The scope of patients, healthcare professionals and healthcare systems responsibilities to reduce the carbon footprint of inhalers: a response to commentaries

I am grateful for these four wide-ranging and incisive commentaries on my paper discussing the ethical issues that arise when we consider the carbon footprint of inhalers.[1] As I am unable to address every point raised, instead I focus on what I take to be the common thread. Each response has something to say regarding the *scope* of healthcare's responsibility to mitigate climate change. This can be explored at the intuitional or structural level, or at the individual patient and practitioner level leading to a further issue of the relationship between these perspectives.

John Coverdale argues for broadening the scope of individual responsibilities regarding the climate.[2] Discussing inhalers does not go far enough and doctors, argues Coverdale, are well placed to draw attention to the various behaviour changes patients can undertake both through role-modelling and in the clinic. Whilst Coverdale makes some excellent points, I have three worries about his proposal. One is relevance. Climate concerns may not always be pertinent in the clinical encounter. Think of counselling a bereaved patient or somebody needing a fit note. Related to this is opportunity. General Practitioners capacity to cover an inordinate amount in a ten-minute consultation is remarkable. But to include dietary modification, transport and energy consumption, as well as the other public health measures mentioned is perhaps optimistic. The final concern is normative. Whilst space limits a full examination, the basic issue is that if those who consult their doctor tend to experience various other forms of disadvantage, and those who are disadvantaged tend to contribute the least to climate change, at the very least doctors need to be careful not to burden patients with responsibilities that pre-existing disadvantage means they might struggle fulfil.

On the other hand, Travis Rieder contracts the scope of individual responsibilities to claim that individuals might have a reason to change inhalers just not a duty.[3] For Rieder individuals changing inhalers doesn't make a difference to climate change such that it grounds any duty. Individuals could participate and be part of the solution rather than the problem, there is just no moral requirement. It is not clear what sort of reason individuals have to undertake behaviour changes that aren't difference-making. And it does seem odd that individuals could be part of a solution if their actions make no difference to the problem. Rieder doesn't explain this causal connection. Rieder views the scope of the clinical interaction as the patient in front of the doctor and he agrees with my view that support for inhaler changes should be institutional.

Interestingly, Anders Herlitz *et al* want to narrow the scope of "green" individual responsibilities and widen institutional ones. Their proposal, I suppose, pushes Rieder's view further. Doctors and patients should not concern themselves with the climate, rather institutions should take inhalers with a greater carbon footprint off

the menu.[4] Whilst I have sympathy for the motives behind their proposal I cannot see how this is feasible in practice. Metered-dose inhalers (MDIs) cannot be removed from the formulary absolutely because not every patient can use an alternative. There would need to be a mechanism to remove them only for specific patients. The question then is which? The problem is that it is difficult to specify in advance exactly which patients will benefit sufficiently from a dry powder inhaler such that metered-dose inhalers can be removed from the menu just for them. Inevitably, the policy will rely on saying that MDIs are unavailable to patients in whom an alternative is clinically appropriate, but determining clinical appropriateness relies on a doctor assessing the patient and making a judgement. If this is what 'off the menu' means I cannot see how this is different to my proposal. Even if Herlitz and colleagues are able to dissect metered-dose inhalers out of the formulary just for the cohort who can use a dry powder inhalers and who will obtain adequate benefit at the institutional level without recourse to the clinical interaction, there is still the question of how to approach patients who are already established on a metered-dose inhaler. If a patient has well-controlled asthma, say with a Fostair 100/6 MDI device, and then Herlitz *et al* remove this from the formulary, how do doctors go about switching? Do doctors just go ahead and prescribe the dry powered equivalent without consultation? Do they discuss this with the patient? If they do, what should they discuss? How should the clinician respond to the patient who doesn't want to switch or who is concerned that their control should worsen? I can see the attractiveness of taking an institutional or structural approach to the problem of inhalers but it is myopic to think this can be divorced from the interactions that doctors have with their patients. Indeed, I came to this issue because of challenges I faced in my own practice.

Anand Bhopal and Kristine Bærøe provide perhaps the most explicit exploration of this idea of scope.[5] They focus at the institutional perspective and ask whether healthcare should be concerned with "all relevant externalities". The key question then is how to understand the idea relevance with regards to the potentially far-reaching externalities of healthcare systems? I whole heartedly agree with Bhopal and Bærøe's view that cutting-edge philosophical work is necessary to understand what is required of healthcare systems regarding the relationship between climate change, health and healthcare. My hope is that my paper alongside these insight commentaries is a contribution to Bhopal and Bærøe's vision.

References:

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