beaumont. Most physicians are unaware that after his groundbreaking experiments on digestion when he was an army surgeon in Michigan, Beaumont moved to St. Louis where he had a successful medical and surgical practice and was elected president of the St. Louis Medical Society.

Beaumont was born in 1785 in Connecticut. Thomas Jefferson, John Adams and other founding fathers of our country were still alive when he started medical practice, which was quite primitive at that time. As was often the custom of the day, his entire training consisted of a two-year apprenticeship to a practicing physician. He had no formal training in chemistry, physics or science, which makes his later accomplishments all the more remarkable.

Beaumont became an army surgeon. His future fame rested on a chance medical encounter with Alexis St. Martin, an illiterate worker who was accidentally shot in the chest by a musket. Beaumont attended to the patient within a half hour of the injury. St. Martin’s left lung and stomach had prolapsed into the wound. The stomach had been perforated by a spicule of rib. Beaumont gave a fatal prognosis but nevertheless did everything possible to save his patient’s life, dressing the wound on a daily basis. To his astonishment, St. Martin survived. His lung sloughed. He developed a gastric fistula, which Beaumont was unable to close. The fistula was large enough for Beaumont to insert his entire forefinger into St. Martin’s stomach. Food and drink constantly extruded unless prevented by a compress and bandage. The fistula persisted until St. Martin’s death at age 86.

The most amazing thing about Beaumont’s experiments on St. Martin is that they occurred at all. Beaumont had minimal medical training. He was not tutored in the scientific method. He was apparently motivated solely by scientific curiosity. He undertook his research at his own expense. Although he petitioned the government for financial support, he received none. Nor did he receive financial support from any other source. He performed his laborious experiments over a period of eight years from 1825 to 1833. In return for letting Beaumont in and out of his stomach, St. Martin was to get board, lodging and about $150 a year. He also performed some odd jobs for Beaumont. A legal contract sealed the agreement.

Beaumont measured gastric secretion and the digestion of various foods that he tied to a silk string that he would insert into the stomach through the fistula. He even studied the effects of emotions on digestion. He kept meticulous records of his experiments, which still exist. He sent samples to university chemistry laboratories at Virginia, Yale and Stockholm, which confirmed his view that the main active constituent of gastric juice was hydrochloric acid.

Beaumont published a book in 1833 titled _Experiments and Observations on the Gastric Juice and the Physiology of Digestion_. His book immediately received international acclaim. Because the book was held in such high esteem, it was reprinted in 1929 for distribution at the first physiological congress to be convened in the Americas and distributed to the members along with a medallion of its author.

**Beaumont’s Career in St. Louis**

After serving in the Michigan Territory, Beaumont was transferred to Jefferson Barracks in St. Louis. He invited St. Martin to continue the experiments in St. Louis. However, a visit could not be arranged and they never saw each other again. Beaumont eventually resigned from the army and developed a lucrative private medical and surgical practice. He became a good friend of Lt. Robert E. Lee who was stationed at Jefferson Barracks at the time.

In 1840 Beaumont was one of three physicians who treated a man who had been attacked and beaten on the head with an iron cane. The patient died and the assailant was tried for murder. The attorney for the defense contended that the operation performed by Dr. Beaumont, which was approved by both of the other treating physicians, and not the blows to the head, caused the patient’s death. Three local physicians who had not seen the patient testified against Beaumont.

In 1841 Beaumont was elected president of the St. Louis Medical Society. He was furious at the doctors...
who, in his opinion, had testified falsely against him. In his inaugural address he delivered a scathing denunciation of these physicians and their supporters. Parts of his speech, which were printed in the St. Louis Centennial Volume, are excerpted below:

“… But not until the admission into the Society and development of some pernicious influences, emanating from that anomalous assemblage of discontented spirits, deceived strangers and duped imbeciles … in 1839 were the seeds of discord introduced amongst us. Yet since that time we have witnessed little else at our meetings than one continual series of strife, jargon, and confusion—angry debate, personal invective, and total disregard of the honor, interest, or reputation of the society.

