Editor's Briefing

Euan Lawson

CLIMATE CHANGE ACTION AND INDIVIDUAL RESPONSIBILITY

This month's editorial on climate change, which is being published simultaneously in over 200 health journals, calls for emergency action to limit global temperature increases. As the editorial states, there seems to be a growing resignation in some quarters that a rise of 1.5°C is *'inevitable, or even acceptable, to powerful members of the global community'*. There is no 'safe' rise in temperature and there will be serious global health impacts with the most vulnerable experiencing disproportionate harm. This dull resignation, this 'doomism' is blunting the response needed, risking much greater temperature rises, and the spectre of tipping points being breached.

If you are looking for immediate action for primary care then the accompanying editorial by Kemple and colleagues offers some suggestions. In all this, we should be mindful of the individual as well as the collective. You don't have to march in the tinfoil hat brigade to recognise that there are, for instance, substantial vested interests in the dismantling of the fossil fuel industry. It suits those corporations and governments when responsibility gets pushed down to individuals. Notably, our editorials call for policy and societal changes; not shaming and blaming at individual level for people not perceived to be doing enough.

Healthcare professionals need to be wary of this. Of course, we should advise people to get out of their newly bought electric cars, to walk and cycle more, to adjust their diets, to engage in local communities. It's a happy confluence that many climate conscious actions will benefit our health and our communities. Yet, it is not enough, on its own, to address the climate emergency and climate activists are highlighting how it is being used to deflect attention from the utterly necessary system changes governments need to implement.

As GPs we are adept at managing these public health imperatives and balancing them in the intimacy of the consultation. Yet, one doesn't have to look too hard to see other areas where this has already happened. Efforts to regulate the food industry or re-shape obesogenic environments are castigated, shamelessly, as nanny statism to preserve profits. All too frequently obesity is characterised as solely a matter of individual responsibility.

One could argue that addressing inequalities is often similarly blinkered. Social prescribing has worthy ideals, though a limited evidence base, and yet the arc of responsibility bends back to the individual and does little to address the root causes. Governments are, again, off the hook.

We need bold policy in all these areas that doesn't lay blame on individuals, but it is tempting, with the ingrained caution and hedging of the scientist and academic, to fall back on the cliché, 'more research required'. Caution can be a virtue but there is a point at which it is simply dithering. Stewart Mercer points out the perils of 'pilotitis' in his editorial. And we need to ensure all voices are heard. David Misselbrook calls attention to the 'inverse power law': those most in need of healthcare still have the least say in how it is delivered.

Euan Lawson,
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Issue highlights

The climate change editorials are eye-catching but articles on young and old are important and could change practice. We report on a trial of a one-off dose of ondansetron in vomiting children with gastroenteritis, young people's perspectives on self-harm, and the integration of social care for older adults. The use of a cardiovascular risk prediction tool in older people is explored, and we have a review of out-of-hours services and end-of-life hospital admissions. We offer clinical guidance on the 'tapestry' of reflux syndromes and hepatitis B. And don't miss the chance to debate whether we should screen for poverty.

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