

Euthanasia among the Idu Mishmis of Arunachal Pradesh: Understanding Issues and Concerns of a Frontier Tribe

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Abstract: In the present paper, the authors bring an account of the historical and cultural aspects of euthanasia as existed among the Idu Mishmi tribe of Arunachal Pradesh. It addresses the practical issue of management in which the family members of the victim had to make difficult decisions when faced with a person expressing a wish to die. Focusing on case studies on different forms of euthanasia the paper has tried to understand how, when and why an Idu Mishmi desire for such distinct form of dying. An attempt has also been made to extract how the attitudes toward such practice have varied over time and space. Perhaps, in the entire northeast India, the Idu Mishmis are the only tribal group which practiced euthanasia in its own uniquely rudimentary form much before it came to be known to the modern world.

Key words : Euthanasia, Misi-muh, Idu Mishmi

Derived from the Greek terms *eu* meaning good, and *thanos* meaning death, euthanasia is the act of bringing death to another person in a relatively painless way for reasons of mercy. It is generally defined as the intentional killing by act or by omission of a dependent human being for removing his or her suffering (Prabhu, et. al 2013). According to the dictionary euthanasia means, 'a gentle and easy death', but it is now used to refer to the killing of those who are incurably ill and in great pain or distress, for the sake of those killed, and in order to spare them further suffering or distress (Singer, 1993:175). Euthanasia has historically been a common practice in many societies, it remains one of the most controversial topics today (Polacek, 2013). It came to be used in the last decade of the 20th century to mean a death that is perpetrated or accelerated with the help of medicine. The practice has drawn increased attention and discussion in recent decades as a result of advances in medicine and technology and a growing interest in human rights (Kyriaki, et.al. 2005:96).

The definition of euthanasia as well as the interpretation of the terms like "good death", "dying with dignity", "physician assisted suicide", etc has been scrutinized ethically and critically and still has remained one of the biggest controversies of this decade (Bamgbose, 2004). For example, defining euthanasia as good death is not adequate because to die a natural death after spending many years on earth is equally conceived by many cultures as good death. Thus, the word euthanasia is ambiguous and better not to be defined but described. Such definitions, at the same time, are also not adequate because they often exclude the forms of euthanasia such as voluntary, involuntary and non-voluntary euthanasia.

Attempts have been made by many to classify euthanasia on the basis of the consent and on the basis of the action. On the basis of consent, that is, whether the patient is consenting or capable of consenting to death, we can differentiate euthanasia into three types – voluntary, non-voluntary and involuntary euthanasia. Voluntary euthanasia is when the person themselves feels their life is not worth living and thus request by the sufferer for euthanasia. Involuntary euthanasia is that when the competent person is not consulted and is against the will of the patient. Non voluntary is that when the person is not competent to decide for themselves, for example, the person is demented. According to the way the euthanasia is practiced, it is further classified into active and passive euthanasia. Active euthanasia entails the use of lethal substances or forces to kill a person, e.g. a lethal injection given to a person with terminal cancer who is in terrible agony. Passive euthanasia entails withholding of medical treatment for continuance of life, e.g. withholding of antibiotics where without giving it a patient is likely to die, or removing the heart, lung machine, from a patient in coma (Prabhu and Kalita, 2013:47-48). However, passive euthanasia is no longer used as an expression especially in the dutch standard definition of euthanasia, because it is not considered euthanasia. What is required is the intention to end life. Cases in which there is no patient's request are also not considered to be euthanasia (Haves, 2001: 507).

Over the years, euthanasia has been a subject of much debate. The topic holds interest for a large number of stakeholders including physicians, anesthetists, surgeons, nursing personnel, ancillary healthcare staff, legal experts, theologians, journalists, community leaders and public at large, apart from psychiatrists (Punnoose and Sarkar, 2014). It is also argued on the ground that every human being has a right to life, and a number of international human rights instruments assert this right to life. For example, the Universal Declaration on Human Rights (1948), the United Nations Charter (1945), European Convention for the Protection of Human Rights and Fundamental Freedom (1950), American Convention on Human Rights (1969) and the African Charter on Human and Peoples Rights (1981) are some of the instruments which explicitly and implicitly prohibit the unlawful taking of life. As a general principle of law, they stand for the protection of life (Bamgbose, 2004). Therefore, it seems that the debate on euthanasia from multidimensional perspective will continue to grow and for now it is certainly a difficult task to draw a general consensus for and against the act of euthanasia. Also a considerable number of studies concerning physicians' attitudes and practices regarding euthanasia and physician- assisted suicide have been carried out across the world. Since almost none of these studies have a common design, international comparison of factual findings is problematic. There can be little doubt that much of the trouble is due to inappropriate and too vague definitions of euthanasia and physician assisted suicide in many studies (Materstvedt and Kaasa, 2002).

