The American Journal of Bioethics

ISSN: 1526-5161 (Print) 1536-0075 (Online) Journal homepage: www.tandfonline.com/journals/uajb20

What Ought a Physician Do?: Climate Conscious Codes of Medical Ethics

Ana Komparic, Ross E. Upshur & Patrick Garon-Sayegh

To cite this article: Ana Komparic, Ross E. Upshur & Patrick Garon-Sayegh (2025) What Ought a Physician Do?: Climate Conscious Codes of Medical Ethics, The American Journal of Bioethics, 25:7, 33-35, DOI: 10.1080/15265161.2025.2509926

To link to this article: https://doi.org/10.1080/15265161.2025.2509926

THE AMERICAN JOURNAL OF BIOETHICS
2025, VOL. 25, NO. 7, 33–35
https://doi.org/10.1080/15265161.2025.2509926

Taylor & Francis
Taylor & Francis Group

OPEN PEER COMMENTARIES

What Ought a Physician Do?: Climate Conscious Codes of Medical Ethics

Ana Komparic[a,b], Ross E. Upshur[b] and Patrick Garon-Sayegh[c]

[a]University of British Columbia; [b]University of Toronto; [c]University of Montreal

INTRODUCTION: CLINICAL MEDICAL ETHICS AND CODES OF ETHICS

Hantel et al. (2025) argue that clinical medical ethics (CME) ought to include environmental and climate-related considerations. They contend that 'climate conscious' CME is justified by multiple moral theories undergirding CME, and that it could be operationalized by adapting Jonsen and Siegler's (2022) Four Topics Model (FTM) for clinical ethics.

This proposal presumes that clinicians have moral duties regarding the environment and climate change mitigation. Although ethical theories may *persuade* clinicians, theories alone do not *bind* clinicians who are otherwise bound by norms posited in legal or quasi-legal sources, especially professional codes of ethics (codes). Codes are a key mechanism for operationalizing CME, functioning as public statements of a profession's moral commitments and as quasi-legal documents for self-regulation (Komparic et al. 2023). Accordingly, any meaningful and binding shift to climate conscious CME would include code revisions. Hantel et al.'s analysis is silent on the role that codification could play in grounding environmental and climate-related considerations.

Notably, the World Medical Association's (WMA) 2022 revision of the International Code of Medical Ethics (ICME) includes duties to practice in environmentally sustainable ways and to contribute to the health and well-being of future generations (WMA 2022; Parsa-Parsi et al. 2023). This gives prima facie support to Hantel et al.'s (2025) assertion that climate change mitigation involves both "an individual responsibility" related to clinicians' practice and a "general responsibility related to the impact of the practice of medicine," as codes are collective in scope while binding individuals. Focusing on physicians, this commentary addresses three interrelated challenges facing the introduction of environmental duties into medical codes. Analogous challenges may be faced by other professional codes.

FIRST CHALLENGE: ENVIRONMENTAL DUTIES ARE NOT SPECIFIC TO PHYSICIANS

Duties to mitigate climate change are not specific or unique to physicians. Even if we grant that physicians, qua physicians, have specific duties (such as reducing the environmental impact of their medical practice), complex interpretive work is required to discern the right course of action in specific cases. This complexity arises for two main reasons.

First, climate change is characterized by dispersed cause and effect, as Hantel et al. acknowledge: no individual is causally responsible for it, and it is caused by actions that are temporally and spatially removed from their effects. It is therefore difficult to determine the environmental impact of particular actions. As discussed later, this also requires complex evidentiary infrastructures.

Second, codes (or frameworks like FTM) are not self-applying. As codes are inherently 'multivocal', physicians must necessarily engage in significant interpretive work to discern the specific actions required of them (Komparic et al. 2023). The duties posited in any code (or combination of codes) are often abstract or in tension. Interpretive work and judgment are required to resolve tensions and discern what ought to be done in specific cases; a substantial margin of reasonable disagreement is to be expected in many, if not most, cases.

