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RESEARCH ARTICLE

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FROM CLINICS TO COMMUNITY: THE PHYSICIAN'S PRESCRIPTION FOR A HEALTHIER PLANET

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ABSTRACT

The traditional role of the physician has centred on diagnosing disease, treating illness and preventing complications. However, many of the major health threats of the twenty-first century originate beyond the walls of hospitals and clinics. Air pollution, climate change, extreme heat, unsafe water, environmental contamination, biodiversity loss, inappropriate waste disposal and unsustainable patterns of consumption increasingly influence the spectrum of human disease. Climate change is already associated with increasing heat-related illness, infectious diseases, malnutrition, respiratory and cardiovascular morbidity, mental-health consequences and disruption of health systems [1,2]. Physicians occupy a unique position at the interface between science and society. Their responsibility therefore need not end with treating the consequences of environmental exposure; it can extend to identifying environmental determinants of disease, educating patients, making health-care facilities environmentally responsible, participating in community interventions, generating evidence and advocating for policies that protect population health. This responsibility is particularly relevant because the health-care sector itself contributes substantially to greenhouse-gas emissions and waste generation [3]. India's National Programme on Climate Change and Human Health (NPCCCH) provides an important framework for translating climate-health knowledge into surveillance, capacity building, preparedness, resilient health infrastructure and multisectoral action.[4] This paper proposes a practical framework—Recognise, Reduce, Resilient, Reach and Represent—through which physicians can progress from individual clinical care to environmental health advocacy. Environmental advocacy should not be viewed as an activity outside medicine; when grounded in scientific evidence and directed toward disease prevention, it represents an extension of the physician's fundamental duty to protect health.

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INTRODUCTION

The Patient Outside the Consulting Room. A patient enters a clinic with breathlessness. We prescribe an inhaler. Another presents with heat exhaustion. We administer fluids and cooling. A child develops recurrent wheezing during periods of severe air pollution. We adjust medication. An elderly person becomes dehydrated during a heatwave. We treat the resulting complications. A sanitation worker suffers an injury while handling improperly segregated biomedical waste. We manage the wound. Each clinical decision may be entirely correct. Yet an important question remains:

Are we treating the disease while ignoring the environment that repeatedly produces the disease?

Medicine has achieved extraordinary progress by understanding biological causes of illness. The next challenge is to apply the same seriousness to the environmental determinants of health. The World Health Organization (WHO) recognises climate change as a major threat to health because it compromises clean air, safe water, food security and shelter. WHO has estimated that between 2030 and 2050, climate change could cause approximately 250,000 additional deaths annually from heat stress, diarrhoea, malaria and undernutrition alone [1,5]. The Intergovernmental Panel on Climate Change (IPCC) has concluded with very high confidence that climate-related illness, premature mortality, malnutrition and threats to mental health and well-being are increasing [2]. Environmental health, therefore, is no longer exclusively the domain of environmental scientists. It has entered the physician's consulting room. And if environmental factors

enter our consulting rooms as disease, doctors have legitimate reasons to step outside those consulting rooms as advocates for prevention.

Environment Is Becoming a Clinical Variable for generations, physicians have asked:

What do you eat?
Do you smoke?
What medications are you taking?
What is your occupation?

Increasingly, another group of questions deserves a place in clinical thinking:

Where do you work?
Are you exposed to extreme heat?
What is the air quality where you live?
What fuel is used in your home?
Is safe drinking water consistently available?
Are there environmental or occupational exposures relevant to your symptoms?

Climate and environmental exposures affect health through multiple interconnected pathways [1,2]. Extreme heat can produce dehydration, heat exhaustion, heatstroke, renal stress and cardiovascular decompensation. Air pollution contributes substantially to respiratory and cardiovascular disease. Changing ecological conditions influence vector-borne diseases. Floods and extreme weather can cause injury, displacement, contamination of drinking water and interruption of medical services. Food insecurity can worsen malnutrition. Climate-related disasters may produce anxiety, psychological distress and other mental-health consequences. Environmental medicine is therefore not a new specialty disconnected from ordinary medicine. It is increasingly becoming part of ordinary medicine.

