Health professionals from every corner of the health sector—from allergy to vascular surgery, from epidemiology to environmental health, from nursing to hospital administration—have recognized the magnitude and urgency of the climate crisis. A growing literature provides guidance on how to conceptualize and meet the vast challenges we face and on how to keep our spirits up as we do so.

Sorensen et al propose roles and responsibilities for health professionals in the context of the climate crisis. They outline a far-reaching job description—from primary prevention to disaster preparedness and response to attribution science, from clinical care to patient education to policy advocacy. They point out that neither our current professional training nor the configuration of our health sector is fit for purpose: the climate crisis calls for substantial enhancement of health curricula and for systemic change across the health sector and beyond.

Several aspects of the article by Sorensen et al are noteworthy. First, they apply the traditional prevention hierarchy to the climate crisis. In this model, primary prevention consists of efforts to prevent the onset of disease, such as through immunization or smoking cessation; secondary prevention consists of early detection of disease such as through Papanicolaou tests, followed by interventions to improve outcomes; and tertiary prevention involves treatment or rehabilitation of people already affected, such as diabetes management or stroke rehabilitation.

However, these categories are grounded in clinical thinking; they do not always lead us upstream, to consider what have been called the causes of the causes. Climate change, as the ultimate system problem, demands upstream thinking, far upstream of the health sector. Accordingly, as Sorensen et al point out, primary prevention in this context means tackling the root causes of climate change: reducing carbon emissions, reversing destructive land use changes, and promoting carbon drawdown. In the parlance of climate action, this is mitigation (ie, avoiding the unmanageable). Since climate change is already amplifying such outcomes as malaria and malnutrition, measures that would conventionally be considered primary prevention (eg, mosquito eradication programs and nutritional supplements) are best viewed as secondary prevention, or in the parlance of climate action, adaptation (ie, managing the unavoidable). Finally, tertiary prevention in the climate context consists of efforts to reduce suffering among those already affected by climate change, including care for climate refugees displaced from their homes, those affected by weather disasters, and those with climate anxiety. These tertiary prevention actions correspond to disaster response.

This reframing of prevention categories with the shift from clinical care to climate action is not just an academic exercise. It has real implications. Few physicians are transportation planners, few nurses are agronomists, and few public health professionals are electrical engineers, but the pathways to preventing climate-related suffering run directly through low-carbon transport, regenerative agriculture, and renewable energy. As Sorensen et al point out, a transdisciplinary approach is necessary, because climate change is so far reaching in its causes and effects. Health professionals need not become experts in these domains, but they need to understand them well enough to help integrate health into the work of other sectors, to endorse them as health strategies, and to advocate for them.

A second key point Sorensen et al make is the need for coordination between clinical care and public health. The disconnect between these domains has long been recognized and was highlighted during the COVID-19 pandemic. For example, clinical insights and clinical data need to flow into public health surveillance systems, which need to transform the data into actionable information, which needs to flow back to clinicians (and to the public and policymakers).
However, the integration of clinical care and public health is only a beginning. We also need collaboration between the health sector and other sectors, including meteorology, which provides invaluable climate models and weather forecasts; emergency management, which responds to climate disasters; parks and recreation, which manages nature-based solutions in cities; and agriculture, which produces food in the context of changing climate constraints. Should required premedicine courses include not only biology and chemistry, but also earth sciences and ecology? Should medical students rotate not only through pediatrics and surgery wards, but also through transportation and emergency management agencies?

A third major aspect of the article by Sorensen et al is implicit: the role of ethics. The article is unabashedly prescriptive; the word “must” appears no fewer than 29 times in its 10 pages. This seems to reflect more than pragmatic considerations. A strong sense of moral conviction permeates the article. This is appropriate.

However, conventional medical ethics, like the aforementioned prevention hierarchy, is grounded in clinical care. Autonomy, beneficence, nonmaleficence, and justice—its 4 traditional pillars—relate largely to the delivery of health services. This is a severe limitation. The climate crisis calls for a metamorphosis of medical ethics into planetary health ethics. Such ethics would reckon with the shameful mismatch between those most responsible for carbon emissions and those most at risk from climate change. It would extend to the rights of future generations, the rights of nonhuman species, and perhaps even the rights of ecosystems. Just as the roles and responsibilities of health professionals need to expand in response to the climate crisis, so does our ethical framework.

A final question Sorensen et al raise is, What should health professionals do? The authors answer this question at some length, identifying a palette of professional responsibilities: learn about the health impacts of climate change, assess vulnerabilities in our communities, prepare our health systems accordingly, and educate patients and communities. Health professionals can do even more, however, in both their professional role and in their personal capacity. How might physicians and nurses make climate-friendly decisions in their own lives, including the food we eat, the goods we purchase, and the ways we travel? How might we talk about climate with family, friends, and acquaintances in our neighborhoods, congregations, and clubs, using the extraordinary public trust that health professionals enjoy? Should we divest our savings portfolios of fossil fuel companies? Push our medical societies to take climate-friendly positions? Speak out publicly in support of climate-friendly policies? Support hope and avert climate despair in ourselves, our colleagues, our patients, and our communities? These and many other actions likely advance prevention at every level, in line with the well-placed exhortations of Sorensen et al, and position health professionals as leaders in confronting the paramount health challenge of our time.
REFERENCES