These two reasons compound each other. For instance, uncertainty about the impact of one's actions is especially vexing when environmental duties conflict with other, more concrete duties to patients. Relatedly,

CONTACT Ana Komparic ana.komparic@ubc.ca W. Maurice Young Centre for Applied Ethics, School of Population and Public Health, University of British Columbia, 213-2206 East Mall, Vancouver, British Columbia, V6T 1Z3, Canada.

the dispersion of cause and effect raises 'scalar' and 'temporal' questions (Komparic et al. 2023). For example, how should a physician consider the needs of patients in front of them alongside the needs of distant communities or future generations? Additionally, physicians' duties are influenced by the multiple institutional and jurisdictional contexts within which they work. On the one hand, since institutions and jurisdictions exist on different temporal and spatial scales than individuals, should they not support collective action by positing binding norms for individuals (Parker et al. 2023)? On the other hand, the multiplicity of directives from institutions and jurisdictions can increase the tensions that clinicians need to resolve.

SECOND CHALLENGE: PHYSICIANS' PRIMARY DUTIES TO PATIENTS

For Hantel et al. (2025), "healthcare providers' assumption of a fiduciary responsibility for humans' health establishes a basis for their responsibility for climate change mitigation" (10). However, physicians' fiduciary duty is to prioritize the best interests of their patients as *individuals*, rather than a general duty to human health writ large. Although duties to society are a longstanding feature of codes, none to our knowledge has deprioritized the patient. For example, the ICME (WMA 2022) states:

> The primary duty of the physician is to promote the health and well-being of individual patients […]. The physician also has a responsibility to contribute to the health and well-being of the populations the physician serves and society as a whole, including future generations.

Hantel et al. critique the individualism and anthropocentrism of CME. However, it is worth considering whether disentangling the individual and the environment in decision-making is beneficial to patients and physicians. First, it can confer clarity of purpose and orient one's actions: as a clinician, my primary purpose is to treat the patient before me as best I can, for even this task is difficult and fraught. Second, it can prompt ethical and epistemic humility regarding the extent and limits of one's knowledge and abilities. Recognizing where one has an insufficient understanding of the environmental impacts of one's practice may help protect against potentially harmful, inconsistent, or inequitable recommendations. Third, a fiduciary relationship is a relationship of trust: patients are reassured that clinicians make decisions in their best interest (rather than prioritizing "the environment").

Although patients may wish to reduce the environmental impact of treatments based on their values (Salloch 2024), clarity is required as to whether environmental considerations can override considerations of patient benefit (including safety, efficacy, and accessibility). Likewise, environmentally sustainable practice may also be the most clinically beneficial. For example, deprescribing unnecessary medications can benefit patients' health and reduce environmental impacts (McDermott et al. 2025), given the significant carbon footprint of developing, manufacturing, assessing, and distributing medications (Kaur et al. 2025). Although environmental concerns may motivate physicians to alter prescribing practices (McDermott et al. 2025), clinical benefit should provide sufficient moral justification for deprescribing. It is where the two imperatives conflict—where environmental sustainability comes at the expense of safer or more effective treatment, or at costs that constrain access—that presents unresolved challenges.

THIRD CHALLENGE: ENVIRONMENTAL DUTIES MAY NOT BE ACTIONABLE IN PRACTICE

A third challenge facing climate conscious CME concerns the practicability of environmental duties. Even if we grant that physicians have environmental duties that sometimes outweigh duties to individual patients, saying that physicians ought to consider the environment in clinical decision-making presupposes that they can and are adequately equipped to do so. Hantel et al. propose to operationalize a climate conscious CME by adapting the FTM. Similarly, codes could be revised to include environmental duties as in the ICME. Yet, not only are the proposed revisions abstract, but a physician's ability to consider environmental concerns depends on a broader evidentiary infrastructure.

Consider how physicians already rely on evidentiary infrastructures to fulfill their duties. For example, a complex evidentiary infrastructure (including clinical trials, regulatory assessments, health technology assessment, clinical practice guidelines, and continuing medical education) enables the generation, appraisal, assessment, and translation of evidence to support prescribing decisions and consistency across practice contexts. A similarly sophisticated infrastructure is required to avoid potential harms, disparities, or inequities that could result from abstract, evidence-poor understandings of environmental impact, no matter how well-intentioned.