Globally, countries like Netherlands became the first country in Europe to legalize euthanasia. Nevertheless, this was not legalised without strict conditions guiding it. It was followed by Belgian in 2002. In 1997 Oregon became the first state in the United States to decriminalize physician-assisted suicide.

Until recent, attempt to commit suicide under the Indian Penal Code (IPC) 309 was a criminal offence and was punishable by imprisonment or fine. However, in its recent decision, the Government of India has decided to repeal the said section noting that attempt to suicide may be regarded more as a manifestation of a diseased condition of mind, deserving treatment and care rather than punishment (The Times of India, dated 10th Dec' 2014 issue). On the other hand, under the current Indian laws, euthanasia amounts to homicide by the physician and suicide by the patient. However, there are many who support for the legalization of euthanasia. For instance, recently, a constitution bench of 5 Justices of the Supreme Court of India has issued a notice to states and union territories suggesting for a country wide debate on the matter of passive euthanasia. This was in response to a plea by Common Cause, a non-governmental organization which called for allowing voluntary withdrawal of life support for persons with terminal diseases (Punnoose and Sarkar, 2014). Following this notice, in the Arunachal Pradesh State Legislative Assembly, the issue was raised by some legislature for a debate but it was not accepted by the State Government considering euthanasia as a century old issue (The Arunachal Times, dated 30th July, 2014 issue). Another example is of Aruna Shaunbaug versus King Edward Memorial hospital case in the Supreme Court of India in March 2011 (Prabhu and Kalita, 2013). Many bills proposing this action have been introduced in the Indian Parliament, but these have not been accepted. It must be admitted that passive euthanasia is being practised in India without it being legalized (Verma et al., 1999: 28).

It is against such backdrops that the present paper seeks to look at the prevalence of the practice of euthanasia among the Idu Mishmi tribe of Arunachal Pradesh – one of the eighth Northeastern states of the Indian Federation. The authors bring an account of the historical and cultural aspects of euthanasia as existed among the Idu Mishmi⁹ tribe of Arunachal Pradesh until recently. It addresses the practical issue of management in which the family members of the victim had to make difficult decisions when faced with a person expressing a wish to die. Focusing on the case study of different form of live burial, the paper has tried to understand how, when and why an Idu Mishmi desires for such distinct form of dying. The paper has also tried to extract how the attitudes toward these practices have varied over time and space. This will also reflect broader social system, people's attitude towards death. Perhaps, in the entire northeast India, the Idu Mishmis are the only tribal group which practiced euthanasia in its own uniquely rudimentary form much before it came to be known to the modern world.

LOCATING THE TRIBE

The Mishmi tribe of Arunachal is divided into three sub groups: Taraon Mishmi, Kaman Mishmi, and Idu Mishmi.¹ Out of these, the Idu Mishmis are chiefly located in Lower Dibang Valley, Dibang Valley and Lohit Districts of Arunachal Pradesh, some of them also inhabit East and Upper Siang Districts of the state.” Culturally speaking, Idus are quiet distinct from rest of the two Mishmi sub groups which is reflected in various aspects of their day to day life and social structure as well as value systems. However, their dialect has very close affinity with that of the Taraon Mishmi. Idu Mishmis are popularly known as the Chulikata Mishmis because of their distinct hair style. It is widely believed that this nomenclature was bestowed upon them by the people from the plains with whom Idus have traditionally shared trade relations (Bhattacharjee 1983:13).

The practice of euthanasia (*Misi-muh* in the local parlance) among the Idus is widely recalled and recounted by them. In sharp contrast to the modern-day practice which is couched in medical and legal lingo, euthanasia enjoyed social sanction amongst the Mishmis on entirely practical considerations. In one such widely reported case, a certain *Pwiti Mepo* of *Engalin* village volunteered to be put to death. Sick of his illness, he requested his son and other family members to do the needful. A small stone house (*Ju*) was constructed with no ventilation which acted as a death chamber. After performing the necessary self-funeral rites and rituals, *Mepo* walked into the stone house and eventually died of suffocation.² The occurrence of the same incident is also noted in Baruah’s study. Baruah locates the above incident in Ahui Valley in 1948 wherein *Pietyi Mepo* had volunteered for an end to his life. Before embracing death, Baruah mentions, *Mepo* had summoned all his close relatives over a feast as per the custom in order to see them all for one last time. Soon after the relatives left, *Mepo* entered into the stone structure, erected for the purpose of causing his death, never to walk out of it (Baruah, 1960:57).

Baruah also records four other unrelated cases of infanticides in his study. However, these incidents were largely related to adultery among the Idu Mishmi. As he observes, “adultery is viewed with great abhorrence and a woman is severely punished for it. It is considered dishonour for a girl to have an illegitimate child. So to avoid social castigation and disgrace, the child is put to death immediately after it is born. Of the four infanticide cases in the last twelve years, about which I have detailed information, one child was strangled, one buried alive, the third was abandoned in the jungle, and the fourth child was killed with drugs in the womb” (Baruah, 1960: 64). Although Baruah puts all the four cases under the blanket category of infanticide, the nature of each specific act could be seen as very different from the others, leading to very different outcomes. While the first case represents the classic case of murder, the second and third incidents characterize the act of involuntary euthanasia wherein the infants were buried and abandoned alive obviously without their

consent. The issue of obtaining prior consent was simply out of question given the age of the victims. The fourth case, however, was a typical example of abortion.

