Special Section:
Praxis: Ethical Issues in Medical Education and Training

What Constitutes a Just Match?: A Reply to Murphy

D. MICAH HESTER

In April of 2001 I published a brief commentary in the journal *Academic Medicine* questioning the current character and functioning of the National Residency Matching Program (or "the match," as it is known in medical schools and teaching centers).[1] The purpose of the article was to stimulate a rethinking of process. At 50 years old, the environment through which the match operates (and has helped to create) has changed, and as such I thought it time to ask ourselves whether or not the match, its algorithm, and, more important, the values it manifests might well need an overhaul.

Timothy Murphy's article, "Justice in Residency Placement,"[2] is an attempt to work through ethical issues raised by the match and to do so using my own commentary as his foil. It is to Murphy's credit that he takes up my call to converse on this matter in a positive and well-considered way (letters to the editor of *Academic Medicine*, published in November of 2001, did not strike me as quite so generous and affable). However, although it is clear that Murphy has correctly noted important problems with my commentary,[3] in the end I believe that he missed the point of some of my argument.

The primary focus of my original commentary was on the competitive character of the match and my concern that this kind of competition is counterproductive to the aims of medicine itself. Based on a claim I believe to be uncontroversial—namely, that means are constitutive of the ends they produce—I argue that competitive means produce competition. Competition, although capable of producing positive, progressive behavior—such as inner resolve, extra effort, and so forth[4]—creates also the danger of divisiveness, underhandedness, and cruelty. Actualizing such negativity depends on a great many factors, but such danger is always there, lurking, waiting to be stimulated into being.

The match, and much of medical education for that matter, is competitive and therefore *runs the risk* of producing truly negative behavior. However, as a profession, medicine aims at something else. Medicine aims at healthy living for patients. As I have argued at length elsewhere, healthy living is intimately tied up with intelligent habits of community where cooperative and participatory behaviors are nurtured.[5] As such, the ends of medicine have no place for the negative side of competition. Of course, this says nothing about the positive behaviors that can arise in competition, and those I listed above, such as resolve and effort, have the potential to be of great benefit to "community as healing." What is not clear is whether competition is *necessary* to develop those positive behaviors we might all agree *can* follow from it. I suggest that surely it is not the only method and, in fact, other methods have a decided advantage because they do not come with the same risks that competition does.

Cambridge Quarterly of Healthcare Ethics (2003), **12**, 78–82. Printed in the USA.

Short of recounting my entire argument from *Academic Medicine*, suffice it to say that my concern led me to wonder about what system might avoid the competitive aspects of the current match system. I decided to suggest a lottery process where both medical students and residency programs go into a "hat," neither having a say about who is placed where. Clearly, this would undermine competition because chance would be the only factor involved. But further, and this I did not mention explicitly in my commentary (though I did in my response to the letters to the editor[6]), a lottery-based system has the benefit of responding to social-justice concerns that clearly linger in the match today. For example, it is clear that even though there are more potential residents than positions, many places go unmatched, and it turns out that community-based, inner-city and rural hospitals go unmatched at higher rates than large university and research medical centers.[7] Thus, concerns of resource allocation of medical expertise continue to go unheeded by the current matching process. That is, those places that need help the most are the places most hurt by the match.

Of course, I hope no one thinks me foolish enough to believe such a suggestion is flawless. Even in my brief article I noted several pitfalls to a lottery-based approach—lack of choice, ignoring merit, and heightened uncertainly and stress, to name but a few. The question, then, is do these problems outweigh the advantages, or alternatively, can these problems be addressed through means that would still allow a lottery-based system to function with all its advantages?

Murphy's position is that a lottery cannot do the work and, in fact, there may be no real work to be done. His argument seems to support the match as is (noting its flaws but deciding they do not rate highly enough to merit a change). In part, however, his argument against my own stated position, I believe, misses the point.

In particular, Murphy addresses an analogy I made concerning the way major professional sports draft players. Much of the negative critique he heaps on this analogy is clearly my own fault, so let me try to fix some of that. In my commentary, I mention, "Baseball, for example, drafts players who can be sent to any number of locations. . . ."[8] Murphy, accidentally I am sure, takes on football as the analogous sport, and although in many ways this makes no difference to his argument, I used baseball quite deliberately. Baseball, unlike football, has a minor league system, where professional teams help train players to prepare them for Major League play. Of course, not all minor league players make it to the Majors, but the goal of every minor league team is developmental. Furthermore, these teams are scattered throughout the United States and Canada in cities as big as New Orleans, Louisiana, and as small as Augusta, Georgia. Players who want to play Major League baseball have little choice but to go where the teams tell them to, and they accept (not always happily) that this is the price to pay to play the sport they love and to get a chance at something more. In these respects, the minor leagues and residencies are quite analogous.