The Paradox of Health Care: Healing Patients While Harming the Environment. There is an uncomfortable paradox within modern health care. Hospitals exist to protect health, yet health-care delivery itself consumes large quantities of energy, water, pharmaceuticals, plastics and other resources and generates substantial waste. An influential global assessment estimated that health care accounts for approximately 4.4% of global net greenhouse-gas emissions[3]. Thus, health care can simultaneously be a victim of climate change and a contributor to it. The solution is not to compromise patient care in the name of sustainability. The solution is better-quality, resource-efficient and environmentally responsible health care. WHO recommends action across four fundamental domains:

health workforce;
water, sanitation, hygiene and health-care waste;
sustainable energy services; and
infrastructure, technologies and products.[6]

Environmental sustainability should consequently become part of quality improvement rather than an optional charitable activity.

Why Doctors?

Why should physicians become environmental advocates when environmental ministries, pollution-control authorities, municipalities and governments already exist?

Because doctors bring something particularly valuable to the discussion:

the language of health.
Pollution statistics can appear abstract.
Carbon emissions can appear technical.
Climate projections can appear distant.
But asthma in a schoolchild is understandable.
Heatstroke in an outdoor worker is understandable.

A myocardial event precipitated during extreme environmental stress is understandable. When an environmental problem is translated into a human-health consequence, society perceives it differently. Health professionals also possess substantial potential to influence public and policy conversations on decarbonisation and environmental health.[7] In a multinational survey involving 4,654 health professionals, respondents largely recognised climate change as a health problem and felt a responsibility to educate the public and policymakers, although barriers including lack of time and resources limited engagement.[8]

The physician therefore has several identities

Clinician, educator, scientist, role model and advocate.
These identities need not compete.
They can reinforce one another.

4. From Treatment to Prevention: Moving Upstream Consider a river.

A doctor standing downstream repeatedly rescues drowning people. Initially, rescue is essential. But if patients continue floating downstream, eventually someone must walk upstream and discover why people are falling into the river. Environmental advocacy represents medicine moving upstream. We should certainly treat asthma—but also advocate for cleaner air. We should treat heatstroke—but also support heat-health preparedness. We should treat diarrhoeal disease—but also support safe water and sanitation. We should manage occupational injuries—but also advocate for safer workplaces. We should treat disease associated with tobacco and polluted environments—but also support evidence-based policies reducing population exposure.

Clinical medicine asks:

“How do I treat this patient?”
Public health asks:
“Why are so many patients developing this condition?”
Environmental health adds:
“What can we change in the environment so that fewer people become patients in the first place?”

Air Pollution: Where Environmental Advocacy Meets Everyday Medicine. Few examples demonstrate this connection more clearly than air pollution. Particulate and gaseous air pollutants are associated with cardiovascular and respiratory morbidity and mortality [9]. For the practising physician, therefore, air pollution is not simply an environmental measurement.

It is a cardiovascular risk issue.
It is a respiratory health issue.
It is a paediatric health issue.
It is a geriatric health issue.

And increasingly, it should be a preventive-health conversation. A physician caring for susceptible patients can educate them regarding high-exposure periods, occupational exposure, appropriate activity modification and adherence to treatment. At a broader level, medical organisations can communicate the health evidence supporting cleaner transport, cleaner energy and improved air-quality policies. The doctor's role is not to become an atmospheric scientist. The doctor's role is to explain what polluted air does to human beings.

Heat: A Growing Indian Clinical Challenge. India provides an especially important setting for climate-health action. Extreme heat does not affect everybody equally. Outdoor workers, older adults, infants, pregnant women, people with chronic disease, economically disadvantaged populations and people living in poorly ventilated housing can face disproportionate risks. The experience of extreme heat in India has highlighted the interaction between temperature, housing, water availability, occupation and socioeconomic vulnerability.[10]

Heat illness also illustrates why treatment alone is insufficient. When a heatstroke patient reaches the emergency department, the clinician must act immediately.

But prevention began much earlier:
with early-warning systems,
community awareness,
availability of drinking water,
occupational protection,
recognition of vulnerable individuals,
prepared health facilities,
and trained health-care workers.

This is precisely where clinicians, public-health professionals, administrators, meteorological agencies, local governments and communities must collaborate.

7. India Has Already Created an Opportunity for Physician Leadership. India's National Programme on Climate Change and Human Health (NPCCHH) provides an important institutional framework. Its objectives include increasing awareness of climate-related health impacts, strengthening health-workforce capacity, improving preparedness and response, developing adaptation plans, strengthening climate-resilient health infrastructure and building multisectoral partnerships [4]. Its thematic areas include heat-related illnesses, air-pollution-related illness, vector-borne disease, extreme weather events and green and climate-resilient health-care systems.[4] This is highly significant. Climate-health advocacy in India does not need to begin from zero. Doctors can connect their hospitals, professional associations, medical colleges and community initiatives with existing national, state and district frameworks.