Prevalence of euthanasia among the *Idu Mishmis* has also been documented by other scholars. Bhattacharjee, for example, records the practice of burying a person alive in extreme cases of sufferings from incurable diseases. However, this would happen only after exhausting all possibilities of curing the diseased person by the Shaman (*Igu*). The final step would precede all the rituals of offering supper and drinks before accompanying the concerned person to the grave (Bhattacharjee, 1983:138).

All the three dominant types of euthanasia i.e. voluntary, non-voluntary and involuntary were found to be prevalent amongst the *Idu Mishmis*. Voluntary type include cases in which the concerned person invariably suffered from certain incurable diseases (at least in those days) like leprosy (*chede*),³ cancer (*wa*), swelling of body (*Asha Agisi*), epilepsy (*Emo*), etc. Most of these diseases were conventionally linked to *evil* forces. Most of the non-voluntary cases of euthanasia included those people who suffered from certain abnormalities (*Atho/Kapa*), paralysis (*Ikhibi/asapucheyala*), tuberculosis (*Ithri*), etc, while involuntary euthanasia comprised of those who had become some kind of a burden, owing to the terminal nature of their illness, on those who were the caretakers but who had to helplessly assist involuntary euthanasia. The method used in assisting euthanasia among the *Idu Mishmis* is in sync with the prescribed custom of disposition of the dead among them. Since the dead has to be buried as per the prevailing custom, the same method is followed also in the case of assisting euthanasia. It is done in two distinct ways: one, in which a grave (*Bro*) is dug, and in the second case a stone structure in the shape of a small room (*Ju*) is erected on the ground which is then plastered with mud in order to block any passage of air. In the course of fieldwork, the prevalence of some thirty six cases of different forms of euthanasia was traced among the *Idu Mishmi* community. For the purpose of this paper, we zero in on only five of these of which two each are voluntary and non voluntary while last one is the case of involuntary euthanasia. These incidents occurred between the 1940s and 1970s in the Rango and Awahali villages of Lower Dibang Valley and East Siang Districts of Arunachal Pradesh.⁴ In presenting these incidents below, we have taken utmost care to reproduce them verbatim as narrated to us by the interviewees. This is done as a conscious decision in order to avoid interfering with the flow of the narration. Hence, the reproductions below are being presented in the first person.

CASES OF VOLUNTARY EUTHANASIA

Case No. 1

I was 27 years old when I witnessed the second incident of unnatural death in my life. It relates to the case of a 65 year old woman, Jeelo Umpe of Rango village, whose unnatural funeral was arranged by her relatives on her

persistent requests to put an end to her sufferings. It probably occurred 6 to 7 years after the 1950 earthquake which had badly devastated the region. Jeelo was a widow with a dumb daughter who was nearly half her age at the time of the incident. She was suffering from a form of edema, locally called *Asha Agisi*, for the last two years. Her situation had deteriorated to the extent that she had slipped into a permanently vegetative state. She could not even lie down owing to intolerable pain, as her body had swelled beyond imagination. The only way she could somehow manage to keep herself alive was by the way of sitting in a constant posture at one given place with her hands holding a rope tied to the raft overhead. It was not at all easy for her to sit in this posture all through the day and night, as it was excruciatingly painful and became unbearable after some time. She prepared her mind to quit. Feeling absolutely hopeless about any possibility of recovery, she started pleading her relatives to kill her so that she could get liberated from the day-to-day torture that she had to undergo. At last, her persistence paid off with the relatives agreeing to give in to her request/demand.

Accordingly, a female Shaman (*Igu*) named *Meli Molo* was summoned from *Amili* village to perform the last ceremonial rituals. On the opening day of the two-day funeral ceremony, Jeelo herself supervised all the arrangements, requesting her relatives to make sure that everything was in place. The second day afternoon witnessed some protest from her dumb daughter who did not want her mother to die like this. However, given the fact that Jeelo herself was having bouts of emotional outbursts, requesting everybody to bring an end to her sufferings, the relatives had no option but to ignore her daughter's protests. After all the rituals were carried out, Jeelo was carefully wrapped in a blanket (*Badu*) and was taken to the burial ground. She was then gently laid down in the grave. Following the prevailing customs, different items supposedly required to live even after death was put in the grave alongside her body. Finally, Jeelo was made unconscious through the performance of a ritual called *Agra-Lati* which is similar to *Dirge* chant whereby, as per the belief, the soul of the person is overpowered to facilitate smooth burial. This is a ritual which is followed in all instances of euthanasia among the Idu Mishmis.⁵

Case No.2

This relates to the case of Tudu Mimi of Rango village who was put to death in the late 1970s. He was just about 26 years old then. Orphaned by the death of his parents at a very young age, he was brought up by one of his uncles, Anati Mimi. Tudu was suffering from Leprosy (*chede-che*). Except the face, his entire body had swelled with blisters leading to unbearable pain. The same status continued for almost three months. His situation worsened so much that he could barely move his body. More than wanting to put an end to his personal sufferings, Tudu believed that if he were to die a natural death he might pass the disease on to the other members in the family. Scared of such a prospect, he earnestly urged his uncle and others in the family to bury him alive.

