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Deep Ecology and End-of-Life Care

Abstract

Physicians and nurses caring for terminally ill patients are expected to center their moral concerns almost exclusively on the needs and welfare of the dying patient and the patient's family. But what about the relationship of traditional medical ethics to the emerging new theories of environmental ethics, like deep ecology? As we glide into the twenty-first century, can anyone seriously doubt that the mounting global concerns of environmental ethics will eventually influence the ethics of medicine too?

For example, suppose physicians were to integrate the core values of an ecocentric environmental ethic like deep ecology into contemporary North American norms of healthcare for the dying. How would this shift affect the attitudes and treatment decisions of caregivers toward the terminally ill? Specifically, would the medical community's adoption of the deep ecology ethic help or hurt the interests of the dying and their families? [*excerpt*]

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Whoever wishes to pursue properly the science of medicine, must proceed thus. First he ought to consider what effects each season of the year can produce . . . The next point is the hot winds and the cold, especially those that are universal . . . He must consider the properties of the waters . . . The soil, too, whether bare and dry or wooded and watered . . . Through these considerations . . . [the physician] will have full knowledge of each particular case, will succeed best in securing health, and will achieve the greatest triumphs in the practice of his art.

—*Hippocrates, 5th Century B.C.*
Airs Waters Places

Introduction

Physicians and nurses caring for terminally ill patients are expected to center their moral concerns almost exclusively on the needs and welfare of the dying patient and the patient's family. But what about the relationship of traditional medical ethics to the emerging new theories of environmental ethics, like deep ecology? As we glide into the twenty-first century, can anyone seriously doubt that the mounting global concerns of environmental ethics will eventually influence the ethics of medicine too?

For example, suppose physicians were to integrate the core values of an ecocentric environmental ethic like deep ecology into contemporary North American norms of healthcare for the dying. How would this shift affect the attitudes and treatment decisions of caregivers toward the terminally ill? Specifically, would the medical community's adoption of the deep ecology ethic help or hurt the interests of the dying and their families?

In particular, suppose the dying patient were a partisan of the deep ecology philosophy of the Norwegian philosopher Arne Naess.¹ Would this dying patient then feel some added pressure to opt for voluntary active euthanasia? In fact, does deep ecology implicitly encourage the notion that the terminally ill should quit life early in order to conserve medical and other valuable resources in a world as over-populated by humans as ours? And would the adoption of a global environmental ethic such as deep ecology diminish or reinforce the autonomy of the dying patient?

In pursuing these issues, I am going to focus on conflicts between the scope of traditional anthropocentric medical ethics and global ecocentric environmental ethics. My thesis is that in its noble effort to upgrade the value of non-human animal and plant life and to redirect our moral attention to caring for the broader biotic community, deep ecology in effect downgrades the value of human individuals living now. This is particularly so for those who are aged, chronically sick, and terminally ill. To be sure, I will raise questions about what I call the tendency toward "environmental paternalism." I will argue that we should be cautious of importing global environmental ethical theories into our healthcare ethics precisely because these environmental theories, often with the best intentions, may undermine respect for individual human life.

My plan of inquiry is threefold. First, I will introduce the case study of Mildred Vanderwall, a terminally ill patient. This case will illustrate some possible moral stresses and conflicts experienced by patients newly diagnosed with Alzheimer's disease and flirting with suicide. Second, I will explicate and critically discuss some of the leading concepts and principles

associated with Naess's deep ecology program. I will suggest how this program, should it become influential in society, might affect the attitudes and medical choices of caregivers and terminally ill patients. Last, I will extrapolate from this case to explore some of the larger implications of the deep ecology ethic for healthcare ethics generally. Admittedly, it is bold to imagine that physicians or patients will become deep ecologists or environmental partisans any time soon. Even so, by exploring the cross currents of environmental ethics and healthcare ethics, this essay reveals some of the particulars of their uneasy marriage.

The Case of Mildred Vanderwall

Mildred Vanderwall, age 61, was recently diagnosed with Alzheimer's disease. She is in the early stages and may live for 8 to 10 years before Alzheimer's takes her life.