Murphy focuses on concerns for the kinds of negative attitudes that might be fostered by lottery-based assignments, stating, "Random assignment would disrupt important interests for more than a few residents, and this disruption could easily undermine selfless anticompetitive attitudes."[9] And he "suspect[s] that most professional football players would like some say about their assign-

ments."[10] Both comments, it seems to me, foreshadow Murphy's later claim that "voluntary relationships" is a "key value at the core of healthcare,"[11] and although it is hard to argue with the *sentiment*, I simply do not agree with such a *principled* statement. Although voluntariness is important, in fact, the existence of HMOs questions whether voluntariness is fundamental to medicine (unless you argue that simply being part of an HMO is voluntary—but this seems, at best, a minimal assertion and, at worst, wrong for many people whose only access to healthcare is through their employers). What is more important is that physicians treat their patients as participants in their own care, creating space for participation by patients as individual valuers. This kind of practice relies on *cooperative* activities of moral agents.

Murphy goes on to point out correctly that the drafting analogy is not a random lottery and is, thus, not a perfect analogy. Professional teams get a choice, whereas the players do not. To be equivalent, my suggestion would have to be redeveloped such that residency programs were allowed to choose their residents whereas residents simply get chosen. However, the draft analogy was not intended as an exact analogy but as an instructive, emphatic one. Medicine is a profession that affords physicians a good deal of prestige and money (even the lowest paid specialty, family practice, averages over $100,000 in annual salary[12]). The title "Doctor," although it is held by many persons not in medicine (including myself), means one thing in colloquial English—viz., physician. It is professionally conferred but honorifically spoken. This is not unlike sports figures, who for many are honorific characters and are no doubt well paid for their efforts.

One place where both Murphy and I think the analogy breaks down is that sports teams and residencies are not morally equivalent. However, the conclusions we draw from this fact are very different. Whereas Murphy demonstrates (rightly, I think) that different residencies prepare their residents differently, that emphasis on research or diagnostics can vary from one place to another, creating thereby very different specialists "who will fill specific roles in the delivery of healthcare,"[13] I wish to emphasize the moral point that, unlike athletes, physicians perform a *vital* service to the well-being of patients and communities. Further, their position is licensed by the state, and their ability to practice is a function of vital *public* interest. As such, the need for physicians to fulfill social needs and not just individual ones (whether of particular patients or themselves) is of greater importance than in sports. Surprisingly, even though the title of his article does use the word "justice," Murphy does not go this route, with no discussion of justice to be found. Like the detractors to my *Academic Medicine* article,[14] Murphy seems content to accept individual choice (what we might roughly call "autonomy" concerns) as paramount without question. However, until an argument is put forth that individual choice necessarily trumps social-justice concerns in this case, I see no reason to accept Murphy's claim at face value. In fact, I have given reasons that such a position—because of the competitive character that can manifest itself in such choices, and the lamentable, even deplorable, results for underserved populations, along with the social responsibility constitutive of medicine itself—should not be taken as paramount.

I would further argue that this individualistic approach to medicine, as if individualism is a core value,[15] is simply wrongheaded. I will not recount here all my reasons[16] for making such a claim but will note that bioethical work in

feminism, narrative and care ethics, communitarianism, and pragmatism have all questioned, if not undone, the highly individualistic approach to medicine and bioethics championed since the 1970s.

As it pertains to residency matching, individualism is detrimental for both the resource-allocation concerns I just mentioned as well as the diversity problems I merely hinted at in my commentary and pedagogical concerns I tried to highlight in conjunction with the allocation problem. To leave residencies to their own devices where, for example, "a residency is already free to seek diversity among its trainees"[17] and "nothing in residency selection . . . prevents top schools from recruiting among candidates who more than compensate for the lack of lustrous educational pedigrees by force of native intelligence . . ."[18] has barred minorities and traditionally repressed people from getting matched.[19] And further, the excellence of our residents is dependent on access to the best education possible. Certainly, not all residents can go to the top programs nor all top students go to their first choice. However, if we took advantage of the fact that there is a transactional character to education, where good teachers make their students better *and vice versa*, by distributing students across all residencies in a merit-blind fashion, good students will land in programs that will improve by their presence and good programs can help improve those students who *need* more help. This is admittedly simplistic (maybe even naive), but when good doctoring can mean a vital difference for patients, how can we sit by and allow the "them that's got shall get" reality of a semi–free market system to continue without sincere inquiry into its *costs and consequences*?