Once his request was conceded, he became actively involved in overseeing the entire process of arranging his own funeral. He personally chose Khukta Mimi from Elope village to act as the Shaman for the funeral. Since I was myself a witness to the whole episode, I clearly remember how fearless Tudu was and relished his own funeral feast with much delight and contentment. What really struck me about him was his level of self-confidence and clarity about life which he summarized thus, "I do not know anybody amongst my ancestors who wished to have food and drink with me. Not even my father or mother, let alone other relatives. Hence I wish to have my last supper with you all here on this last day of my life. I do not want much to be offered to me in my grave as I will die soon after I am buried". With such kind of philosophy, he truly enjoyed his food and drinks with others around him. After the feast got over, Khukta Mimi carried Tudu on his back to the grave in a large size basket (*Aagra*) which was especially knitted for the purpose⁶. As soon as the basket was lowered down, Tudu himself walked out of it and lied down on the bed inside the grave. Lying on the bed inside the burial, he repeatedly pleaded not to offer much to him as he is soon going to die, and he would not consume anything thereafter. However, he was offered some food and drinks as per the ritual before his burial was roofed with mud and boulders. No *Agra Lati* was performed in this case which is usually done in order to make the person unconscious before he/she is buried.⁷

CASES OF NON- VOLUNTARY EUTHANASIA

Case No.1

It was my first experience of witnessing the incident of somebody being put to death alive. I was so very much amazed that it took me a while to understand its long-term implications. As far as I can recall, it happened exactly about two years before the Rango Village was hit by an earthquake in 1950. Gali Umpe, who was married to Akhola Mimi with a son Bano and two daughters Dumaye and Emimeh, was physically challenged. Given her inability to reason out what is good or bad for her, she could not decide for herself as to what should be done with her.⁸ Her condition demanded that she be looked after all the time by a caretaker from amongst the family members. Given her state of affairs, she was never left alone owing to the fear that she might unintentionally and unknowingly harm herself or others. On many occasions, she was prevented from causing self-harm and/or injury to others. Once she threw burning firewood onto the *Apo*,⁹ where domestic articles like baskets are kept. It could have completely burnt the house if it had not caught the attention of a family member. Sometimes she would defecate on the same plate she had had her meal on minutes before. On one occasion, she removed the skull of a wild animal hung from the wall, and consumed it after roasting it in the fire.¹⁰ Her acts led to increasing frustration and an overwhelming sense of hopelessness amongst the family members, not knowing what to do

and how to make her calm herself down. After much deliberation and soul-searching, it was decided that it might be a better idea to help her die.

Resultantly, Ami Elapra, a female shaman from Ebuli village, was called upon for performing the funeral rituals. While Gali Umpe witnessed all the funeral-related activities on the first day, she could not make sense of it at all owing to her mental state. On being taken to burial the next day, she thought that she was being shifted to a new house where she would have to live in seclusion. I vividly remember her uttering these words angrily, "If I am made to live all by myself in a separate house, I can very well do so. What do they think?" After reaching the burial ground, she walked into the grave and lied down on the bed continuing to repeat what she had said while being carried to the funeral site. Unable to comprehend the chanting of *Anja* (dirge chant) by her husband in the background, she queried, "*Aw eseya ni tro.. tro.. tro.. lazi ba*" (who is making sound like *tro tro tro*). On being told it was her husband, she remarked, "*oh! Akhola mo wela bala ne lazi we do*" (oh! Akhola is reciting it so sympathetically!). Finally, the funeral ritual came to an end with the chanting of *Agra lati* by her husband, which made her unconscious before being buried in the grave.¹¹

Case No.2

This was my first experience of witnessing somebody being put to death before actually dying. It relates to Mupi Mimi from Rango village who was in her late twenties and unmarried at the time of the incident. She had lost her mother as well as two younger brothers while she was a young child. Emiyu, her younger sister, was alive at the time she was put to death.

Mupi was born a normal child and was all fine until she became sick at a much later stage and developed some problem because of which she started behaving abnormally. She would often play with fire at great risk to herself and others. She once ate the skulls of wild animals after roasting it in the fire, an act which is actually considered a taboo for females. She was prone to committing such acts while she was alone at home. Her sickness continued for almost a year, eventually turning her into a vegetative state. Owing to her illness, she could barely move herself and had to remain constantly stationed in one place. Her father could not bear the sufferings of her daughter and decided in consultation with other members of the family to bring an end to her day-to-day angst and pain. Accordingly, Khuka Mimi, a male shaman from Elope Village was summoned to arrange her funeral with a view to putting an end to her life in order to ease her of her sufferings once and for all.