An accomplished symphony musician and a divorced mother of three adult children, Mildred's failing memory led her to resign her violinist position two months ago with the Cleveland Symphony Orchestra. She took early retirement, declining a European tour that was to have begun later in the year.

Just last month, Mildred was informed by her personal physician, Dr. Stanley Rosenbaum, of the inevitable course of Alzheimer's. She intends to live independently as long as she can. As her powers slip, she intends to move into a nursing care facility. She is frightened by the hopelessness of her diagnosis, a diagnosis currently shared by four million Americans nationwide. Yet she has vowed not to be a burden to her adult children. The thought of suicide has entered her head.

Mildred learns that there is no single test for Alzheimer's. She learns that it is diagnosed by ruling out all other likely diseases. She also learns that there is no cure, and that only one drug, Tacrine, is FDA-approved specifically for Alzheimer's. She discovers that Tacrine slows somewhat the onslaught of the debilitating symptoms. Mildred tries to comprehend that she will in time become a total stranger to herself—she

will experience a total loss of her core identity, her sense of being human in the world.

This unalterable fact depresses her. The option of suicide never completely fades even though she is being treated with the antidepressant Zoloft[®]. She is also currently in individual counseling biweekly with a geriatric psychotherapist.

Fundamentally, Mildred Vanderwall believes in God; she is a practicing Lutheran. Though she has flirted with thoughts of suicide, four months have now passed since Mildred received her Alzheimer's diagnosis. Following a personal visit by her pastor, Reverend Turner, she now feels opposed to both voluntary active euthanasia and physician-assisted suicide. She feels this would be for her a cowardly and sinful way out. (Her rejection of physician-assisted suicide also conforms to current Lutheran church doctrine.)

End-of-Life Decisions

In exploring some of the links between traditional medical ethics and environmental ethics, and with an eye toward anticipating some of the ethical implications of physician-assisted suicide for the terminally ill (an option recently reviewed and denied by the U.S. Supreme Court), I begin with three observations.

First, Mildred's opposition to voluntary active euthanasia for the terminally ill is defensible on moral if not also on religious grounds. I will offer a brief sketch of this defense shortly and at least show that it cannot be easily dismissed.

Second, stock environmental ethics concerns about the global impact of human overpopulation, or worries about depleting limited medical or other resources resulting from longterm care of Alzheimer's patients like Mildred, challenge but do not defeat moral resistance to voluntary active euthanasia.

Third, one of the primary benefits to discussions of medical ethics derived from environmental ethics is that the latter's broader, global concerns invite us to weigh more carefully several significant metaphysical questions that are seldom introduced by medical ethics investigations alone. These grand questions include:

- 1) Where does humanity fit into the general scheme of things?
- 2) What, if any, moral obligations to end their lives do the infirm or dying elderly owe to future, unborn generations?
- 3) What moral consideration do humans owe to nonhuman life, like hemlock trees, ante-lope, or chimpanzees with whom we share this planet?

A Metaphysical Mind-Shift

Arne Naess and his leading American disciples, Bill Devall and George Sessions, have sketched or hinted at tentative answers to these three questions. In an effort to explicate the core ideas of the deep ecology mindset, let us turn to their theses.

For example, in answer to (1), Where does humanity fit into the general scheme of things?, their *doctrine of biocentric equality* asserts that humanity is not privileged: people are only a part of nature.² Humanity has no greater or lesser inherent value as a life form than any other living thing.³

In answer to (2), What, if any, moral obligations to end their lives do the infirm or dying elderly owe to future, unborn generations?, the deep ecology view suggests that the infirm elderly and dying may owe to future generations of humans (and other nonhuman life forms too) the moral duty not to linger when the quality of their lives is profoundly reduced by the ravages of disease. Why? Because to prolong human life when that life is not capable any longer of reaching its species-defined potential—due to disease or decrepitude—contradicts the deep ecology ideal of the mature “ecological self,” a self that all must strive to attain. As Devall and Sessions clarify, in deep ecology “the sense of self requires a further maturity and growth, an identification which goes beyond humanity to include the nonhuman world” and our impact as humans on that world.⁴

That is, one must think beyond one’s own self-interests in the present to the needs of nonhumans and other life forms and what is best for the posterity of the earth in the long run. This consti-

tutes a radical new vantage point from which to experience oneself in relation to other beings and to nature. If adopted by healthcare professionals, this perspective also implies that those nurturing the dying need to rethink whether their support and resources might be better spent nurturing the larger, equally valuable biotic community. No doubt to some this sort of question smacks of inhumane, environmental hubris. But to others it marks a long overdue correction in the resetting of global healthcare priorities. For example, is it not much more fiscally and environmentally prudent to encourage physician-assisted suicide for the dying rather than to encourage the dying to hang on in their usual misery or reduced quality of life?