“Does not gratuitous swearing or rank perjury before courts of law, designed to screen a murderer from punishment, and blacken the characters and blast the fair reputation of honest and honorable members of the profession, go unpunished. … Have we not the degrading instance in this city of medical men, claiming to be respectable in the profession, conspiring to afford collusive testimony to the public tribunal, discreditable and damning even to themselves, with evident malicious design and dishonest intent to debase the medical character of this community, injure individual reputations, pervert justice, rob the gullows and subvert the best moral principles of society? Can we not discern green-eyed jealousy, envy, and disgusting arrogance disseminating baneful influence among us?”

Later Beaumont was the object of a malpractice suit in which a patient developed a fecal fistula following an appendectomy. Beaumont was not present and had no connection with the operation, but was called in for one consultation. In those days the law disqualified a party of record from testifying at the trial. Beaumont was sued jointly with the operating surgeon so as to deprive the defense of his testimony in court. The jury exonerated Beaumont and the surgeon. But again a vicious war of words ensued within the St. Louis Medical Society. Apparently this was the final straw. Beaumont resigned from the Society never to return.

Over time members of the St. Louis Medical Society recognized the importance of Beaumont’s pioneering research. One member of the Society, Jesse Meyer, MD, wrote a biography of Beaumont. At the 100th anniversary of the Society, four physicians gave lectures about his career. They lamented that although Beaumont had become internationally famous and was considered to be the world’s first experimental gastroenterologist, St. Louis, the city where he practiced medicine and surgery, the city he called home and where he was buried, had not seen fit to honor him with a monument describing his contributions or even, for that matter, a lectureship. This oversight continues to the present day. Hopefully it will be corrected in the future.

Dr. Gale is a past president of SLMMS and frequent contributor to St. Louis Metropolitan Medicine.
Seemingly no one opposes the idea of high quality education or the cultivation of youth. If you’re ever in a pinch at a cocktail party – or better yet, if you’re running for office – espouse the education of young people. You’ll find plenty of friends and supporters for that platform.

The subject of medical education is no different. How often do we hear patients, family and friends agreeing about the importance of having “good doctors?” Physicians are still held in high regard. Some would say, “It’s not like it used to be!” OK, this may be true in some ways. But as a group, physicians are consistently regarded as one of the top three or four most respected professions in the country by numerous polls, decade after decade. Moreover, young people still view medicine as a highly desirable field to pursue. Total applications to medical schools for the 2010-2011 year numbered more than any applicant pool for 15 years, and more women applied for spots last year and matriculated than ever before.1

Yet, all is not roses for undergraduate medical education. Despite the encouraging trends above, medical education continues to confront a growing and pernicious problem at its very foundation: Cost.

Between 2000 and 2010, the mean debt of medical school graduates increased from $88,495 to $157,944. That represents a 78% increase in graduation debt in 10 years. Comparatively, the consumer price index (CPI) increased 23.5% over that stretch.2 Thus, for the last decade, the debt increase for medical school graduates more than tripled the rate of inflation.

In 2010, 30% of all medical students graduated with greater than $200,000 debt, with 42% of private medical school graduates exceeding this $200,000 threshold. Only 14% of all medical students graduate from medical school without student debt.

The average in-state medical student paid an average of $25,122 in annual tuition and fees in 2010, an increase from $12,082 ten years prior. The average medical student attending private medical school in 2010 paid $42,314 per year, an increase from $28,251 ten years ago.

Rising Medical Education Debt

Graduates also face less favorable repayment terms, shortage of training positions

By Timothy P. Craft, MD, and Joseph A. Craft III, MD, FACC

While tuition increases account for the largest majority of the absolute dollar increase, these numbers do not account for the cost of health insurance and cost of living that typically add $15,000 to $25,000 per year to a medical student’s total cost of attendance. Over a four-year period, these non-tuition costs can often exceed $80,000. Indeed, some private medical schools asked fall 2011 matriculants to budget $75,000 for their first year. The expense of a medical education has become staggering.