This decision was initially not disclosed to others from the village. Hearing the howl and cry at her home, the villagers assumed that Mupi was finally dead. Ignorant of the actual plan, I too believed that Mupi was dead and I went and sat beside her body in order to perform dirge (*Anja*) as is usually the custom during funeral. I was completely shocked when I realized that Mupi was

stealthily holding my right arm. I remember how I pulled myself back almost screaming in disbelief as to how could a dead person suddenly wake up to hold somebody's hand! I got back to normal state only on being told about the actual reality. Till then I had no idea whatsoever was going on. I had absolutely no idea about the existence of such method of putting a live person to death. However, once the funeral process started and people started gathering, the real motive behind arranging the funeral was revealed to everyone. Since Mupi could not have been a part of the decision-making process about the end of her own life given her mental state, it was her father who had to take the final call with a view to bringing an end to her sufferings. Once the decision was taken, others could only join, as per the existing norms, in accomplishing the act in a peaceful manner.

Although Mupi was a witness to all the arrangements being carried out like gathering of the people, chanting of rituals (*dirge*), and preparation of food and drinks, she could not fathom the underlying motive behind it, as she was in a semi-conscious state. On the second (final) day of the funeral, the *dirge* chant (*Anja*) was performed by her father in the presence of the shaman, Khuka Mimi, before burying her in the grave.¹²

A case of Involuntary Euthanasia

This relates to the case of 60 year old Gimiya Mito, a deaf and dumb woman from Awahali village of East Siang district, who was otherwise quite sturdy and full of life. She along with other women agriculturalists from her village had once gone to the field in the early morning, as is the usual practice, for harvesting millet. Suddenly, Gimiya had bouts of diarrhea, making her so weak in the process that she could not even get up from the place till the evening. Her friends did try to help her, but to no avail. Initially, Gimiya kept assuring her friends that she would soon get alright and then she will collect and carry bamboo shoots and fire-woods for all. However, her situation deteriorated considerably owing to severe dehydration. To this, her friends got angry considering her as useless and slothful and there was no sign of recovery. Not knowing what to do, her friends decided to bury her alive. They went ahead with the process of live burial without bothering to performing funeral rituals which is otherwise invariably always followed by the Mishmis. They dug a grave and laid her down and covered it with mud and boulders. To this day, the women folk of Awahali village in particular are sometimes jestingly referred to as 'undertaker of live burial of men', as informed by the informant.¹³

POPULAR PERCEPTION OF EUTHANASIA

Even though the term 'euthanasia' was unknown to most of its practitioners, the actually existing practice of putting out somebody's life while alive was very much in sync with what the modern term has come to signify in contemporary times. In line with the modern definition, the actual practice of

the act in the universe of this study was very much in accordance with the principle of 'mercy killing'. The trigger for effecting euthanasia under the voluntary category was clearly the concerned person himself. It was only on the basis of a manifest request or plea from the sufferer that a subsequent decision to take recourse to what is today called euthanasia was taken by others in the family. Even in the cases of non-voluntary euthanasia covered in this study, the prime motivational factor was a general concern amongst the family members to cut short the lingering angst and suffering of the person. Other factors like lack of adequate medical aid and prevailing myths about the nature of the specific disease or illness one was inflicted with served only as retrospective or secondary explanations.

Based on in-depth interviews with a cross-section of people amongst the Idu-Mishmis cutting across age, gender, educational and occupational backgrounds, this section seeks to highlight the differing perceptions of people on the current raging debates on euthanasia. Interestingly and predictably, a majority of the interviewees had never heard the modern technical jargon, 'euthanasia', even though they had very definitive views on the efficacy of the practice which some of them had firsthand experience of witnessing at some point of time in their lifetimes.

An overwhelming majority of the elderly interviewees held very positive views about the practice, as they invariably empathized with those who were suffering from long-term incurable diseases.¹⁴ As is evident from the observation of Jinge Mega, a 70 year old woman, who had been witness to several cases of voluntary euthanasia:

"It is pitiful to see someone suffering endlessly from some prolonged incurable disease with absolutely no hope of recovery. What does one do in such a situation? It is better to concede to the plea of the sufferer to ease him/her of unending sufferings".

Such a view is representative of the general perceptions amongst the older people, as several women interviewees like Debiya Mili, Kiche Linggi, Timiya Mihi and many more all in the age group of 70 plus held similar views. The views of their male counterparts like Diko Miwu and Emuko Miwu from Maroli village in Dibang Valley District in the same age group were no different, as they echoed the same sentiments of helplessness and unending sufferings. Recalling his father's direct involvement in five different incidents of voluntary euthanasia as an *Igu*, Diko Miwu shared his father's observation,

"... when people themselves are asking to be buried alive owing to their unbearable anguish resulting from unending suffering, how could I shy away from performing my duty?"