Additionally, where clinicians already uphold population-oriented duties, such as resource stewardship,

priority setting decisions are often made outside of and preceding clinical encounters. This leaves clinicians to advocate as best they can for their patients within the constraints of their practice context, rather than bearing the burden of making macro- or meso-level priority setting decisions in each patient encounter.

Given the nascent stages of the evidentiary infrastructure required to support a fulsome understanding of the environmental impacts of medical decisions, it is unsurprising that the ICME articulates physicians' responsibilities in a decidedly aspirational manner: "12. The physician should strive to practise medicine in ways that are environmentally sustainable with a view to minimising environmental health risks to current and future generations" (WMA 2022). Codes often include both aspirational content, representing ideals that physicians should strive for, and prescriptive content, defining minimum standards that physicians must meet (Komparic et al. 2023). Translating environmental ideals into standards that physicians can reliably meet requires coordinated and concerted efforts reaching far beyond individual clinicians.

CONCLUSION

Anthropogenic climate change threatens the health and well-being of humans, non-humans, and the environment, and healthcare has a significant environmental footprint. Hantel et al. claim that the individualism and anthropocentrism of CME is artificial and misguided. We suggest, instead, that climate-conscious CME may be thought of not as doing away with medicine's primary focus on human health, but as prompting ontological and epistemic shifts toward recognizing the social and ecological embeddedness of individual patients (as acknowledged by the authors). Although this recognition lays the foundations for further moral shifts, considering how environmental duties are grounded and operationalized in practice—namely through codification—indicates the need for humility concerning the role of individual clinicians and that effective climate change mitigation requires significant cross-disciplinary and cross-sectoral efforts.

DISCLOSURE STATEMENT

No potential conflict of interest was reported by the author(s).

FUNDING

The author(s) reported there is no funding associated with the work featured in this article.

ORCID

Ana Komparic http://orcid.org/0000-0002-7223-7563
Ross E. Upshur http://orcid.org/0000-0003-1128-0557
Patrick Garon-Sayegh http://orcid.org/0000-0002-1234-8069

REFERENCES

Hantel, A., J. M. Marron, and G. A. Abel. 2025. Establishing and defining an approach to climate conscious clinical medical ethics. *The American Journal of Bioethics* 25 (7):8–21. doi: 10.1080/15265161.2024.2337418.

Jonsen, A. R., M. Siegler, and W. J. Winslade. 2022. *Clinical ethics: A practical approach to ethical decisions in clinical medicine*, 262. 9th ed. New York, NY: McGraw Hill.

Kaur, H., F. Parascandalo, G. Krantzberg, E. Ko, N. Mathur, A. S. Gill, F. Razack, and M. Sergeant. 2025. Journey of a pill. *Canadian Family Physician Medecin de Famille Canadien* 71 (4):263–9. doi: 10.46747/cfp.7104263.

Komparic, A., P. Garon-Sayegh, and C. M. Bensimon. 2023. The promises and limitations of codes of medical ethics as instruments of policy change. *Bioethics* 37 (4):406–15. doi: 10.1111/bioe.13143.

McDermott, E., R. Halil, W. S. Nash, R. J. Douglass, A. Train, E. Zvereva, S. Kandasamy, D. Zahid, and M. Sergeant. 2025. The environmental elephant in the office: Medications. *Canadian Family Physician Medecin de Famille Canadien* 71 (4):233–7. doi: 10.46747/cfp.7104233.

Parker, J., N. Hodson, P. Young, and C. Shelton. 2023. How should institutions help clinicians to practise greener anaesthesia: First-order and second-order responsibilities to practice sustainably. *Journal of Medical Ethics.* doi: 10.1136/jme-2023-109442.

Parsa-Parsi, R. W., R. Gillon, and U. Wiesing. 2024. The revised international code of medical ethics: An exercise in international professional ethical self-regulation. *Journal of Medical Ethics* 50 (3):163–8. doi: 10.1136/jme-2023-109027.

Salloch, S. 2024. Ecological preferences and patient autonomy. *Journal of Medical Ethics.* doi: 10.1136/jme-2024-110432.

World Medical Association (WMA). 2022. WMA International Code of Medical Ethics. https://www.wma.net/policies-post/wma-international-code-of-medical-ethics/