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Not the Last Word

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Not the Last Word: Are Medical School Loans Mortgages Without Houses?

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Odds are, if you are an American orthopaedic surgeon, either you have been enriched by a medical career or are on the path to getting there. According to the National Bureau of Economic Research, the lifetime earnings of typical American physicians exceed USD 10 million [12], with potential earnings in orthopedics reaching four times that amount.

Given the substantial earnings American doctors make over their careers, asking medical students to invest in their education through student loans is only fair. Nonetheless, our current system of funding medical school education with student debt is not perfect either. To begin with, the daunting prospect of substantial debt—akin to taking on a mortgage-sized loan but without acquiring the house—can deter many well-suited individuals from pursuing a career in medicine. This is particularly germane to students from underrepresented groups, who may be more likely to lack the resources to attend medical school without financial aid. Also, crushing debt forces some young doctors to remain in medicine long after they or their supervisors have determined they should leave the profession [4].

One constructive step toward reforming student loan practices would be to allow such debt to be erased through personal bankruptcy. Unlike other forms of debt today, federal law prohibits discharging student loans in bankruptcy unless the borrower can prove "undue hardship" [10]. This stringent standard, defined as the inability to maintain a minimal standard of living, makes loan discharges "exceedingly difficult to obtain," according to the National Consumer Law Center [20]. These rigid bankruptcy rules for student debt need to be rewritten [13].

Granted, if debtors could routinely discharge loans through bankruptcy while keeping their benefits, irresponsible behavior might ensue. For example, if one could default on a home mortgage and still keep the house, not many people on the edge would keep up with their payments. The mortgage system works because a bankruptcy judge can not only erase the debt but also seize the house. This fail-safe may not apply in education, however, because it's impossible to take back the knowledge gained in school even if loans go unpaid. This difference, some critics say, makes student debt more prone to potential abuse in the case of bankruptcy.

I am less concerned about this form of potential abuse, at least in the case of medical school debt. That is because the main value acquired in medical school is not the knowledge one acquires, and not even the title one attains. The main value is the medical license earned [5]. This license is a prerequisite to earning any medical income, let alone the high incomes described by the National Bureau of Economic Research.

As such, one's medical license could be considered by the bankruptcy court as an asset subject to confiscation—just like a house. That is, doctors defaulting

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on medical school student loans would be required to surrender their medical licenses, unless they adopt a repayment plan acceptable to the lender. (A lender may choose to restructure a loan and allow some borrowers to keep their licenses—and earning potential—just as a lender might allow insolvent business firms to retain some assets to stay open.)

I'd take this reform further and demand the school "suspend" the degree financed by an unpaid loan. We can't stop a person who defaults on a medical school loan from making restaurant reservations under the name of "Dr. Smith," but we can insist that all schools, when asked to confirm the defaulting student's graduation, reply that the degree was suspended in a bankruptcy proceeding.

In fact, schools' responsibilities should go even further. I propose that schools with defaulting former students be held responsible for some fraction of the unpaid bad debt too, say 10%. This would be akin to the homebuyer's down payment that would be lost when house purchasers default on their loans. This rule might make schools a bit more circumspect about admitting and promoting students with poor prospects for repayment.

Because of our liberal bankruptcy laws, Americans boldly start new businesses in the face of long odds [15]. This country has one of the most vibrant and innovative economies in the world as a result. On the other hand, because of our harsh student loan bankruptcy laws, America might not attract the people it wants in medicine, and it may have trouble weeding out those who should leave. Society has an obligation to itself to fix this, not only out of compassion for students drowning in debt, but for the sake of these students' future patients.

Foster Chen MD

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Dr. Bernstein draws an intriguing comparison between student and home loans that should interest physicians and economists alike. Lenders need some ultimate form of leverage against borrowers in the form of a seizable asset, such as a physical house. For those in medicine, Dr. Bernstein suggests this asset to be the medical license.

However, the license does not carry financial value as collateral. It is not fungible, tradable, or saleable. Every step of the transaction with a home is monetary, from the money transacted to purchase the home, to the payments (and failures to pay), and to the liquidation of their property after a bank seizes their home. While a bank may not want a house, they can at least recoup some of their losses. Cash is the common denominator for homes. The same is not true for licenses.

