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Reviews Personal views

When doctors learned to speak carbon

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To start with health professionals paid little attention. After all, it was an environmental issue and their core business was health. But the burning of fossil fuels was increasing the concentration of carbon dioxide in the atmosphere to alarming levels. This was rapidly changing the earth's climate, threatening the balance of the biosphere with serious implications for human health (*Lancet* (2002);360: 1347-60 and *BMJ* 1999;318: 1682-5).

The stakes could not have been higher. Reducing carbon dioxide emissions required global, national, and personal commitments to reduce fossil fuel energy use. Governments would not implement the necessary measures without public support, but personal carbon rationing required a carbon literate society and radical changes in lifestyles.

Societal changes of this magnitude required leadership, but many of those in positions of responsibility enjoyed the most carbon profligate lifestyles of all. Doctors were a particularly energy profligate group. They took long haul flights to conferences and enjoyed regular exotic holidays, they drove large energy hungry cars and burned it up big at home (*BMJ* 2005;331: 643). But the public trusted them and so when they stopped flying, avoiding all unnecessary travel, started walking and cycling rather than driving, when they insulated their homes, hospitals, and offices, buying only the most energy efficient appliances, and when they began lobbying for greater energy efficiency and renewable energy sources, the public listened and followed their example.

Of course, in the early days of the climate crisis, relatively few doctors were carbon literate. The *BMJ* helped to change that by publishing helpful articles on low carbon living, explaining how doctors could measure their own carbon footprint and providing simple web based carbon emission calculators.

Professional organisations and medical societies also played a key part. Organisations like the Cochrane Collaboration stopped hosting international meetings, instead building regional networks and using information technologies such as mass videoconferencing to cut air travel. The conference, as a medium of continuing medical education, became obsolete. The research funding bodies carried out carbon audits on all publicly funded research projects and carbon intensive research was strongly discouraged. Medical journals printed details of the carbon dioxide emissions associated with all published research papers and groundbreaking research by the NHS R&D Methodology Programme led to the development of the low carbon clinical trial.

As carbon literacy became more widespread, the health benefits of a low carbon world became increasingly obvious. Doctors realised that personal carbon rationing was not only a mechanism for averting catastrophic climate change but also provided a policy context that promoted physical activity, created safer environments for children, and reduced socioeconomic inequality. Under carbon rationing, it was in everyone's interest to reduce carbon use, and so there was a strong incentive for healthy transport (walking and cycling) and a disincentive to use motorised vehicles. A virtuous circle was created of more active transport reducing road danger leading to more active travel.

Carbon rationing also began to reduce the gap between rich and poor, which had huge health benefits. In the early days of rationing, the more carbon profligate people, who were mostly rich, had to buy unused carbon rations from the more carbon thrifty, who were mostly poor. This was great for Africa, the world's most energy thrifty continent, which in those days was desperately poor. Health professionals soon began to explain to both patients and policy makers how carbon rationing was the foundation for improving public health in Britain and worldwide. But more important than this, by learning to speak carbon, health professionals played their part in saving the planet.



When doctors stopped flying, the public followed their example

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