For reasons to be explored below, I personally remain skeptical of the therapeutic implications of deep ecology for the humane practice of medicine.

Finally, in answer to (3), What moral considerations do humans owe to non-human life?, it follows from Naess’s deep ecology framework that the moral duties that humans owe to nonhumans may at times be equivalent in moral force to those duties that humans customarily owe only to each other. To elaborate:

Biocentric equality is intimately related to all-inclusive *self-realization* in the sense that if we harm the rest of Nature then we are harming ourselves. There are no boundaries and everything is interrelated. But insofar as we perceive things as individual organisms or entities, the insight draws us to respect all human and non-human individuals in their own right as parts of the whole without feeling the need to set up hierarchies of species with humans on top.⁵

To further summarize, Naess’s deep ecology “eco-sophy” (as he dubs it) declares that human communities will live in cooperation with nature provided that at least two conditions are met: (1) each person’s self-identification with nature is regularly practiced as a set of personal habits; and (2) the biocentric equality of all living things is accepted as a moral starting point.

Again, self-realization means that each individual's spiritual growth must transcend the isolated, competitive human ego, maturing to experience the oneness and harmony of the entire biotic community. Relatedly, biocentric egalitarianism means that all living things, including humans, plants, animals, and even rivers, mountains, and ecosystems, are of equal moral worth, of equal intrinsic value. The revolutionary ethical credo is that humans are not above or outside of nature. Nor should humans continue to view themselves in such a pre-Darwinian, ignorant way.

Moreover, no account of the deep ecology philosophy would be complete without mention of Naess's formula for right living:

"Rich life, simple means."

In a 1995 essay Naess states that this aphorism "suggests for medical bioethics a strengthening of preventive medicine, and a reduced reliance on technologically advanced treatments—especially if they require large investments of resources and energy." He concludes, "Medical bioethics can learn from ecological bioethics the need for a moral vision that can reorder its priorities."⁶

Respect for Human Life

Let us return to the case of Mildred Vanderwall. We recall her eventual opposition to voluntary active euthanasia, especially following her discussion with her pastor. At least two sturdy arguments can be marshaled in support of Mildred's rejection of voluntary active euthanasia. The first is the secular respect for human life argument. The second is the theological sanctity of human life argument. Although Mildred adheres to the theological version especially, each has deep roots in our Western ethical heritage.

The secular version of the respect for human life argument says that human life has moral worth in and of itself. Why? Precisely because human life is the highest known form of life. Furthermore, human life is asserted to have a basic dignity, intelligence, and autonomy setting it apart from all other creatures. Therefore, to willfully destroy human life—except possi-

bly in self-defense or to prevent an even greater evil—is wrong. But voluntary active euthanasia willfully destroys a human life. Therefore, it is wrong. On this particular argument, the act of killing a person is not wrong because it produces a social disutility like, say, removing a gainfully employed citizen from the tax rolls. Rather, it is wrong because human life is inherently valuable, irrespective of what people can or cannot contribute to their society.

What about the theological sanctity of human life argument, which also condemns voluntary active euthanasia? A standard version of this argument arises from the notion that human life is a gift from God. For example, Aquinas writes, "it belongs to God alone to pronounce sentence of death or life...⁷ We are, in effect, trustees of this unique life. According to this argument, then, human life is a divine-like, special gift. Therefore, to willfully end one's own life via active euthanasia offends God. Indeed, such human ingratitude is morally repugnant and sinful. It falls far short of God's moral law as expressed in the Old and New Testaments.