Working physicians already have a readily seizable asset alternative to their present wages: their *future* wages. The obligatory wage-garnishment mechanism exists and is enforceable in court, negating the need for additional recourse extending to the license [9]. Wage garnishment is the most involuntary form of a "payment plan," but hedges on the future productivity of borrowers while still allowing banks to recover their costs. When productivity itself becomes impossible for a borrower (such as with disability or loss of license), we have reached the point of "undue hardship," and the loan should be discharged.

Dr. Bernstein astutely discusses that medical schools should scrutinize the quality of the borrower. To add to the analogy of lessons learned from the 2008 mortgage crisis, there are "prime" borrowers and "subprime" borrowers.

We do not have to look too far to find "subprime" student borrowers. Predatorial international medical schools with high admission but low graduation and match rates leave students with a 1-in-2 chance of leaving with USD 400,000 debt and no obvious means to pay it off [22]. For many, there is not even a license to be seized. Schools serve as loan agents and should be held partially responsible for the consequences of bad loan decisions. Ironically, schools also determine loan amounts needed by setting their own tuitions so they also have control over how much a student needs to borrow.

As sarcastically suggested on the White Coat Investor blog: "Too bad there isn't some insurance product out there that schools could purchase to at least wipe out some or all of the debt for their non-matchers. They could market it as 'guaranteed match or $100K back!' If med schools are going to be 'for-profit' they might as well run them like any other business" [23].

For the dropouts and the never-matched, the lack of their own license is the least of their worries. Structured work mechanisms seem like a sensible way forward and would be in the bank's, the school's, and the borrower's best interests. For those unmatched or who cannot get a hired, required but facilitated participation as an "Associate Physician" or physician extender in an underserved area would allow them to keep working, and thus, generate income for themselves and their loan payments, while simultaneously addressing our system's areas of need. This provides a mutually beneficial avenue to continue to participate productively while simultaneously allowing for repayment.

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There is much to agree with in Dr. Bernstein's interesting and provocative column. Education cost and associated debt loads deter many people, especially those from underrepresented groups, from higher education, and discharging student loan debt in bankruptcy requires debtors to meet the unique burden of proving "undue hardship" [1].

And, yes, it is certainly possible that moral hazard could follow overly liberal bankruptcy relief, although some scholars have found this fear overstated. Before student loans faced special bankruptcy rules, reportedly less than 1% of federally insured student loans were discharged in bankruptcy [17]. Economists who have looked for bankruptcy-related moral hazard among student loan debtors have "not found evidence" that bankruptcy-related moral hazard affected borrower behavior [8]. But to the extent moral hazard is an important problem, it seems likely that Dr. Bernstein's license-termination proposal could help combat it.

His approach does face some issues, though. First, many states already have analogous provisions for suspending professional licenses for unpaid student debt. The trend seems to be against such measures. As of 2019, six states prohibited debt-related license suspension, although 13 expressly provided for it [16].

Second, it is at best unclear under current law that bankruptcy courts can simply treat a medical license like any other asset in bankruptcy. The bankruptcy court administers the debtor's "estate," consisting of certain property interests [2], and medical licenses have been held not to be estate property [19]. There are good reasons for this: Most assets in bankruptcy, such as houses, have value that can be transferred straightforwardly from one owner to another. Bankruptcy sales typically move valuable assets from debtors to buyers and move cash from buyers to creditors. Dr. Bernstein's proposal simply eliminates the value of the bankrupt doctor's medical license and the expertise it represents.

Dr. Bernstein argues that medical licenses have negative value in some hands, so that confiscating the license increases value to society. But his approach seems to equate physician quality too blithely with the ability and desire to repay student loans. He suggests that license confiscation in bankruptcy will help "weed out those who should leave."

I am no expert on the medical field, but it seems unlikely that the fourfold gap between the highest- and lowest-paid specialties entirely reflects relative worthiness (even accounting for the fact that higher-paid fields may involve more training and more debt) [25]. And it seems reasonable to suppose that students from lower-income backgrounds will be particularly likely to be deterred from entering lower-paying but useful fields if doing so puts medical licenses at risk.

Over the past few years, I have come to believe that the three major forms of student debt relief (income-driven repayment, categorical discharge, and bankruptcy) should be viewed as one system with complementary components. Income-driven repayment (IDR) is likely the best solution for most borrowers, as other scholars have suggested [6] and other countries, such as Australia, have recognized [18]. The "right" percentage of income for different types of borrowers to pay will be debated, much as the "right" tax rates are. The administration is moving to expand IDR by reducing the percentage of discretionary income undergraduate federal student-loan borrowers must repay and increasing the income exempt from repayment obligations from 150% to 225% of the federal poverty guidelines [3].