Their approval of the method adopted to put an end to the prolonged sufferings of people could perhaps be out of a deep-seated realization, given their own precarious old age-related problems, that it is perhaps better to embrace death than to suffer endlessly. The level of attendance in the funeral

could also be seen as an indicator about the general social acceptability of the practice. Barring a few cases, most of the euthanasia-linked funerals invariably attracted a huge gathering, as the co-villagers not only approved of such a practice, but also extended all possible help in arranging them. Such unstinted support is clearly a reflection of not only the shared worldview, but also of the much-needed unconditional compassion with the sufferer and emotional support to the family under duress.

Low level of attendance in a euthanasia-linked funeral is also popularly viewed, on the other hand, as an indicator of its unpopularity and social disapproval. As is evident from the testimony of Anoko Mega, a shaman from Cheta village, who was summoned to perform the death ritual of Sumi Menjo of Anaya village.

“I was not aware of the fact that the person I was summoned to perform funeral rituals of was still alive. I was told that the person was dead. I got to know about it only when I was half-way through with the rituals. Even though I did express my reluctance to continue, I could not stop the process, as Sumi Menjo’s elder son requested me to do so. Poor attendance by the villagers in the funeral clearly revealed that there were many others like me who disagreed with the practice of killing somebody before natural death”.

Another Shaman, Sipa Melo, from Aleney village located in Dri Valley of Dibang Valley District voiced strong reservations about its popularity and social acceptability,

“Such cases of unnatural death did not enjoy social sanction, as the decision to put an end to somebody’s life was kept a closely guarded secret. Apart from the affected person who volunteered to die, only a few very close members of the family were involved in taking the final decision. In cases where the concerned person was not in a position to take an informed decision, it was invariably decided by a few core members of the family. Nobody else from the clan or the village was ever consulted. Moreover, the prevailing myth among the Idus that ‘evil’ disease (*Khinu Hembe*) like leprosy, epilepsy, tuberculosis, swelling, etc. could spread like an epidemic further contributed towards maintaining the veil of secrecy shrouding such a practice”.

In sharp contrast to the perceptions of the older generation which invariably, albeit with rare exceptions, approved of the traditional modes of ‘euthanasia’ on grounds of mercy killing; the younger generation does not approve the practice in modern times and tend to look at the older practice more as a kind of necessary evil. Historical marginalization and geographical isolation of the region are seen as the major contributing factors for the prevalence of such practices by the younger generation.¹⁵ As Sunil Mow, a practicing *Idu* advocate, eloquently observed;

“Most of the cases took place in the absence of medical and legal establishment in the region and were largely influenced and supported under the *Idu* socio-cultural dimensions. But in the modern days, there are plenty

of agents through which people's perception could be changed against misconception of diseases like leprosy and tuberculosis which were the root cause and are considered evil and untreatable by the Idu people. Now there are medical camps, resettlement camps, etc, in many parts of the nation where people with leprosy disease could be transported and could get medical treatment. If there is any case of euthanasia among the Idus in recent time than that must have been kept in secret or not publicized at large. Otherwise serious criminal case may be initiated against those persons who are involved in assisting such form of death even if it is voluntary".

It is important to note that in case of non-voluntary and involuntary euthanasia, the act of 'mercy killing' is kept as a closely guarded secret with only the very close family members being a party to the decision making process. Others – from outside the family – have no clue about what is actually happening, and they participate in the funeral procession as they would ordinarily do.¹⁶ The reason behind maintaining a veil of secrecy about such cases is that unlike the case of voluntary euthanasia, the motivating factor here is not mercy killing, but the back-breaking burden of caretaking of a person who happens to be in a vegetative state with no hope of ever recuperating from his/her present status. Poor material conditions may often combine with heavy emotional drain on the part of the caretakers in thus reaching a decision to get rid of the concerned person in order not only to relieve the sufferer but also equally those who have been hopelessly taking care at times for years together. The relatively old age of the sufferers along with the nature of incurable diseases (at least in those days) were other contributing factors in taking recourse to such extreme measures.¹⁷

DISCUSSION AND CONCLUSION

While the prevalence of the practice of live burial among the Idu Mishmis in the past may not tantamount to the modern practice of euthanasia, it would certainly not be out of place to assert that what they actually practiced was indeed very close to the modern practice, albeit in its own rudimentary form.¹⁸ To draw a parallel between the two would thus not only be fallacious but overstretching the case a bit too far. What, however, does remain common between the two is the broader concern – to ease the last turbulent and trying days of the sufferer by facilitating untimely death.