Let us consider medical school cost in context. Over the last several years, the expense of attending college in the U.S. has risen sharply, despite recent economic stagnation and higher unemployment. Meanwhile, other professional schools uniformly have raised tuition. Plenty of young people want to become doctors, and practicing physicians still earn incomes higher than most professions. So, why should anyone feel sorry for medical students or graduates?

Historically, public opinion and policy decisions have treated physicians differently than many other professionals. Physician supply has been consistently treated as too important to leave to market forces alone. For nearly 50 years, the great majority of post-graduate medical residencies have been subsidized by Medicare, Medicaid, the Departments of Veterans Affairs and Defense, and sundry other governmental agencies.3 In similar fashion, the number of medical schools and the available number of post-graduate residency and fellowship training spots in this country have been tightly regulated by federal law. Thus, many argue that the growing cost of medical education, and its potential impact on high-quality physician supply, looms as a matter of great public importance.

Loan Repayment Terms Less Favorable

The tuition cost equation does not conclude at graduation. While many generations of physicians have weathered school loan repayments well past residency, new graduates must cope with unprecedented initial debts, often accumulating at unfavorable rates. Worse yet, repayment options have become more financially chal-
lenging.

In 2009, the reauthorization of the Higher Education Act and the College Cost Reduction and Access Act resulted in the elimination of the “20/220” medical student loan repayment pathway. In its place, Congress implemented the Income Based Repayment (IBR) plan. Under the 20/220 pathway, the federal government paid the accrued interest of subsidized loans during residency, while interest continued to accumulate on unsubsidized loans. Approximately two-thirds of medical student graduates in residency training qualified for the 20/220 pathway, and they were not required to make repayment during the deferment, or 20/220 qualifying, period.4 5

While nearly all resident physicians who qualified for 20/220 deferment are eligible for IBR, stark differences in programs exist. Most notably, deferment is now effectively unobtainable, and monthly payments are required starting at the beginning of residency.6 Alternatively, resident physicians may enter a period of forbearance, where interest capitalizes on all loans until a repayment period is instituted. The Association of American Medical Colleges (AAMC) estimates that the average first-year resident physician (PGY-1), earning a median salary of $47,716, will pay $393 per month for the average medical student debt. Higher earners with higher debt face $500-600 per-month payments.7

Under the current IBR plan, only federally guaranteed loans are eligible for repayment under IBR. As the percentage of indebted students increases, and as their total debt burdens grow, many students require more financial support than federal Stafford loan allotments can cover. Increasing numbers of students must rely on supplemental loan sources, including Graduate Plus Loans – a federally backed education loan with fixed rates at 7.9%. Moreover, the IBR rules and repayment options do not apply to many private loans, some of which accrue interest at 9 to 12%.8

So, if you run the numbers, the transition to IBR was a big deal for medical students and graduates. Suppose a maximum Stafford subsidized loan borrowing of $8,500 per year, for a total of $34,000 at graduation. Compound that total monthly for three post-graduate years, the same period of time that interest previously did not accumulate under the 20/220 plan, and it equates to $7,670 of interest, a total that continues to compound over a physician’s 10- or 20-year repayment period. Given that Stafford subsidized loans have the best federal borrowing terms, nearly every medical student graduates with the allowed maximum borrowed – thus, the IBR decision affected the vast majority of graduates.

Recent changes to Stafford loan interest rates further confound the financial problem. Until 2006, interest rates for Stafford subsidized and unsubsidized medical student loans were advantageous for students and residents. Interest rates ranged from 1.87% while in school, grace periods, or deferments, to 2.47% while in forbearance or repayment. Since 2006, graduates have faced a starkly different financial picture. Stafford loan interest rates are now fixed at 6.8%, up to 3.5 times higher than the pre-2009 era,8 and 3.5% over the current prime interest rate (today’s rate, as we write this article).9 While fixed rates of 6.8% do not compare historically very high, they are substantially higher than most other conventional loan rates in the current climate. With the stock market and general economy puttering, rates in the 6% to 12% range are tough to swallow.