Of course, some philosophers would dismiss this and similar theological arguments. For one thing, they demand a compelling proof for the existence of a purposive, caring God of the sort this argument requires. However, it deserves repeating that this is a theological argument, not a philosophical one. Hence, as Tom Beauchamp has pointed out, *if* theology provides reasons that are valid *independently* of philosophy, as a variety of religious traditions have insisted (for example, revealed truths, miracles, prophecies, etc.), then philosophical objections to such arguments are far from fatal.⁸ For this reason, Mildred Vanderwall's religious objections to voluntary active euthanasia cannot be discounted. She has a fair point if one grants that there may indeed exist theological, revealed truths in our universe.

Yet how different these two arguments look—the secular respect for human life argument and the theological sanctity of human life argument—when weighed against the implied force of Naess's deep ecology program. As I will show, deep ecology tends to undermine these arguments.

Take, for example, two related claims. The first claim is that long-term care of doomed Alzheimer's patients is morally questionable because it squanders valuable and limited medical and other resources. These resources could be more usefully pressed into the service of the biotic community elsewhere. For example, according to one study, Mildred and her family will incur individual expenses exceeding \$213,000 during the usual 4 years between diagnosis and death from Alzheimer's.

The second claim is that long-term care of doomed Alzheimer's patients is morally questionable because in the wake of global human overpopulation, the dying aged are too great a burden on the entire ecosystem—fellow humans, other living things, the whole planet.

So on this account not only is there nothing wrong morally with voluntary active euthanasia for those who are terminally ill, should a patient like Mildred elect it. What's more, there may be a *prima facie* duty to quit life in such terminally ill circumstances based on global environmental considerations such as air, land, and water pollution; deforestation; ozone depletion; global warming; loss of biodiversity. That is, most of this environmental destruction and biological impoverishment identifies the swelling human population as a major cause of these ecological ills.

To be sure, the balancing and regulation of human populations, human goods and services, and their global impact ultimately involve questions of individual human worth and distributive justice. For example, should we redistribute our healthcare resources away from those who are hopelessly ill and toward those who are healthy, those who are recovering, and the young?

Deep Ecology and Healthcare Ethics

To briefly explore the force of this last query, consider that deep ecologists (as opposed to shallow, strictly human-centered ecologists, in Naess's language) assert that our dominant Western world view is responsible for much of the world's current environmental degradation. Therefore, we need an alternative world view to the flawed

Judeo-Christian or capitalist-dominated perspective held by most medical practitioners in the richer, first world nations. Part of the alternative world view of deep ecology is borrowed from Eastern philosophies like Hinduism, Buddhism, and Taoism.⁹ These are oriental religious traditions that tend to see humans as fully integrated into nature rather than dominating nature (as in the typically Western schema). Another part of deep ecology's alternative world view is taken from the pages of evolutionary biology and scientific ecology: namely, the notion that all life forms function as an interdependent holistic web, no part of which is completely isolated from any other.

In this section, I shall show how deep ecology's alternative world view, coupled with a pair of its central platform principles, pushes terminally ill patients in the direction of physician-assisted suicide.

Naess and Sessions have articulated a platform of eight "eco-philosophical" principles as both a summary and a decidedly pacifistic call to arms. These eight principles are designed to provide a core platform around which the eclectic deep ecology movement can be deployed worldwide by local and regional activists, who sometimes call themselves "eco-warriors."¹⁰ With an eye to the moral endorsement or condemnation of voluntary active euthanasia for Alzheimer's or other terminal patients, only two of these eight principles will be investigated here:

4. The flourishing of human life and cultures is compatible with a *substantial decrease* of the human population. The flourishing of non-human life requires such a decrease. [population reduction principle]
7. The ideological change [needed] is mainly that of appreciating life quality . . . rather than [humans] adhering to a high standard of living. . . . [life quality principle]¹¹

These two crucial social policy norms associated with the deep ecology program together have often-overlooked implications for the humane practice of medicine.

How do Naess and Sessions defend the population reduction principle? Their starting point is that high human population growth rates in many developing countries will ultimately diminish the quality of life for millions of people across the globe.

Like many areas of debate in environmental law and public policy, these two principles are easily adapted to consequentialist (or results-based) reasoning. For example, the *population reduction principle* tacitly alludes to the fact that in less than 60 years our human population is projected to almost double, going from 6.3 billion today to perhaps over 10 billion by the year 2050.