Having said all this, I shall stop here, having let much of Murphy's work go without reply. However, I will end by admitting my own ambivalence to a lottery approach. It is clearly not without its problems, and they are problems that should be addressed and corrected if such an approach were to be implemented. Surely, married couples who wish to work together would be disappointed. Students with familial, emotional, or economic ties to a particular city, state, or region might be left wanting. Research-minded students might end up in practice-based programs, and clinically minded students might be forced to take up more biostatistics than they can handle. These concerns are not only important but potentially detrimental. However, unlike Murphy implies by way of his own argument, the solution cannot be that we stick with what we have, for this ignores the important concerns I have listed, and they are ignored without good argument to ignore them. As such, I reiterate that it is still necessary to keep rethinking this problem to find a system that can address all the issues of concern to Murphy, myself, students, programs, and, more important, patients across this country.

Notes

1. Hester DM. Rethinking the residency matching process and questioning the value of competition in medicine. *Academic Medicine* 2001;76(4):345–7.
2. Murphy TF. Justice in residency placement: is the match system an offense to the values of medicine? *Cambridge Quarterly of Healthcare Ethics*, this issue, 66–77.
3. Though this may sound like an excuse, in the worse sense of that term, it is important to note that such commentaries in *Academic Medicine* are limited to 2,000 words and, as such, not everything that should have been said was said.

4. The positive side of competition (which I did not emphasize in my original commentary) was duly noted in: Elliot RL. Competition, justice, and the match. *Academic Medicine* 2001;76(11):1082–3.
5. See: Hester DM. *Community as Healing*. Lanham, Md.: Rowman & Littlefield, 2001.
6. See: Hester DM. In reply. *Academic Medicine* 2001;76(11):1083–4.
7. A discrepancy can be seen between large urban centers, on the one hand, and smaller cities and rural facilities, on the other. For example, whereas family-practice residencies for Emory and Morehouse (Atlanta, Ga.) have matched at 100% (38:38) from 2000 to 2002, residencies with Medical College of Georgia (Augusta, Ga./Waycross, Ga.), the Medical Center of Central Georgia (Macon, Ga.), and Memorial Health (Savannah, Ga.) associated with Mercer University matched at 51% (32:63) over the same period. Also, even within the same city, matching rates differ with community-based, inner-city hospitals doing worse than university-based medical centers. For example, in Nashville, Tennessee, Vanderbilt University's internal-medicine residency matched at 100% (98:98) from 2000 to 2002 whereas Meharry/Metro General only matched at 32% (9:28) for the same period. Admittedly, this survey of the match results is nonscientific, and there are difficulties in carving up these data in a consistent manner that does not beg important questions about what inferences are warranted. For the years 2000–2002, see: National Residency Matching Program. *Results and Data*. Washington, D.C.: NRMP; 2002.
8. See note 1, Hester 2001:346.
9. See note 2, Murphy, this issue.
10. See note 2, Murphy, this issue.
11. See note 2, Murphy, this issue.
12. This is a purposefully low estimate. See: http://www.physicianssearch.com/physician/salary2.html.
13. See note 2, Murphy, this issue.
14. See note 4, Elliot 2001.
15. Though it can be inferred from Murphy's article that "core values" is my term, it is not.
16. See note 5, Hester 2001.
17. See note 2, Murphy, this issue.
18. See note 2, Murphy, this issue.
19. See: Prieto D. Rates at which underrepresented minorities were not matched in the NRMP, 1984–1988. *Academic Medicine* 1989;64(7):418. Jordan WC. Success of minority applicants in the National Residency Matching Program. *Journal of the National Medical Association* 1986;78(8):737–9. Colquitt WL, Smith IP, Killian CD. Specialty selection and success in obtaining choice of residency training among 1987 U.S. medical graduates by race-ethnicity and gender. *Academic Medicine* 1992;67(10):660–71. Oriel KA, Madlon-Kay DJ, Govaker D, Mersy DJ. Gay and lesbian physicians in training: family practice program directors' attitudes and students' perceptions of bias. *Family Medicine* 1996;28(10):720–5.