Greater loan totals, a worse borrowing environment, and increasingly prolonged periods of post-graduate training (and thus delay to capably repay loans) combine to make medical student loan repayment more challenging than ever before. Many stakeholders believe that current tax law sides unfavorably against those carrying medical education loans.

Interest repaid on qualifying medical student loans can be deducted from federal taxes, and is usually the lesser of $2,500 or the total interest repaid per year.10 In that the vast majority of IBR repayments during residency and fellowship go to interest, and not principal, individuals participating in IBR typically repay in excess of the maximum allowed tax deduction for medical student loan repayment.

Moreover, medical school graduates can only deduct interest repaid for single incomes $75,000 or less; if married, $150,000 or less.11 That is, tax deductibility disappears for nearly all graduates upon completion of their residency or fellowship training. During the re-
mainder of their repayment period, whether 10, 20, or 30 years, they are unable to deduct any further interest repayment.

Are Specialty Choices Impacted?

Many stakeholders have raised concerns that rising medical education debt may be fueling current trends toward physician sub-specialization, away from traditionally lower compensated primary care fields. In the 2009 AAMC Medical School Graduation Questionnaire, over 9,300 fourth-year medical students responded to the impact of debt on their specialty choice. Six percent replied that debt had a strong influence and 16% replied that debt had a moderate influence on their specialty choice.\textsuperscript{12}

When the AAMC and other organizations posed the question to the U.S. Government Accountability Office (GAO) in 2009, the GAO reported no significant concern that levels of indebtedness were influencing specialty choice.\textsuperscript{13} Anecdotally, many physicians, particularly in younger generations, report that debt definitely affects specialty and primary care supply. Markedly decreased graduate enrollment in primary care residencies coincide with debt growth over the last decade and seem to speak against the GAO’s conclusions. Furthermore, the GAO’s report contrasts with other reports and articles from the mid-2000s,\textsuperscript{14, 15} which suggest that the amount of medical education debt substantially impacts specialty choice – and perhaps even physician diversity. In a smaller survey, when gifted undergraduate students not applying to medical school were asked why they were not, only minority students said the cost of medical education was the #1 reason.\textsuperscript{16}

Other studies suggest financial reasons contribute to lukewarm interest and decreased number of applications to primary care residencies. In a study by the Josiah Macy Jr. Foundation, scholarships were strongly associated with increased likelihood of primary care practice, family medicine careers, and rural practice.\textsuperscript{17} Moreover, in a 2011 survey, medical students considering primary care, but ultimately selecting controllable lifestyle specialties, were more likely to consider applying for a primary care specialty if provided a financial incentive.\textsuperscript{18} These incentives included pre- or post-residency bonuses, or increases in annual salary.

Emotional and Psychological Burdens

The emotional and psychological burden of medical education debt may weigh more heavily on young physicians than previously understood. Recently, West and colleagues at the Mayo Clinic performed a comprehensive study of more than 16,000 Internal Medicine residents in the United States. Residents who owed greater than $200,000 scored lower on quality of life and work-life balance survey scores, when compared to colleagues with less than $50,000 in education debt. Responses from these same heavily indebted residents indicated greater emotional exhaustion, depersonalization and burnout potential, versus their peers who owed less. Perhaps just as alarming, higher debt residents performed consistently lower on the 2008 Internal Medicine In-Training Examination than trainees with less loan burdens – irrespective of gender or year in training.\textsuperscript{19}