The physician can become the bridge between:

policy and patient,
data and disease,
climate science and community behaviour.

The Clinic Itself Can Become a Demonstration Laboratory. Advocacy becomes credible when our own institutions practise what we recommend.

Every hospital and clinic can ask simple questions.
How much electricity are we consuming?
How much water are we wasting?
Are biomedical wastes correctly segregated?
Are unnecessary single-use materials being consumed?
Can appropriate processes be digitised?
Can energy efficiency be improved?
Can renewable energy be incorporated?
Are procurement decisions considering environmental impact?
Is the facility prepared for heatwaves, flooding, water shortages or power disruption?

WHO specifically advocates climate-resilient and environmentally sustainable health-care facilities that minimise environmental harm while maintaining safe, accessible and high-quality health services.[6] Importantly, sustainability must never become indiscriminate cost cutting. The principle should be: reduce waste, not care.

Biomedical Waste: Environmental Responsibility Begins at the Bedside. Doctors often associate biomedical waste management with housekeeping personnel or hospital administrators. That perception is inadequate. Waste is generated because of clinical decisions. Every procedure, dressing, injection, investigation and operation produces a material footprint. India's Bio-Medical Waste Management Rules provide a regulatory framework for segregation, collection, treatment and disposal of biomedical waste [11]. Yet compliance should represent the minimum standard. The broader goal should be a culture in which every member of the health-care team understands that correct waste segregation protects health-care workers, waste handlers, communities and the environment.

A simple rule is worth remembering:

The safest waste is the waste that did not need to be generated—provided patient safety and quality of care are never compromised. 10. The Operating Theatre: A High-Impact Opportunity For surgeons, environmental sustainability has particular relevance. Operating theatres are resource-intensive environments. They require energy, sterilisation, air handling, pharmaceuticals, surgical materials, packaging and substantial quantities of disposable products. The objective should never be to compromise sterility or surgical safety. Instead, surgical teams can examine:

Unnecessary opening of implants or consumables,
avoidable wastage,
appropriate segregation,
energy use during non-operating periods where technically permissible,
procurement practices,
inventory management,
and opportunities for safe reuse where regulations and validated sterilisation protocols permit.

Environmental stewardship and patient safety are not opposing concepts. Properly designed systems can support both. 11. The Five-R Framework for Physician Environmental Leadership. For practical implementation, I propose a simple Five-R Framework. R1 — Recognise. Recognise environmental determinants during clinical assessment. Consider heat exposure, air pollution, occupation, water and sanitation, environmental allergens and disaster vulnerability where relevant. We cannot prevent what we fail to recognise. R2 — Reduce. Reduce the environmental footprint of clinical practice without compromising care. Reduce unnecessary resource use, energy consumption, water wastage and incorrectly segregated waste. Evidence-based reduction of low-value care can simultaneously improve quality and reduce environmental burden.[12]

R3 — Resilient

Make health-care facilities climate resilient.
Hospitals must remain functional precisely when communities need them most—during heatwaves, floods, storms, power failures and other emergencies.
Resilience therefore requires reliable energy, water, sanitation, trained personnel, infrastructure planning and emergency preparedness.[6]

R4 — Reach

Move beyond hospital walls. Educate schools, senior-citizen groups, occupational groups, community organisations and local leaders. Physicians can communicate practical health messages on heat protection, clean air, safe water, sanitation, waste segregation, active transport and healthy sustainable lifestyles.

R5 — Represent

Represent health in environmental decision-making. When urban planning, pollution, transport, heat action plans, waste management or environmental regulation is discussed, somebody must ask:

“What will this decision do to human health?”

Doctors and medical organisations can help ensure that this question is not forgotten.

Advocacy Must Remain Scientific

Physician advocacy acquires credibility only when it remains evidence based. Doctors should avoid exaggeration, partisan positioning and unsupported claims. Environmental health advocacy should follow the same principles as clinical medicine:

evidence, proportionality, transparency and professional ethics.

We should distinguish between established evidence, reasonable precaution, emerging evidence and personal opinion. A doctor need not become a political activist to become a health advocate. Writing a scientifically accurate newspaper article about heatstroke prevention is advocacy. Educating schoolchildren about air pollution is advocacy. Helping a hospital improve biomedical waste segregation is advocacy. Participating in a district heat-health plan is advocacy. Presenting evidence to municipal authorities is advocacy. Conducting environmental-health research is advocacy. Professional advocacy can therefore remain entirely consistent with scientific neutrality.

