

When the Jar Keeps Growing

To the Editor:

Aziz and Jarjour's editorial, "When Everything Matters: Choosing What Truly Counts in Academic Medicine," offers thoughtful guidance for academic physicians navigating increasingly complex professional lives.¹ Their call for intentionality, prioritization, and aligning one's work with a deeper sense of purpose will resonate with many faculty members.

We agree that academic physicians benefit from clarity about their "big rocks." However, the essay largely frames the problem as one of individual choice. Many faculty are not overextended because they have failed to define what matters. The decision to pursue academic medicine reflects what matters most: generating and disseminating knowledge, educating future generations, and improving patient care.² Rather, many are overextended by institutional expectations that exceed the limits of time, energy, and human attention.

Patient care is a clear example. Academic physicians are increasingly expected to maintain clinical productivity comparable to private practice colleagues while simultaneously fulfilling academic responsibilities. Yet much of modern care occurs outside traditional productivity measures through documentation, inbox management, patient messages, and regulatory requirements. A hospital-wide survey found that academic physicians spent 24% of working hours on patient-related administrative duties, with two-thirds reporting negative effects on their ability to deliver high-quality care.³ Much of this work remains difficult to measure but not difficult to feel.

The same is true for academic work. Teaching, mentorship, scholarship, program development, quality improvement, committee service, and contributions to professional organizations require substantial time and effort. Service contributions have been described as invisible labor that is systematically undervalued relative to research metrics such as citation indices.⁴ Despite progress in recognizing clinician-educator contributions, inconsistencies remain in how academic work is valued and rewarded.⁵ Scholarship often comes at the expense of personal time, as academic structures continue to reward work performed outside standard working hours.⁵

The familiar image of a jar filled with rocks,

pebbles, and sand remains useful, but perhaps it no longer fully captures modern academic medicine. The jar itself has become larger and heavier. New expectations, expanding clinical demands, administrative responsibilities, and electronic work have enlarged the jar while leaving unchanged the finite hours available to fill it.

Clarity remains necessary. But clarity alone cannot solve problems created by misaligned incentives, insufficient protected time, and growing clinical and administrative demands. Perhaps the next question for academic medicine is why so many talented physicians struggle to devote time to what matters most...and whether we have designed the jar wisely in the first place.

— Jayshil J. Patel, MD; Michael J. Malinowski, MD; Manpreet S. Mundi, MD

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Heat Stress and Chronic Kidney Disease Among Nepali Migrant Workers: A Global Health and Climate Change Perspective

To the Editor:

Climate change is increasingly shaping patterns of human disease, and chronic kidney disease of unknown etiology (CKDu) has emerged as a sentinel example of a climate-sensitive illness.¹ First recognized among agricultural workers in El Salvador in the 1990s as Mesoamerican nephropathy, CKDu now affects individuals across India, the Middle East, Africa, and the Americas. Unlike conventional kidney disease linked to diabetes or hypertension, CKDu predominantly affects younger workers exposed to extreme heat, dehydration, and intense physical labor. Recurrent heat stress leads to repeated subclinical kidney injury that progresses to chronic kidney failure.²

A similar crisis is affecting migrant workers from Nepal who return from the Middle East. Every year, over 1.5 million people leave Nepal to work in the extreme heat of the Gulf region, where temperatures often hit 45°C to 50°C (113°F to 122°F). While the money they send home makes up nearly a quarter of Nepal's entire economy, occupational protections remain limited. Data suggest that over 90% of returnee migrant workers presenting with renal failure have "unknown etiology," with many requiring dialysis before age 40.³ Similar CKDu clusters have been documented among sugarcane workers in Central America, miners, and agricultural laborers across South Asia and Africa, underscoring that this is a global climate-linked occupational disease.³⁻⁵

Pathophysiology is increasingly understood for every 1°C rise in WetBulb Globe Temperature (WBGT); the risk of acute kidney injury increases by approximately 18%. Recurrent heat stress, dehydration, and nonsteroidal anti-inflammatory drug (NSAID) use contribute to subclinical tubular injury and medullary hypoxia, ultimately leading to irreversible renal failure.⁴ Current safeguards are inadequate, as occupational protections are often clock-based rather than WBGT-based, and migration systems lack mandatory baseline renal screening.

We propose 3 priorities: (1) awareness – recog-
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nizing CKDu as a climate-sensitive occupational disease and strengthening surveillance; (2) advocacy—integrating kidney health into climate and labor policy; and (3) accountability: enforcing WBGT-based stop-work laws and evidence-based water–rest–shade protocols. Although these patterns have been described primarily abroad, rising temperatures and frequent heat waves in the United States—including the Midwest—underscore the need for greater clinical awareness of heat-related illness and occupational health risks, especially for our agricultural and construction sectors. Health care providers and educators can contribute by raising awareness, integrating climate considerations into clinical practice and curricula, promoting research, and advocating for policies that protect vulnerable populations. Protecting manual laborers from heat-related kidney disease is both a clinical priority and an issue of climate justice. As climate change alters occupational disease patterns worldwide, the medical community must support evidence-based policies to protect vulnerable migrant workers.

—Roshan Thapa, MD; Pinky Jha, MD

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