Of course, relying on IDR requires a well-functioning system for administering it, and it is not clear that the United States has that at this point. The nonprofit Student Borrower Protection Center argues that "IDR has failed millions of borrowers in dire need of relief that the program promised to provide" [21].

The second type of debt relief, categorical discharge, covers special, clearly defined situations, such as total and permanent disability [11]. The categories should be designed to cover borrowers who cannot appropriately be asked to make standard IDR payments.

With most borrowers paying a fixed percentage of income, and others in clearly defined categories receiving administrative discharge, that leaves bankruptcy as a residual type of relief to cover special cases that the other two parts of the system do not address. A prototypical example would be the family with justifiably high expenses that do not fall into standard categories—a family that cannot reasonably afford the standard IDR payment. Each such case is unique, so bankruptcy's case-by-case approach with an open-ended "undue hardship" standard may be justified.

The problem with this approach is that it often is expensive and burdensome for debtors. Indeed, procedural hurdles, rather than the undue-hardship standard itself, may be the main reason that such a small percentage of bankrupt student-loan debtors seek relief [14].

The Biden Administration has recently adopted an approach, consistent

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with scholarly proposals [7], that moves many bankruptcies toward the categorical discharge bucket. For example, debtors with objectively defined "allowable expenses" greater than income who are over 65 and have made at least one loan payment qualify for government consent to their discharge, although the bankruptcy court makes the final decision on undue hardship [24].

With expanded IDR and categorical discharge, the pool of debtors who need case-by-case bankruptcy relief ought to shrink. That creates the possibility that better legal-aid funding, through public or private sources, combined with a tolerant judicial attitude toward pro se litigants, could be enough to make sure that student-loan debtors who need bankruptcy are adequately served.

Expanding the two bright-line components of the student loan debt relief system should lead to a more rational approach than has existed in the past—and one that does not overly identify debt repayment with physician quality.

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Why can't we treat a medical school student loan more like a home mortgage? Dr. Bernstein suggests that we should. Whereas a home loan can be discharged in bankruptcy if the borrower is unable to pay, student loans can haunt the borrower for life. He makes the interesting point that whereas the home can be treated essentially as collateral, student loans have no real collateral. And he opines that perhaps the medical license can act as that collateral. That's a great point and worth pursuing further.

I think that most of us would agree with asking future doctors, who are likely to be high-earners, to shoulder some of the burden of their medical school costs. But it should not be a complete deterrence either, which might make it particularly difficult for students from low-income backgrounds to consider a career in medicine. I find his suggestion of the bankruptcy option intriguing, but I wonder how many physicians would qualify for it, even with broader criteria applied. I do also like the idea of the medical school having some skin in the game—but is it their job to select the candidates who have the best potential to be excellent physicians, or to select those who are more likely to be able to pay back a loan? I'm not sure the latter is the path we want to take.

Dr. Bernstein also does not address why higher education is so expensive in the first place. By simply accepting the rapidly rising costs of higher education and forcing ourselves to figure out a way to deal with the debt, we are capitulating to fiscal irresponsibility in the higher education industry. The recent federal government initiative to discharge student loans certainly doesn't incentivize universities to rein in their costs either.

Name another industry that has delivered the same product for the last 50 years but whose costs have continued to rise at a higher rate. There is almost no incentive for many universities to lower tuition rates and instead deliver value. Instead, university presidents are charged with filling the endowment coffers. Students continue to demand more amenities and universities frequently comply in order to attract more of them. As a society, we need to reprioritize what we want and need from a university education. Do we really need four years of college plus four years of medical school, when the fourth year is mostly residency auditioning, "research" blocks, and free time?

The pandemic taught us that a lot of education can be delivered online, especially when the main format is lectures. This can allow substantial centralization and standardization of classroom learning across universities. Why do we need hundreds of biochemistry professors across all of our medical schools each giving their own lectures? Why not have a common online resource for lecture-based material that is standardized and shared amongst universities? We need to reexamine our ancient models of classroom education and use modern approaches to reduce costs and avoid the $500,000 tuition bill that will be soon upon us.

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