So where do medical students and graduates turn for help? Some resources exist to help students plan borrowing and repayment, such as those posted on the websites of the New England Journal of Medicine, the American Academy of Family Physicians (AAFP), and the AAMC.\textsuperscript{20, 21, 22} These resources include information about The National Health Service Corps (NHSC), which provides primary care physicians $60,000 towards student loan repayment, working full-time at an approved NHSC site, for two years of service. Physicians can apply to extend their service, for as much as $170,000 for five years.\textsuperscript{23} About half of NHSC physicians serve in federally-supported health centers. Other approved sites include rural and Indian Health Service clinics, public health department clinics, hospital-affiliated primary care practices, managed care networks, prisons, and U.S. Immigration and Customs Enforcement sites.\textsuperscript{24}

The Patient Protection and Affordable Care Act (H.R. 3590) attempted to address physician workforce distribution disparities, particularly the relative paucity of primary care physicians. As it pertains to medical student debt, this law increased the annual NHSC loan repayment amount.\textsuperscript{25} Prior to this, the American Recovery and Reinvestment Act of 2009 expanded Title VII and NHSC programs. The NHSC estimated these changes would result in an additional 4,250 NHSC practitioners.\textsuperscript{26} While this program will continue to help a small percentage of medical school graduates, past trends suggest it will ultimately have little impact on the indebtedness of most medical school graduates.

Graduates Face Shortage of GME Training Positions

As prospective medical students calculate the risks and benefits of attending medical school, another variable has emerged in the equation: graduate medical education (GME) training positions. The AAMC issued a 2006 statement calling on medical schools to increase enrollment by 30% over 2002 levels in the following decade.\textsuperscript{27} Assuming an average of four years of GME training per resident, this growth in annual graduates would require more than 21,000 additional GME positions during the next decade.\textsuperscript{28} However, in 1997, the Balanced Budget Act (BBA) placed a ceiling on the number of residents and fellows that the Medicare program, the
largest financial contributor to funding of graduate medical education, would support.

In 2011, the National Residency Matching Program (NRMP) reported match data consistent with increased medical student applicants for a relatively unchanged pool of graduate medical education positions – 23,421 PGY-1 positions were offered through the NRMP match, for 24,413 U.S. senior medical student applicants. Moreover, the number of 2011 NRMP scramble positions was 1,035, a significant decline from 2,383 ten years prior, and a significant shortcoming for the 2,352 unmatched applicants applying to these positions. Of these 1,035 scramble positions, 606 of them were for preliminary positions only, not full residency spots. These data reflect the fact that the number of medical student applicants has already outpaced available PGY-1 positions, and continued increase in medical student class size without concomitant increase in PGY-1 position will only worsen this issue.

Current and potential medical students may find these numbers create a dichotomous situation – one that seems to make physician supply of public importance at the undergraduate level, but does not fully support the path to complete training at the graduate level. Combined with rapidly rising student debt, medical education may be perceived as a greater gamble than ever before.

**Conclusion**

The medical profession, particularly through organizations like the St. Louis Metropolitan Medical Society and the American Medical Association, has already advocated for many potential improvements in response to this mounting concern. It has called for transparency of tuition costs, changes in borrowing and repayment environments, increased tax deductibility of loan interest payments, and matching of GME spots collinearly with the increase in undergraduate medical education positions. Indeed, had it not been for professional medicine’s efforts, policy decisions like the IBR would likely have been worse for physicians. Despite efforts by the house of medicine, medical student debt grows. It is hard to imagine a rapid turnaround of the financial environment for medical students and graduates, particularly in the context of our country’s economic times. As a profession, however, we must continue to advocate for our young colleagues and emphasize that the cost of medical education goes far beyond the bottom dollar – medical education is, and always will be, of great public importance.

In conclusion, the percentage of medical students graduating with debt is higher than ever. The total costs of medical school by graduation and by completion of training are higher than ever. These debts are growing at a rate that far outpaces inflation, and are occurring in a setting of stagnant reimbursement rates. Debate continues as to whether this trend will influence specialty choice and physician diversity. Recent data suggest that heavy debt loads may levy a weighty psychological burden on young physicians, putting them at risk for burnout and interfering with the quality of their education and job performance. The number of medical school graduates has increased in recent years, in attempt to address projected physician and primary care shortages. However, available post-graduate training spots have increased to a much lesser degree, leaving the proposition of attending medical school a potentially larger financial risk than in decades past.

