

of South Dakota in the USA. As applied in Tamil Nadu, there would be five stations and candidates rotate through them. Each gives a clinical scenario: there may be a medical professional who acts as a patient and gives history, and answers questions from the candidate to assess his skills in history taking. The method of eliciting clinical signs may also be tested, and perhaps, when actual patients are available the examiner could assess the candidates' ability to elicit physical findings. One may have X-rays and ECGs to assess the ability of the candidate to interpret them. At present, this is a learning experience for both examiners and examinees.

My own inadequacy when I entered general practice (I suppose it would be called family practice now) led me to ponder over the purpose of the MBBS course. Surely, the aim should be to produce a doctor who can set up a practice and treat all the common conditions that afflict the majority of people. He should be able to do minor surgery such as suturing wounds, incising abscesses, and should treat fevers, diarrhoeas, aches and pains. He should be able to recognize the patient who needs more specialized attention, so that he can refer him or her to the appropriate specialist, or in a rural setup, to the centre with more facilities. I see no point in ignoring common conditions altogether, and producing a doctor who cannot recognize and treat them, but can diagnose valvular and congenital heart disease, major respiratory conditions, brain tumours, none of which he will be able to treat himself. Today, not even the top cardiologist diagnoses mitral stenosis without an echocardiogram, and we are prepared to fail candidates in examinations for missing a minor degree of mitral incompetence in addition to the stenosis.

When I began teaching, I decided I would teach candidates what they needed to know to be good family practitioners. In the outpatient clinic, I took 6 consecutive patients from the waiting line and allotted each to one of the students who was given just 10 minutes to see him, make a diagnosis and present him to the class with his suggestions of how he would investigate further

if necessary, and treat. The majority should be treated without investigations. All admissions in the wards were allotted to one or other of the students posted in the unit, irrespective of whether they were considered 'examination material' or, more often, not. I took the patient on bed one on day one, bed two the next day, and so on so that the class saw a cross-section of the patients who came to the outpatient clinic and of those who were ill enough to warrant admission. Over the years, large numbers of my students have told me that their time with me was the most useful preparation they had for their life as family practitioners.

However, as long as the examiners continue to keep questioning candidates about what they would do to investigate an aortic systolic murmur and what would be the indications for surgery, students taught by me would not pass their examinations. I had to get them through their examinations, so I had to teach them about 'examination material' also. In practice, if they found a patient with an aortic murmur, they would refer the patient to a cardiologist and he would take over the care. Few consultants would report back to the referring doctor so that he could add something to his knowledge. I believe medicine should be taught as I did, but examiners should change their methods so that they could assess what a good family practitioner should know. The OSCE system would be ideal to examine a candidate for family practice. The scenario could be of a patient with dysentery. Is it bacillary or amoebic, would you just treat or investigate, and if you would, how? Will there be exciting changes in the output of our medical colleges, so that we turn out excellent family physicians? Those who want to go on to be specialist physicians and surgeons after further training could do so. Sadly, with our ossified systems, I expect we will need another generation or two to adopt that method, and by that time, the rest of the world would have moved much further ahead.

M.K. MANI

Letter from Glasgow

CLIMATE CHANGE AND HEALTH

Fifty years is a long time ago but I remember 1971 very well. I was 14 years old and having left India aged 5 for Scotland, I went back to India for the first time since leaving. I spent 2 months that glorious summer visiting relatives and having a great holiday visiting Delhi, Amritsar, Dehradun, Agra and Mumbai, among other places.

In the history of climate change, 1971 was also the year that the Study of Man's Impact on Climate conference of leading scientists reported a danger of global climate change caused by humans.¹ Ominously, it was also reported that the Mariner 9 spacecraft found a great dust storm warming the atmosphere of Mars, with indications that Mars had a different climate in the past.

What I do not remember in 1971 is a young man, John Forbes Kerry, who had served in the US Army in Vietnam.² He came back from the war to become a spokesperson for the Vietnam Veterans Against the War. It was many years later I saw his testimony on 22 April 1971 at the hearing on the Vietnam War of the US Senate Foreign Relations Committee. His testimony is electrifying in its 'telling truth to power' of the lies told about US intervention in Vietnam.^{3,4} If you have not heard the speech, do so and feel the hair on your neck stand on end.