What's more, the related *life quality principle* almost certainly invites a consequentialist argument favoring a prima facie duty for the terminally ill to seek a form of voluntary active euthanasia. Again, this life quality principle asserts that the quality of human life must be our chief moral concern, not the mere quantity. In addition, this principle is compatible with a cost-benefit perspective according to which prolonging a nonproductive human life unjustly drains limited medical and other resources.²⁴ This last claim may be asserted even though, ironically, the whole notion of what a life worth living is defies any precise definition by strictly quantitative methods of assessment.

We are now ready to uncover the more opaque implications of the deep ecology framework. I suggest that, overall, unanswered momentous questions and conflicting moral duties abound.

Deep Ecology and Patient Care

Broadly construed, how would the deep ecology philosophy of Arne Naess, George Sessions, and William Devall reshape Western medicine? Specifically, how would this philosophy challenge the time-tested quartet of bioethical principles: autonomy, beneficence, justice, and nonmaleficence?²⁵ Would patients and their caregivers be better or worse off were the deep ecology paradigm shift to go through?

Autonomy

Take the concept of patient *autonomy*. This notion requires that the competent patient be understood as a self-determining agent of his or her own aims, goals, or destiny. In my view, under the influence of deep ecology this concept would now be regularly overridden by what I have dubbed *ecological paternalism*. By ecological paternalism, I mean that the proposed actions of an individual or group may be overridden by an informed judgment of the long-term negative consequences likely to result from these proposed actions on the local, regional, or global environment.

Incidentally, who would be licensed to make this patient care judgment? Perhaps a specially trained and duly appointed, environmentally sensitive hospital committee of some sort. Or alternatively, a deep ecology healthcare expert—that is, someone highly educated in the nuances of holistic environmental philosophy and medicine. Or someone who would competently and compassionately monitor a hospital's global environmental interests within the patient care matrix of curing and caring? In any case, such critically important questions about the chain of command and scope of medical decision-making are studiously ignored by the proponents of deep ecology. This is most peculiar, for the individual patient and his or her medical team would certainly be required to yield to the directives of a higher moral authority associated with the utopian thinking of these deep ecology visionaries.

To illustrate, take the case of George, a lung cancer patient who wishes to amuse himself in the last 6 months of his life by taking his favorite chain saw and cutting down a dozen old-growth hemlock trees situated on 10 acres of land he owns in Pine Grove, Pennsylvania. Neither George nor anyone else would be using these cut trees. Nor does George intend them to be used. His aim is simply to engage in some exercise and sheer fun by cutting down these hemlocks that he owns. Because no "vital needs" of George would be served (to employ Naess's and Sessions's

vague phrase), and because the trees are of equal worth due to the principle of biocentric equality, George's joyful chainsawing must be overruled and condemned as morally wrong.¹⁴ Typical of the deep ecology gestalt, the environment and specifically the old-growth hemlocks are in this scenario a more important consideration than the individual's psychological and physical wants. This, even though the satisfaction of these wants may be completely legal and—on a traditional anthropocentric ethical yardstick—morally unobjectionable.

Beneficence

Beneficence, the notion that the physician must try to practice good deeds primarily for the sake of his patient's health and welfare, will need to be modified by deep ecology, too. How so? Because its moral scope of concern will now be expanded to include not just the patient but the entire surrounding biosphere within which the patient lives, works, and plays. So beneficence is, in effect, redefined to mean *biospherical beneficence*.

But what does this mean? Consider Jake, another terminally ill, competent patient. Jake has colorectal cancer. He refuses to quit smoking because at age 80 he still really likes "his smokes," as he affectionately calls them. Legally blind and growing weaker in the last two months of his life, smoking is one of life's few remaining pleasures. But the deep ecologist attending physician would overrule Jake's autonomous desire to continue smoking in the last weeks of his life. He would also overrule the hospice nurses who wink at Jake's smoking. This despite the fact that their own sense of beneficence toward this particular patient's psychological needs is for them the morally decisive factor here. The nurses are required to confiscate Jake's cigarettes, which displeases him greatly and conflicts his caregivers.