Physicians are expected to be busy in coming years with an aging population and with laws permitting citizens to more readily access the health care system. Time will tell how or if quickly mounting medical education debt will impact the physician workforce or the population’s access to high quality and timely care.

Joseph A. Craft III, MD, FACC, is a cardiologist with Mercy Clinic. He is a member of the SLMMS Council and is a councilor with the Missouri State Medical Association. He was 2005-06 national chair of the AMA Resident and Fellow Section and the MSMA Resident and Fellow Section.

Timothy P. Craft, MD, is an orthopaedic surgery resident at the Medical College of Wisconsin. A St. Louisian and brother of Dr. Joseph Craft, he is a 2009 graduate of the University of Virginia School of Medicine. He has served as the 2008-09 chair of the Medical Society of Virginia, Medical Student Section, and as the 2008-09 student representative on the AAMC Council on Medical Education.

3. https://www.aamc.org/advocacy/gme/71152/gme_gme6001.html
8. https://www.aamc.org/services/first/first_first_for_students/148804/all_and_felp_borrower_interest_rates.html
12. CME Report 1, I-10; Association of American Medical Colleges. 2009 Medical School Graduation Questionnaire. All Schools Report (Final).
17. http://services.aamc.org/fed_loan_pub/index.cfm?fuseaction=public.welcome&CFID=7563505
21. CME Rep. 8-A-10 – page 3-4
23. http://jama.ama-assn.org/content/300/10/1174.long
Student debt is a major concern at area medical schools as the institutions take steps to help aspiring physicians manage their debt loads.

At Washington University School of Medicine, debt is “a major problem that attracts a great deal of attention and concern on the part of medical school faculty and administrators,” said W. Edwin Dodson, MD, associate vice chancellor for medical school admissions and continuing medical education, and professor of pediatrics and neurology.

One of the ways the school assists students is by guaranteeing stable tuition during a student’s entire four years at the school, Dr. Dodson said. Another measure is using scholarship funds to cap the amount a student on need-based scholarship can borrow at 35 percent of tuition. Also, the school provides counseling to help students manage their finances and encourages students to keep their borrowing to essential needs, he said.

Saint Louis University School of Medicine is addressing the issue through scholarships and controlling tuition costs, said Dean Philip Alderson, MD (SLMMS). “We have worked hard to raise our scholarship pool and hold down the rate of increase in tuition. We have accomplished both of these goals and will continue to pursue them,” he said.

The University of Missouri-Columbia School of Medicine also is pushing to provide more funds for scholarships, said Cheri Marks, program coordinator and financial aid officer. In addition, she said, “We also started a debt management program in 2009 that teaches students how to borrow less and budget wisely. We are seeing our students live more frugally today.”

A major concern the officials cited is the end of federally subsidized Stafford loans scheduled to take effect July 1, 2012.

“Graduate professionals will no longer be able to borrow interest-free,” Mrs. Marks said. “For medical students, this will increase their interest cost by over $6,000 during medical school which will equate to over $10,000 in repayment dollars.”

Dr. Dodson added, “This will be a severe burden on students who are most financially needy. These individuals already are underrepresented in medical school.”

All endorse public service programs such as the National Health Service Corps and military service which aid graduates in paying off their loans. Mrs. Marks added that this year there is a pilot program through which fourth-year students can apply to the NHSC and if accepted, be assured of a position after residency. The major benefit this offers is some financial certainty for their future, she said.

The difficulty with the NHSC, Dr. Dodson said, is that “it is underfunded and too small to meet the need.”

In spite of the challenge presented by the rising cost of education, each of the schools has continued to succeed in recruiting diverse student populations, officials say. Mrs. Marks says, “Our students are driven to be physicians. They will do whatever it takes to get there.”