Idu Mishmis stand out in terms of being the only known community in India which practiced an ingenious form of live burial. However, along with the practice, the role of the performers of the same – the Idus who held iconic status in the traditional worldview dominated by evil spirits (*khinus*) – is also on decline today.¹⁹

Contestations over ethico-legal issues are increasingly becoming sharper with the younger educated class raising several important questions about the efficacy of such a practice in modern times. Amidst a raging debate in

India, as in other parts of the world, whether or not to allow a terminally sick person the right to die with dignity; the traditional Idu experiences do impel us to ask if they were not wiser than the modern-day skeptics!

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END NOTES

1. Both the terminology "Idu" and "Mishmi" have no concrete and specific meaning in Idu language. Baruah (1960, p 98) mentioned that "the word Idu, ..., is most probably a distortion of the word Midu which means inhabitant of Idu valley and is the name for only one section of the people". It is here to mention that Idus may be categorized into three groups as per their dialectic variation and in few word meaning which are Mindri, Mithu and Midu. Most of the Mindri speaking Idus inhabits the present Upper Dibang Valley District around Dri and Mathu river valley. The Mithu inhabits on both side of the Ithun river valley. The Midu speaking Idus are mainly found in lower foot hills and lower valleys of Mishmi Hills. So most probably, Midu speaking Idus of lower foot hills and valleys first came in contact with outsiders and only from their dialectic nomenclature "Midu" the term 'Idu' was coined to designate the tribe. As I put it Mithu speaking Idus inhabits Ithun Valley, Baruah (ibid, p 11) designated the same Idus of Ithun valley as Bebejiyas, again the term which has no concrete meaning and origin in Idu language. And for the term 'Mishmi', Bhattacharjee (1983, p 13) suggested that there is no clarity of origin of the term though largely believed that it has been coined by the people of plains of Assam to designate the tribe. Further, one may find that Idus refer themselves as Kera-A. Here Kera is believed to be a name of ancestral forefather and A stands for children and thereby meaning children of Kera.

2. Notes and Queries, Man in India, The Anthropological Survey of India, pp 81-82

3. For the leprosy (Chede), the Idus had no medicine to cure. Even these day people in the interior places perceive leprosy as evil, communicable and incurable disease. Sometimes lepers are disposed off from the main dwelling to a separate hut at the periphery of village boundary. For example, Mecho Mimi of Anaya village was a leper who was transported to temporary hut adjacent to his main residence. Eventually, he died of leprosy naturally and after his death the hut was burnt down in an attempt to eradicate the disease completely. After the dead of a leper (by any means) his/her all belongings are burn down to ash along with the house where the victim took his last breath.

4. As the introduction of education is recent development in the region people have no written record, particularly date of any incidences of euthanasia. Though some recent cases (three to five decades back) are still fresh in memory of some elderly Idus but that too have no any written records. On the other hand, Idus prescribe it taboo in uttering

name and sometime even incidence of dead person. Such belief have helped in fading the memory of such incidences. It is here, therefore, the age of the informants, of their parents and the year of the great earthquake in the region i.e. 1950 were taken roughly in calculating the year of the incidence. Sometimes season as per traditional agricultural calendar is also used in calculating the month of the incidence.

5.The information collected from Jinje Mega, Age-80+, Sex- Female, Village- Ashali, Roing and Ango Mimi, Age-90+, Sex-Male, Village- Ashali, Roing.

6.It is said that wherever Khuka Mimi, the shaman, perform funeral ritual in case of the person died of leprosy he used to carry the person alone, may be dead or alive, to the burial place. As per the Idu's perception it is the tutorial spirit of the shaman (dron) who directs him and give power to do so.

7.The information collected from Jinje Mega, Age-80+, Sex- Female, Village- Ashali, Roing and Ango Mimi, Age-90+, Sex-Male, Village- Ashali, Roing.

8.As per the information the victim was not mentally retarded during her early age but later on reaching her old age she started activities abnormally which assured people that her mental status was not normal and considered her to be mad lady.

9.The third shelf of the three layered shelves above the fireplace found in every traditional Idu mishmi households.

10.Eating of wild animal meat is a strict taboo for the Idu women and they never take it. For the male, eating of such meat is followed by taboos which may last for two to three days.

11.The information collected from Jinje Mega, Age-80+, Sex- Female, Village- Ashali, Roing, Ango Mimi, Age-90+, Sex-Male, Village- Ashali, Roing and Akusi kechee, Age-55+, Sex-Female, Village Ashali, Roing.

12.The information collected from Jinje Mega, Age-80+, Sex- Female, Village- Ashali, Roing and Debia Mili, age 70+, Village-Ashali, Roing.

13.Information collected from lete Kichu Lingi, female, aged 100+ of Abali village, Roing. Note: There are reports of at least four cases of involuntary live-burials among the Idu Mishmi where the victims were forcefully buried alive by the kin members due to varied reasons. In this section, only one case may be briefly discussed

14.Notion mostly held by the elderly Idus like Shri Limu Meme, Age-60+ of Kebali Village, Shri Ango Mimi, Age-80+, Smti Jinje Mega, Age 70, Smti Akusi Keche Age-60+, Shri Andro Elapra Age 65+, Smti Dibia Mili, Age70+, Smti Junta Mene, Age 55+, Smti Pema Meto, Age 45+ of Ashali Village, Roing.