It will no longer wash to say, beneficently and with an eye also to preserving Jake's sense of autonomy, "let the old gentleman smoke." Why confiscate the cigarettes? Because secondhand smoke is polluting too many living things—not to mention the unhealthy physical effects on Jake's

lungs and heart. Also, the carbon monoxide and other harsh pollutants in secondhand smoke are in the aggregate threatening to deplete the ozone layer. They contribute, also, to acid rain.

So the old anthropocentric healthcare ethic is adjusted to ask, What is good for the patient's immediate environment, his household, his surrounding community, and the entire biosphere?

These global considerations would easily override Jake's option to smoke, and that of all similarly situated patients.

Justice

Then there is the thorny concept of *justice*. By *justice*, in this context, I mean primarily the duty to render each person what is his or her due. In healthcare settings, the concept of justice presents a variety of rich applications and extensions. For example, allocating transplantable organs or other scarce medical resources in some fair manner of distribution, or ensuring that every citizen has adequate access to medical care. So how does the deep ecology program redirect our concern about justice, especially distributive justice? In my opinion, it does so in at least two ways.

First, deep ecology increases our sensitivity about what constitutes a just response to the needs of nonhuman animals or plants. As we saw in the case of George, we should not encourage a terminally ill patient to amuse himself by cutting down old-growth trees even on his own property. This is so not simply because such conduct is wasteful of trees. That would be a mere instrumental reason; it still ignores the alleged inherent worth of the trees as valuable beings in and of themselves. What's more, following from deep ecology's twin principles of *self-realization* and *biocentric equality*, this conduct is blameworthy because it is unjust both to the trees and to the patient's own sense of his discerning "ecological self," to use Naess's mysterious metaphysical language.

Second, deep ecology increases the sensitivity of the first world peoples living in the Northern, developed nations to the often unhealthy living conditions of the people in the Southern,

developing nations. For example, consider that 99% of all infectious diseases occur in the developing nations.¹⁵ Also, in these same countries, 80% of all diseases are caused by consuming water contaminated with pathogens or pollution.¹⁶ The point is that since deep ecology's eight platform principles also declare (in principle 1) that "the well-being and flourishing of human and nonhuman life on earth have value in themselves," and that "these values are independent of the usefulness of the nonhuman world to human purposes," our concept of justice must widen dramatically.¹⁷ It must now include not only what is due to each citizen living in his or her own society. It must also include what is due to all humans living anywhere on the planet. So what is due to starving Ethiopians or malnourished Haitian children becomes as pressing a question morally as what is due to the endangered elephant or bald eagle.

Nonmaleficence

Lastly, there is the keystone value of healthcare ethics, *nonmaleficence*. "[H]elp or at least do no harm," the Hippocratic physician implored over 2,000 years ago.¹⁸ This is still sound advice in the age of high technology medicine. Moreover, this specific imperative of nonmaleficence (or non-injury) is no less crucial for palliative care of the terminally ill than it is for acute care patients awaiting, say, a kidney transplant. What, then, is the likely reframing of this notion of nonmaleficence if we imagine a paradigm shift in contemporary medicine toward an ecocentrically oriented deep ecology?

Quite simply, it is this: we must broaden our moral commitment of nonmaleficence, parallel to our broadened moral commitment of beneficence, in order to include the entire planet within the scope of our moral concern. It is imperative that we avoid injuring members of the human community in the practice of medicine, to be sure. Yet the deep ecology gestalt further asserts that all members of the biotic community, including nonhuman animals, plants, and even natural elements, deserve some moral consid-

eration from every caregiver too. Unfortunately, such a sweeping scope of moral concern for the *prima facie* duty of nonmaleficence is highly impracticable.

