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Broadening the Scope: A Critical Response to Climate-Conscious Clinical Medical Ethics

Julia S. Chiavegato

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OPEN PEER COMMENTARIES

Broadening the Scope: A Critical Response to Climate-Conscious Clinical Medical Ethics

Julia S. Chiavegato

Dalhousie University

Clinical ethicists typically endorse the centrality of a commitment to "do no harm" in medical practice. While the scope of those harms has generally been restricted to those incurred by the patient, the clinical encounter may also be an important context for protecting other beings who have the potential to be harmed as a result of medical practice. This perspective seems to underpin Hantel et al.'s (2025) introduction of an approach they refer to as "climate conscious clinical medical ethics (CME)".[1] In their paper, they argue that when considering the threat climate change poses to human health alongside the responsibility clinicians have to promote health, it is clear that medical providers have a unique obligation to mitigate ecological harm in their care interactions. Accordingly, Hantel et al. claim CME frameworks should be expanded to incorporate this obligation by replacing the traditional conception of autonomy—autonomy as restricted to a patient's values, desires and interests—with their broader conception of relational autonomy whereby autonomy includes the values, desires and interests of other humans, non-human beings and ecosystems

CONTACT Julia S. Chiavegato julia.s.chiavegato@gmail.com Department of Philosophy, Dalhousie University, 6135 University Avenue, Halifax, NS, Canada.

[1]To be consistent with the Hantel et al. the remainder of this commentary will refer to clinical ethics as "CME."

connected with the patient. So, in climate conscious CME, a physician is not only responsible for mitigating the harms posed to the patient but also harms posed to the environment through the medical interaction.

Hantel et al.'s paper rightfully demands immediate action in the domain of medicine to mitigate climate change. While many bioethicists are already on board with interventions at the systems level—this is evident in movements such as "One Health" (Capps 2022; Lederman 2024; Thompson and List 2015)—what Hantel et al. propose goes beyond this. Rather than focusing exclusively on structural initiatives like introducing biodegradable medical equipment to hospitals, they suggest that intervention should occur within clinical interactions.

While Hantel et al.'s shift in focus is clear, their paper, due to a lack of explicit examples, does not answer a key question, namely "what can clinicians actually do in the context of caring for patients to mitigate climate change?" In an effort to better understand the implications of their view, I will employ an example—albeit a simple one—to explore how climate conscious CME, as opposed to traditional CME, may direct a clinician to mitigate climate change. As I will show, this application of climate conscious CME raises two concerns with the model: 1. It entails clinicians must act beyond their expertise and 2. It makes patients susceptible to the kinds of harms traditional CME frameworks were designed to protect against.

Suppose that a healthcare provider is trying to determine whether medication A or medication B would be best for their patient. These medications have identical side effects and consequently would harm and benefit the patient to the same degree. The only difference between the two is that the production of medication A has significantly more detrimental effects on the environment.

In accordance with a traditional CME framework, the healthcare provider would begin by presenting the two available options to the patient, followed by a discussion of the potential risks and benefits associated with each. Since traditional CME frameworks invoke an individualistic conception of autonomy, in order to respect the values, desires and wishes of the patient, the healthcare provider would allow them to decide what medication best aligns with their preferences. Even if the healthcare provider were to inform the patient of the ecological harms posed by medication A, it would ultimately be up to the patient to determine how that harm factors into their decision. Thus regardless of whether the patient decides on medication A or medication B, acting in accordance with traditional CME frameworks ensures the patient's decision is respected.

However, given the authors are not merely defending the status quo, on my reading it seems as though if a healthcare provider were to follow a climate conscious CME framework, they would be obliged to prescribe the patient medication B instead of medication A. Since climate conscious CME involves a particularly broad version of relational autonomy, the healthcare provider must not only consider the interests of the patient, but the people and ecology they are connected to. Because medication A is significantly more harmful to the environment and healthcare providers have a responsibility to consider these harms, the healthcare provider must play an active role in ensuring that medication B is prescribed.

This example of the application of climate conscious CME raises two concerns. The first is that for a healthcare provider to enact climate conscious CME requires that they have extensive knowledge in domains outside of their expertise. In the case above, for the clinician to consider ecological harms when making a decision about the care of their patient, they must be privy to not only the manufacturing, transportation and disposal process of medications they are prescribing but also be able to compare and contrast the various ecological harms and benefits against one another. To do so effectively requires knowledge that healthcare providers do not receive as part of their medical training.

But, just because healthcare providers are not currently educated in assessing climate harms, does not mean they should not be. After all, Hantel et al. (2025) argue that part of implementing climate conscious CME is revising curricula in medical schools. However, this approach raises another two concerns. First, given the rapidly evolving nature of climate impact related information, revisions to medical education would need to be both ongoing and rigorous. Second, in the interest of consistency, including knowledge related to ecological harms in medical curricula entails that other social harms perpetuated by clinical interactions—like broad effects on mass incarceration (Valles 2023)—be included as well. If medical curricula are required to educate healthcare professionals on harms their care practices can cause to the environment, there would be no reason to exclude education related to how their care practices harm groups of humans on a systemic level as of course many such indirect effects exist. Perhaps such social issues should be included—I will not argue one way or another here—but regardless this raises questions about the appropriate professional scope of medicine. So, if the medical curricula is expanded to include information about climate impact, then both the process of how this information is sufficiently updated

and what implications this has for the inclusion of other social issues must be addressed.

The second concern raised by this application of climate conscious CME is that by prompting clinicians to consider interests of others beyond the patient, it indirectly removes safeguards protecting against paternalism. In the example above, since climate conscious CME makes the healthcare provider responsible for ensuring the decision of medications aligns with the minimization of ecological harm, it seems as though they are permitted to make the medical decision even when the patient is capable of doing so. This does not occur when the healthcare provider is acting in accord with the traditional CME because, under normal circumstances, it does not involve anyone *other than the patient* weighing competing interests or concerns. Thus it seems as though in climate conscious CME, considering the harms posed to others comes at the expense of giving patients the final authority over their medical decisions.

There appear to be two avenues that Hantel et al. (2025) can take to approach the concern of paternalism. The first is that they can maintain the patient's ultimate authority over decision making and instead argue that clinicians are only obligated to advise patients of the potential ecological harms of their medical decision. This approach would be similar to what Hantel et al. call "green consent." However, in this view it is still ultimately up to patients, not the healthcare provider to weigh concerns of harm posed to other beings. This appears to contradict Hantel et al.'s (2025) claim that CME frameworks should ensure "preferences and considerations beyond the individual should be simultaneously and not only subordinately considered" (16). Additionally, even if this approach were taken, there are already concerns related to restricting a patient's autonomy with green consent (Resnik and Pugh 2024). Alternatively, Hantel et al. (2025) could defend medical paternalism in these contexts. Of course, given the associated dangers, justification for this defense would be necessary.

In conclusion, while Hantel et al.'s article presents a novel approach for guiding the medical profession in meeting its ethical obligations to mitigate climate change, it is not yet clear how climate conscious CME would be applied to clinical interactions. I argued that there are two concerns that arise when we do try to apply this framework to clinical cases. First, climate conscious CME requires that healthcare providers must extend beyond their current expertise—this could be addressed by revising medical curricula; however this may not be feasible and it may entail that other social issues ought to also be included. Second, given the particular reconceptualization of autonomy advanced by the authors, climate conscious CME is susceptible to paternalism—perhaps this paternalism is justified, however it would be helpful for the authors to illustrate why this is acceptable.

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