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Hypothesis

Medical education: the adverse effects of student debt

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ABSTRACT

Medical education is expensive. In a growing number of countries the burden of funding medical education is slowly being transferred to the learner. In most contexts the learner is provided with a loan with which to pay fees and live. However this in turn results in a growing burden of student debt. This debt causes stress to students and the effects of this stress may be broadly categorised as "flight" or "fight" responses amongst learners. Flight responses include mental health problems, depression, physical health problems and problems with relationships at home and in the place of work or learning. The "fight" response means that students will take on the challenge of their financial debts and seek to pay them back and ensure maximum returns on their investment in medical education. The only way to achieve this is to obtain a high paying job in a high paying specialty. However this will result in more graduates choosing careers in specialties that do not always meet population needs.

KEY WORDS: Cost; Medical education; Debt

INTRODUCTION

Medical education is expensive and someone has got to pay for it. In a growing number of countries the burden of funding medical education is slowly being transferred to the learner. In most contexts the learner is provided with a loan with which to pay fees and live. However this in turn results in a growing burden of student debt. What effects does this debt have on our students? It is likely to have a number of interrelated effects. All these adverse effects are ultimately caused by the enormous stress that debt places on students and graduates. As with any other forms of stress, the effects of this stress may be broadly categorised as "flight" or "fight" responses amongst learners.

HYPOTHESIS

Let's look at flight responses in the first instance. The stress causes by debt can affect students' mental health and thus their ability to study. People who struggle to repay their debts are more likely to have a minor mental health problem[1]. People with significant debt are "more likely to receive a psychiatric diagnosis". There is undoubtedly a strong correlation between debt and depression and between debt and suicidal ideation[2,3]. Excess debt can also have an adverse effect on physical health[4]. Lastly debt can cause problems with relationships at home and in the place of work or learning. Excess debt can clearly result in financial hardship and can in extreme cases result in bankruptcy. These adverse effects are likely to have most impact on the most vulnerable members of the student population – this includes those who are emotionally as well as financially vulnerable. Students from wealthy backgrounds will be protected as they will not have to become indebted. However this is likely to work against the agenda of widening participation in medical education.

The alternative to the flight response is the fight response. Put simply this means that students will take on the challenge of their financial debts and seek to pay them back and ensure maximum returns on their investment in medical education. The only way to achieve this is to obtain a high paying job in a high paying specialty. Is it anyone wonder then that many students choose specialties based on their financial needs? A variety of factors can and should affect students' career choices. These can range from personality profile to aptitude to preference to lifestyle choice[5,6]. What should not have such an effect however is the level of debt carried by graduates. This phenomenon will ultimately result in more graduates choosing careers that they do not wish to pursue or to which they are not suited, or it will result in more graduates choosing careers in specialties that do not meet population needs. That is the inevitable result of a consumerist culture in medical education where learners wish to protect their consumer rights and see those rights as the equivalent of population rights to healthcare. The endgame of all this process is high cost healthcare of the kind that the population does not need. Is it worth placing enormous financial and emotional burden on students to achieve these outcomes? The simple truth is that the current strategy of indebting medical students that many countries are adopting is not working.

CONCLUSION

The good news is that there is an alternative to the choice between bankrupt students and bankrupt healthcare systems. This alternative involves offering medical education that is free to the student and financed by the state. There are a few caveats. First of all the medical education must focus on patient and population healthcare needs. There is no point in offering a free medical education that concentrates on tertiary care academic medicine when the need is for more primary care physicians. This will require continuing reform in how medical education is being delivered. Medical education must move further into primary care; it must concentrate on generalist rather than specialist care; it must focus on chronic disease management and the needs of an ageing population. At the same time it must ensure the delivery of safe training and safe, high quality care. Secondly medical education must be lower cost than it is now. Medical education is expensive as it is currently delivered – however it need not necessarily be like this. All components that make up the cost of medical education should be examined to see if their costs are fully necessary. For example it might be worth asking if low cost simulation techniques are effective alternatives to high cost ones. It might also be worth asking if all those members of faculty who are required to deliver medical education fulfil their obligations in this regard. Sometimes new technologies (such as e-learning) might help learning and save costs; however sometimes they may not[7,8]. Where they can provide a cost effective alternative to traditional methods, they should be considered. Equally important is the need to promote a culture where medical education researchers are incentivised to research low cost methods of medical education. Thirdly and lastly there will need to be a commitment and possibly a requirement for graduates to work in the country where they received their education and to work in areas of need. In return the state should ensure good terms and conditions for doctors and attractive career pathways in specialties that the population needs. That would be a fair exchange of social goods. The most important currencies in medical education should be those of learning and healthcare. Removing the burden of student debt would reinforce this message.

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