The Mental Health Argument for Forbearing Medical Education Debt

To the Editor: We should pay attention to medical trainee debt. According to the Association of American Medical Colleges, the median debt of graduating medical students rose from $180,000 in 2014 to $200,000 in 2020. To put this loan burden into perspective, a graduating resident with $200,000 in loans, who put them into forbearance during a 4-year residency at a rate of 5%, would pay approximately $111,000 in interest over a standard 10-year repayment plan with a monthly payment of about $2,600. Extend that residency to 7 years, and the average interest cost rises to $161,000, the monthly payment is $3,000, and the total loan repayment amount is $361,000. The mental burden of this debt is real and life-changing.

There is political momentum in the United States to forgive or reduce student loan debt based on fairness and equity, but what about the mental health argument for forgiving debt?

We should consider the mental health of medical trainees in debt. The prevalence of depression in U.S. medical students is as high as 25%, which is double the national average. Medical school graduates carry more than 6 times the average college debt, and their debt rate outpaces both economic and academic inflation. At its current pace, the average medical student debt will exceed $300,000 by 2024. Increased odds of suicidal ideation have been found in medical students with increased levels of debt, especially over $100,000. It remains unclear whether the high prevalence of depression in U.S. medical students is related to debt, but there is a body of evidence showing debt impacts the stress levels and mental well-being of medical trainees. If we accept that student loan debt negatively impacts mental health, we should advocate for its present and future elimination through loan forgiveness.

Climate Change and Environmental Health Must Be Integrated Into Medical Education

To the Editor: We were delighted to read the articles by Goshua and colleagues and Philipsborn and colleagues calling for the inclusion of climate science curricula in undergraduate and graduate medical education and seeing this as critical to broader efforts to reexamine environmental health curricula in medical education. While medical schools now have greater emphasis on social determinants of health, including environmental health, this often focuses on individual risk assessment and treatment. Additionally, as Goshua and colleagues noted, climate health curricula are often relegated to elective instruction. At the University of Wisconsin School of Medicine and Public Health, we currently require a climate change lecture for medical students and offer a climate change elective. However, we recognize that this is insufficient to fully highlight intrinsic connections between the environment, climate change, and health. We are working to integrate environmental health across the curriculum, similar to the approach described by Wellbery and colleagues.

References

Emphasizing the Link Between Human Health and the Environment in Residency Education

To the Editor: Philipsborn and colleagues recently proposed a new framework for integrating evidence-based content on climate change into residency education. These authors have started an important conversation. We argue, however, that medical educators must also explicitly guide residents to challenge what defines human health and the role of the health care system, especially in the context of climate justice. The time has come for medical professionals to acknowledge human health's dependency upon a healthy natural world, which includes clean air and water, green space, and intact ecosystems, in addition to a stable climate. If we fail to expand the purview of medicine to include a healthy environment, we will be woefully unable to meet the needs of our patients and, in particular, to address systemic environmental injustices that disproportionately affect communities of color.

Revising residency education becomes even more compelling once we acknowledge the interdependence of human health and the environment because this would allow us to offer more actionable interventions to residents. Many of Philipsborn and colleagues' proposed learning objectives imply that residents have little ability to influence change from within the patient–doctor relationship. Instead, they are relegated to passive roles of explaining the shifting risks of climate change to their vulnerable patient populations. A broader definition of human health, however, encourages physicians to leverage creative treatments and innovative preventive medicine. What are framed as “climate mitigation activities” briefly touched upon in the residency curriculum can be formalized into patient-centered “prescriptions,” such as green space to treat attention-deficit hyperactivity disorder symptoms and active transport to increase physical activity.

Expanding the definition of human health in residency education and all other areas of medicine to include the environment is critical and long overdue. As physician educators, we have an obligation to prepare the next generation of physicians to provide care that positively impacts the health of both the patient and the planet.

Funding/Support: None reported.

Other disclosures: None reported.

Ethical approval: Reported as not applicable.

Lesley B. Gordon, MD, MS
Assistant professor, Tufts University School of Medicine, Maine Medical Center, Portland, Maine; lgordon@mmc.org.

Katherine T. Liu, MD
Assistant professor, Tufts University School of Medicine, Maine Medical Center, Portland, Maine.

References