Why, I hear you say, is he wittering on (an informal UK term for speaking at length about trivial matters) about 1971, climate change, John Kerry and the Vietnam War? And what has this to do with public health? But bear with me.

John Kerry is now a seasoned American politician and diplomat and is currently serving as the first United States Special Presidential Envoy for Climate. He will be coming to

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Glasgow for COP26, the UN Climate Change Conference UK 2021, in November.⁵ John Kerry has carved out an interest in climate change and has a passion for the urgent need to act. He has stated: 'Climate change, if unchecked, is an urgent threat to health, food supplies, biodiversity, and livelihoods across the globe.' The COP26 conference will bring together governments and non-governmental organizations to agree action to achieve the goals of the Paris Agreement and the UN Framework Convention on Climate Change. If ever there is a need for governments around the world to face the truth on climate change, then having John Kerry on your side is a good start.

Depending on how the pandemic behaves, around 30 000 delegates from 196 countries could attend COP26 in Glasgow. Let's just hope it does not become a Covid-19 superspreader event because so much is at stake. For public health, it is important because the consequences of climate change are profound, and my sense is that health professionals have been a little slow in recognizing the urgency of the situation and the impact on health.

For the avoidance of doubt, climate change is the result of greenhouse gas emissions caused by human activities.⁶ Historically, high-income countries benefited from these emissions and of course, now as low- and middle-income countries try and join the industrialization and urbanization party, we are faced with stark choices of having to limit greenhouse gas emissions. Changes to climate are already 'wired in', and how much we restrict emissions will influence how much the global temperature rises. The UK is already experiencing change with a warmer, sunnier and wetter climate.⁷ Globally, these effects will be magnified and the Maldives face an existential threat.

Public health has highlighted the problems of climate change. For example, in *The future public health*, Hanlon *et al.* argued for public health to rise to the challenge of the collision of the environment and the economy and achieve sustainability.⁸ However, we need to do much more, and soon. In the UK, the direct health impacts of climate change include '...changing exposure to heat and cold, increased exposure to UV radiation, air pollution, pollen, emerging infections, flooding and associated water-borne diseases and the impact of extreme weather events such as storms and floods, notably on mental health'.⁹ In addition, there are indirect effects of climate change on peoples' jobs, and water, food and energy availability.

The title of the Institute of Health Equity report is instructive—'Sustainable Health Equity: Achieving a Net Zero UK'.⁹ As you would expect with research associated with Michael Marmot, it is rigorous, is evidence-based, is thoughtful and focuses on health equity. It reinforces the point that climate change is already damaging the British population and highlights the direct and indirect pathways of health effects from climate change. The report is optimistic, arguing that climate change actions could improve health and health equity. However, that requires political and policy commitment, a clear strategic, operational plan and funding. There is a real danger that we

accept the attitude that 'there is nothing we can do about climate change' and miss the opportunities that we still have to mitigate its effects. The report counters that by advocating practical and realistic changes in five key areas for health and climate change: a just energy policy that minimizes air pollution; designing and retrofitting homes to be energy-efficient, climate-resilient and healthy; building a sustainable and healthy food system; developing a transport system that promotes active travel and road safety, and which minimizes air pollution; and developing healthy and sustainable models of work.

I welcome John Kerry and COP26 coming to Glasgow, even if I am a little apprehensive—about the pandemic not being over yet, and that we need to act more decisively to counter climate change and its health effects. COP26 has a huge task ahead of it. It does not matter if you live in low-, middle- or high-income countries, what religion predominates in your society, whether it is a democratic or autocratic political system in your country or whether a country has a largely rural or largely urban-based population, all countries will be affected. As usual in any crisis, health or otherwise, it is likely that poorer countries and poorer people in all countries will suffer disproportionately. So, it will be with climate change and they will face severe health (and economic and social) effects unless we can act globally and collectively in a fair and equitable way, allowing sustainable development. Let's hope John Kerry's history of talking truth to power helps at COP26 and encourages countries, finally, to act boldly and firmly for the health of people everywhere.

Conflicts of interest. I am a non-executive director of the Scottish Environmental Protection Agency (SEPA <https://www.sepa.org.uk/>). SEPA is Scotland's principal environmental regulator, protecting and improving Scotland's environment.

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