To take but one example, deep ecology would in one stroke condemn almost all animal experimentation now crucially facilitating much of biomedicine's search for cures to a variety of insidious human diseases. To deep ecologists, this animal research is morally questionable: it causes physical and psychological injury to innocent creatures. Most are killed. In fact, virtually all such research animals are sacrificed in the caged wheels of biomedical progress (an estimated 17 to 22 million animals annually in the United States alone).¹⁹

Deep Ecology and Euthanasia

I conjectured that Naess's deep ecology program would endorse active voluntary euthanasia for any terminally ill patient who is competent, hurting, and agreeable to a somewhat earlier than usual exit from the ravages of his or her disease. I argued further that this endorsement follows from Naess's population reduction principle and life quality principle. It also follows from Naess's belief that the human population must be significantly reduced in order to bring into healthier balance all life forms with which *Homo sapiens* share this planet.

What, then, about involuntary euthanasia? Could Naess consistently endorse this draconian measure? He could not, for at least two reasons. First, Naess is on record as opposing the practices of Nazi medicine and Nazi culture. He states, "As deep ecologists, we take a natural delight in diversity as long as it does not include crude, intrusive forms like Nazi culture, that are destructive to others."²⁰ Second, he opposes despotic measures of any sort, especially those crushing to life. He writes, "For deep ecology, there is a core democracy in the biosphere . . . We have the goal not only of stabilizing human population but also of reducing it to a sustainable minimum without revolution or dictatorship."²¹

It comes as little surprise, therefore, that following from these persistent concerns about human overpopulation, the deep ecologists are forced by their principles to endorse the practice of passive voluntary euthanasia for the terminally ill as morally acceptable. Why? Because by declining to use the often high tech, costly rescue procedures involved in prolonging or sustaining the lives of those who are critically ill, aged, or dying, the ecologically mature medical community prudently signals to all persons the importance of conforming to the deep ecology credo, “rich life, simple means.” In so doing, it is hoped that each person will live into old age for as long as nature, and the ecologically sensitive application of biomedicine, warrant. Ideally, each person will flourish at any stage along life’s continuum. This will be accomplished by obtaining, when required, lower tech medical intervention; the discipline of a balanced diet (preferably vegetarian); the norms of preventive medicine; and the personal habits of regular exercise and sound hygiene—until that critical point in the life span of each individual is reached when to further coax life along one would have to resort to possibly futile, often painful, and usually expensive medical therapies.

Conclusion

I conclude with this caveat: theories of environmental ethics cannot and should not be ignored by biomedicine. Doubtless there is much to learn from these global calculations. But practically speaking, the jury remains out on the worth of the deep ecology program, and on an array of other ecocentric theories, for the humane practice of medicine. For when an environmental theory pressures the terminally ill to quit life in favor of the global claims of ecological paternalism, then the dignity, autonomy, and inherent value of that dying patient’s life are diminished. As the earlier case of Mildred Vanderwall showed, a person’s higher sense of duty to the individual worth of each human being, or to God, cannot be dismissed.

Moreover, as we saw, mere appeals to ecologically paternalistic concerns—such as the alleged

negative impact of human overpopulation, or the alleged misallocation of scarce medical resources—that lead to judgments affecting how we care for those who are aged, frail, and dying, *do not* automatically trump either the secular or theological variants of the respect for human life principle. This principle has animated much of the caring tradition in the Western healing arts since the time of Hippocrates. Indeed, to yield that precious ground to any of the environmental philosophers today would amount to increasingly experiencing the patient as a mere means to some fanciful ecological Utopia. Again, if the dying patient is construed as a mere means, that patient is dispensable.

Precisely because the deep ecology program threatens to ignore patient autonomy in favor of environmental paternalism, and precisely because it tacitly cheapens the value of individual human life, deep ecology sows the seeds of a potentially misanthropic program of medical care. Therefore, it ought to be resisted.

Notes

1. Naess, A. “The Shallow and the Deep, Long-Range Ecology Movements: A Summary.” *Inquiry* 16 (1973): 95–100. Naess, A. *Ecology, Community, and Lifestyles*. Edited and translated by D. Rothenberg. Cambridge: Cambridge University Press, 1989. Devall, B. and G. Sessions. *Deep Ecology: Living as if Nature Mattered*. Salt Lake City, UT: Peregrine Smith Books, 1985. Sessions, G. “Deep Ecology as World View.” In *World Views and Ecology* Edited by M.E. Tucker and J.A. Grim, 207–27. Lewisburg, PA: Bucknell University Press, 1993.
2. See note 1, Devall, *Sessions* 1985:65–73.
3. See note 1, Devall, *Sessions* 1985:71. The authors state, “The refusal to acknowledge that some life forms have greater or lesser intrinsic value than others . . . runs counter to the formulations of some ecological philosophers and New Age writers.” (Emphasis added).
4. See note 1, Devall, *Sessions* 1985:67.
5. See note 1, Devall, *Sessions* 1985:68.

