see it as a means to improve communication with their clinicians."[5]

In short, these patients — and I — want more of the conversations that the ABIM set out to promote in 2012. But after 10 years, it's hard to see how Choosing Wisely in its current guise is ever going to get us closer to this goal. Given its limitations, the program is in danger of recapitulating the qualities of the low-value care it highlights, offering little benefit and possibly causing harm.

If Choosing Wisely is to continue, the specialty societies that have participated in it should celebrate its 10th anniversary by coming together to rethink and reinvent it. What have we learned in the decade since we embarked on this campaign? What are the measures available for assessing health care both superficially and more deeply, that can move us closer to our goals of stronger relationships, more conversation, and less low-value testing and overtreatment? We now have 10 years of research inspired by Choosing Wisely.[1] Should any of the strategies or methods we've tested be scaled up?

In this way, Choosing Wisely could make the transition from feel-good gesture and highly imperfect tool to catalyst for meaningful change in the postpandemic world. Though it's unlikely that low-value care can ever be extirpated completely from medicine, we can unquestionably do better. I'd love to live in a world in which this program is actually a part of that change. I'd love to live in a world in which my patients and I are truly choosing wisely.

An audio interview with Dr. Vikas Saini is available at NEJM.org

Disclosure forms provided by the author are available at NEJM.org.

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After COP26 — Putting Health and Equity at the Center of the Climate Movement

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Participation by the Department of Health and Human Services (HHS) in last fall's United Nations Climate Change Conference (COP26) represents an important milestone in the U.S. health sector's work to protect the health of U.S. residents amidst the climate crisis. By joining the COP26 Health Program, we made specific commitments to resilience in our communities and decarbonization in our health systems that signal a new era for our agencies, for federal health care providers, and for stakeholders throughout the health care industry.[1] Closely aligned with the Biden administration's goal of achieving a 50-to-52% national reduction in carbon emissions by 2030 and associated commitments to decarbonization in federal facilities and procurement, as well as the administration's focus on racial and social equity, these pledges demonstrate the urgency with which we are confronting the single greatest threat to global health in the 21st century.[2,3]

We are strongly encouraged by similar commitments from more than 50 other countries and a vanguard of U.S. private-sector organizations, including 19 large health systems.[4] The National Academy of Medicine's Action Collaborative on Decarbonizing the U.S. Health Sector, which we cochair, is also playing a crucial role in convening industry actors to jointly address health care's 8.5% contribution to overall U.S. carbon emissions.[5]

Yet for all the promise of these declarations, they are so far only aspirations. The question facing the health sector now is what it will take to turn these goals into reality. Given that we are seeking unprecedented change on an un-

precedented scale, the inescapable question is "How?"

Part of the answer, we believe, lies in HHS's new Office of Climate Change and Health Equity (OCCHE), created by executive order in January 2021 and launched on August 30, 2021. The OCCHE's mission is to protect the U.S. population from the grave health threats posed by climate change, and especially to protect the oppressed and vulnerable groups that already suffer disproportionately from these exposures and will continue to do so without concerted intervention. We intend to work toward a future in which communities and facilities thoroughly anticipate both the catastrophic and chronic health consequences of this crisis for the people at greatest risk, and in which all organizations that contribute to health care's carbon footprint — providers, payers, pharmaceutical suppliers, device makers, group-purchasing organizations, and others — publicly and energetically seek to reduce it. We will work through all components of HHS, federal health systems, and other departments across the U.S. government to support and coordinate this critical work.

Of course, government alone cannot make the massive changes required in the U.S. health sector. What is needed over the next year is the simultaneous mobilization of public and private organizations on multiple fronts. We can start with common aims for decarbonization and adaptation that prioritize the interests of vulnerable populations, and then provide a combination of supports and incentives that will ignite and bolster action. By attending to four policy areas, we seek to create a context that is highly conducive to the collaborative action required.