Medical Education Must Change

Tomorrow's doctors will practise in a world increasingly shaped by environmental change. Yet many doctors receive limited formal education regarding climate-health interactions. Medical education should progressively incorporate:

climate-sensitive diseases,
heat-related illness,
air pollution,
environmental and occupational exposure,
disaster medicine,
sustainable health care,
planetary health,
risk communication,
and health advocacy.

Education is important because willingness alone is insufficient. Health professionals have identified continuing education, communication training, patient materials, policy guidance and institutional sustainability guidance as important facilitators of engagement.[8]

Environmental health should therefore not be treated as an extracurricular interest.

It is emerging clinical competency.

Doctors as Community Multipliers

One physician may see thousands of patients.
But one physician who educates a community can potentially influence tens of thousands.
And one professional medical association can influence millions.
Medical associations can organise:
public-awareness campaigns,
continuing medical education,
heat-health initiatives,
air-pollution awareness,
tree and biodiversity programmes linked with public health,
sustainable-hospital programmes,
school education,
research collaborations,
and evidence-based policy dialogue.

The collective influence of health professionals can help alter institutional practices, public narratives and policy priorities [7]. The scale of influence changes dramatically when physicians act collectively.

Environmental Action Can Produce Immediate Health Benefits

Climate action is sometimes presented as a sacrifice made today for generations in the distant future. That framing is incomplete. Many environmental interventions produce health benefits now. Cleaner air reduces exposure to harmful pollutants. Walking and cycling, where safe and feasible, reduce emissions while increasing physical activity. Healthier food systems can potentially benefit both human and planetary health. Energy-efficient health facilities can reduce resource consumption. Waste reduction can decrease pollution and unnecessary expenditure.

Thus, environmental action should not be communicated only as: "Save the planet."

For doctors, the more immediate message is: "Protect the patient."

16. From the Prescription Pad to Public Policy

Doctors are trained to write prescriptions.

Perhaps the environmental-health prescription of the future needs several lines:

For the individual:

healthy lifestyle and reduced harmful exposures.

For the hospital:

safe, sustainable and resource-efficient health care.

For the community:

clean air, safe water, sanitation, green spaces and protection from extreme heat.

For government:

health-centred environmental policies.

For medical organisations:

education, research and advocacy.

For ourselves:

leadership by example.

This is not abandoning clinical medicine.

It is extending preventive medicine to its logical destination.

17. A Physician's Environmental Health Pledge

Every doctor can begin with a simple professional commitment:

I will recognise environmental determinants of disease.

I will educate patients about preventable environmental risks.

I will minimise avoidable environmental harm from my clinical practice without compromising patient safety.

I will support climate-resilient and sustainable health-care systems.

I will communicate scientific evidence responsibly.

And when environmental conditions threaten human health, I will not remain merely a spectator.

CONCLUSION

The Doctor's Duty Does Not End at the Clinic Door

The history of medicine teaches us that the greatest advances have not always come from new medicines or operations.

Clean water transformed health.

Sanitation transformed health.

Vaccination transformed health.

Tobacco control transformed health.

Road safety legislation saved lives.

Occupational safety prevented injuries.

These achievements required medicine to look beyond the individual patient toward the conditions in which populations live.

Environmental health represents the next major extension of that philosophy. The physician of the twenty-first century must therefore be more than a healer of environmentally induced disease. The physician must also become a guardian of the conditions necessary for health. We must continue treating the child with asthma—but also ask why the child is breathing polluted air. We must continue treating heatstroke—but also ask why vulnerable people remain unprotected during extreme heat. We must continue treating infections—but also advocate for clean water and sanitation. And we must continue building excellent hospitals—but ensure that the institutions created to protect health do not unnecessarily damage the environment on which health depends. The journey therefore begins in the consulting room, but it cannot end there. It moves from the patient to the population, from treatment to prevention, from clinics to community. The prescription is no longer only for an individual patient. It is a prescription for a healthier community and a healthier planet. And perhaps the most important prescription doctors can write for future generations contains no medicine at all:

Clean air. Safe water. Sustainable health care. A stable climate. A healthy planet. Because ultimately, there can be no healthy people on an unhealthy planet.

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