6. Naess A. "Deep ecology." In *Encyclopedia of Bioethics*, rev. ed., edited by W.T. Reich, 687–88. New York: Macmillan, 1995, at p. 688.
7. Aquinas, T. *Summa Theologica* II-II, Q. 64, Art.5. For a critique of Aquinas' argument, see Beauchamp, T. "Suicide." In *Matters of Life and Death: New Introductory Essays in Moral Philosophy*, 3rd ed., edited by T. Regan, 69–120. New York: McGraw Hill, 1993. See also in that same volume: Singer, P. "Animals and the Value of Life." Ch. 8, 280–321; Callicott, JB. "The Search for an Environmental Ethic." Ch. 9, 322–82.
8. See note 7, Beauchamp 1993:86.
9. Seed, J.J. Macy, P. Fleming, and A. Naess. *Thinking Like a Mountain: Towards a Council of All Beings*. Philadelphia: New Society Publishers, 1988, 19–30. Reprinted in *Environmental Ethics and Policy Book: Philosophy, Ecology, Economics*, edited by D. VanDeVeer and C. Pierce, 222–6. Belmont, CA: Wadsworth Publishing, 1994.
10. See note 9, VanDeVeer, Pierce 1994:238–46. Environmental activists associated with the worldwide "ecology movement" hold diverse environmental philosophies. For a concise overview, see note 7, Callicott 1993. See also Desjardin, J. *Environmental Ethics*. Belmont, CA: Wadsworth Publishing, 1993, 211–63. Desjardin's discussion of distinctions between deep ecology, social ecology, and ecofeminism are particularly instructive at pp. 236–39. See also note 1, Devall, Sessions 1985:17–39.
11. See note 1, Devall, Sessions 1985:70; Naess 1989:Ch. 1.
12. Naess does not explicitly endorse a cost-benefit analysis approach. His philosophy is eclectic and pluralistic, having more in common with the ethics of Gandhi and Kant than with the utilitarians Bentham and Mill. However, no philosopher can regulate how his philosophy will be interpreted, adapted, or even misused by others. In weighing the social as well as the strictly logical implications of deep ecology for healthcare ethics at the end-of-life, it is fair to speculate on even unintended outcomes.
13. Beauchamp, T. and J. F. Childress. *Principles of Biomedical Ethics*. 4th ed. New York: Oxford University Press, 1994, 120–394.
14. Devall, B., and G. Sessions. *Deep Ecology: Living as If Nature Mattered*. Salt Lake City, UT: Peregrine Smith Books, 1985, 71. See also Naess, A. *Ecology, Community, and Lifestyle*. Edited and translated by D. Rothenberg. Cambridge: Cambridge University Press, 1989. Naess and Sessions admit: "The term 'vital need' is left deliberately vague to allow for considerable latitude in judgment" (p. 71). In my view, their failure to operationalize or at least provide necessary conditions for this concept, is the Achilles' heel of their account. Distinguishing in detail between "needs," "wants," and "relative needs," is also largely ignored.
15. Brown, I. R., D. Flavin, and H. Kane. *Vital Signs 1966: The Trends That Are Shaping Our Future*. New York: W. W. Norton, 1996, 130–1.
16. See note 15, Brown, Flavin, Kane 1996, 130–1.
17. See note 14, Devall, Sessions 1985:70 emphasis.
18. Carrick, P. *Medical Ethics in Antiquity: Philosophical Perspective on Abortion and Euthanasia*. Boston: Kluwer Academic Publishers, 1985, 156–8.
19. Office of Technology Assessment. *Alternatives to Animal Use in Research, Testing, and Education*. Washington, DC: U.S. Government Printing Office, 1986.
20. See note 14, Devall, Sessions 1985:75–6.
21. See note 14, Devall, Sessions 1985:75–6.