The first entails promulgating measures to support transparent reporting on progress toward aims such as reducing greenhouse-gas emissions, which should increasingly become a standard for organizations as they take on this work. Transparent reporting will help us identify "bright spots" and learn from variation, and it will hold us all to public account. The OCCHE will collaborate with relevant HHS agencies and external organizations to identify clear metrics for assessing greenhouse-gas emissions and resilience, with the goal of introducing them as measures of health system quality; we will also help develop measures for supply-chain emissions. In addition, we will help to identify straightforward strategies for data collection that do not place an undue burden on providers.

Second, we will focus on development of supports for learning and innovation. Many U.S. health systems are still familiarizing themselves with the basics of resilience and decarbonization. Improving at speed and at scale will require sharing of best practices among providers, suppliers, states, and countries. The U.S. health sector must efficiently collect new approaches from around the world, distill actionable lessons from each, and disseminate them rapidly. HHS has several existing learning networks (e.g., the Centers for Medicare and Medicaid Services' Quality Improvement Organizations [QIO] program and the Hospital Preparedness Program from the Office of the Assistant Secretary for Preparedness and Response [ASPR]), and we are actively exploring ways to introduce content on the health effects of climate change into such programs. We will also seek to increase flexibility within existing innovation and waiver programs so that care providers and communities can experiment with solutions (e.g., funding for cooling assistance for low-income households) that will reduce harm to vulnerable groups, and we will partner with federal research agencies to help expand the existing evidence base to guide the health sector's actions.

In addition, we are reviewing and improving the tools we use to raise awareness about the local health challenges presented by climate variability (e.g., floods, fires, heat waves), with particular attention to the communities that will be disproportionately affected by them. In collaboration with federal partners, our office is developing a bulletin that will provide timely information on upcoming health threats associated with climate change to support greater health system prepared-

What is needed over the next year is the simultaneous mobilization of public and private organizations on multiple fronts.

ness. We will also more effectively harvest insights from communities to inform the agencies that have the resources to enhance their resilience.

Third, once we clarify measures and identify evidence-based practices for reducing emissions and promoting sustainability, HHS will explore a variety of incentives, including payment, funding, and recognition, that can further fuel improvement throughout the sector.

And fourth, we aim to update relevant HHS regulations, which can help spread new standards of care delivery. We believe that several pertinent regulations, including those related to emergency readiness, would benefit from review and potential updating to ensure that they support health care facilities' work on sustainability and climate-change resilience. Any such revisions should also remove problematic guidance and unnecessary hindrances to the preparations health care systems need to make. Equally, medicines, procedures, and processes that are wasteful or contribute substantially to greenhouse-gas emissions should be subject to scrutiny and replacement if safe, effective alternatives exist.

We hope that such policies — and additional actions to be identified — will inspire the sector to address the health threats associated with climate change in an equitable, inclusive manner. In government health agencies, hospital boardrooms, and the executive offices of major insurers, manufacturers, and suppliers, leaders must fully understand the catastrophic human and financial costs of delayed action and lead the nation in addressing the crisis. They will have to collaborate with community leaders and local movements that know all too well the consequences of empty pledges.

Such bold and comprehensive action is hard to contemplate during a pandemic, when providers are already so stretched, but we have no other choice. The good news is that the Covid pandemic has strongly reinforced the interdependencies of all health sector actors, and we can build on its lessons in a variety of areas (e.g., procurement, telehealth, public education) in crafting our response.

In light of the momentum from COP26 and growing interest in the field, we feel cautiously optimistic about what the next year might bring. Our progress on climate change and its health effects has enormous ramifications for our country, our planet, and future generations, and there is no time to waste.

Disclosure forms provided by the authors are available at NEJM.org.

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The Wild West of Checkpoint Inhibitor Development

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Over the past 7 years, the Food and Drug Administration (FDA) has approved seven antibodies directed against the programmed death 1 (PD-1) or programmed death ligand (PD-L1) pathway and more than 85 oncology indications for this class of checkpoint inhibitor drugs. More than 2000 clinical trials are evaluating at least 33 anti–PD-1 or anti–PD-L1 antibodies.[1] Although these products have similar, if not identical, mechanisms of action, safety profiles, and clinical activity, no studies have directly compared them. And although the development of immunotherapy