15.Views provided by Sumo Lingi, male 50+ of Mayu village, Lower Dibang valley district and Thuti Mili, male 45+ of Ashali village, Lower Dibang valley district.

16.The case of Mupi Mimi is an example which was even not known to informant Smti Jinge Mega who at that time was a participant of the funeral ceremony.

17. See list of the victims in the Appendix-I.

18.In order to have an idea of the complex healing mechanism and perception of diseases by the shamans in Idu Mishmi tribe of Arunachal Pradesh one can see article by Sarit K. Chaudhuri (2008) presented in the 20th ECMSAS in Manchester University, UK from 8th to 11th July on 'Igu of the Idu Mishmis of Arunachal Pradesh: Relocating Indigenous Healers and Healing Traditions of a Frontier Tribe of North East India' in the panel on Disease, Possession and Healing in South Asia convened by F.F.Ferrari and P. Srinivasan.

19. In spite of the dominance of the institution of shamanism in village life this institution

is gradually losing its past popularity because of multiple reasons. The number of shamans are reduced to a great extent. In order to have a critical discourse on the plight of the Igu or shamans of the Idu Mishmis, read Chaudhuri's (2008) article on the Plight of the Igu: Notes on Shamanism among the Idu Mishmis of Arunachal Pradesh.

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Appendix-1

Sl. No	Name	Age	Sex	Year	Type	Cause	Village
1	Sundu Melo	70+	Male	1954-55	Voluntary	Normal, only hand fracture	Cheya
2	Ayungi Melo	80+	Male	Mid 1960s	Voluntary	Normal-old age-succeeded after 2 nd attempt.	Achuli
3	Selo Mena,	60+	Male	Late 1960s	Voluntary	Leprosy (Chedi)	Atali
4	Amphi Mili,	60+	Female	Mid 1960s	Voluntary	Leprosy (Chedi)	Aloso
5	Sumi Menjo,	60+	Female	1997-98	Voluntary	Leprosy (Chedi)	Anaya
6	Ronli Mega	60+	Female	Mid 1970s	Non -Volun	Leprosy (Chedi) and Abnormality (Asameh)	Mihundo
7	Ledra Ekru,	60+	Male	1984-85	Voluntary	Disease (not specified)	Wanli
8	Embro Mito	50+	Female	1970s	Voluntary	Normal	Aruli
9	Gimiya Mito	60+	Female	1960s	Involuntary	Dysentery and Dumb and Deft	Awahali
10	Pwiti Mepo	60+	Male	1940s	Voluntary	Leprosy (Chedi)	Engali
11	Leya Umbrey	25+	Female	1970s	Involuntary	NA	Chepe
12	Lache Mili	50+	Female	1970s		Disease (not Specified)	Egiyee
13	Ami Apralo	70+	Female	1980s	Involuntary	Old age	Atili
14	Mare Mili	30+	Male	1980s	Voluntary	Leprosy (Chedi)	Aneli
15	Rundi Apralo	80+	Male	1970s	Voluntary	Leprosy (Chedi)	Akuli
16	Rongo Dele	50+	Male	1960s	Voluntary	Leprosy (Chedi)	Ethoro
17	Unae Aaloyu	60+	Male	1970s	Voluntary	NA	Akoli
18	Hatata Mepo	60+	Male	1980s	Voluntary	Normal	Engali
19	Lukhu Mito	50+	Male	1960s		NA	Eyinli
20	Lape Umbrey	60+	Male	1960s	Voluntary	Epilepsy disease	Epungu
21	Gali Umpe	60+	Female	1947-48	Non- Volun	Mentally retarded	Rango
22	Tudu Mimi	25+	Male	1977-78	Voluntary	Leprosy (Chedi)	Rango
23	Mupi Mimi	60+	Female	1975-76	Non-Volun	Mentally retarded	Rango
24	Jelo Umpe	60+	Female	1956-57	Voluntary	Swelling of body (Asha Agisi)	Rango
25	Mitu Mepo	60+	Male	1970s		NA	Engali
26	Lamane Melo	40+	Female	1970s	Voluntary	Leprosy (Chedi)	Achuli
27	Goma Dele	50+	Male	1960s		NA	Elope
28	Kadu Mega	60+	Male	1960s		NA	Taloni
29	Khusa Mimi	40+	Male	1970s		NA	Kronli
30	Muya Mimi	70+	Female	1970s	Involuntary	Mentally retarded	Anaya
31	Amili Tacho	60+	Female	1985-86	Voluntary	Leprosy (Chedi)	Maroli
32	Anjo Miwu	60+	Male	1940s		Leprosy (Chedi)	Maroli
33	Ahu Miwu	60+	Male	1940s		NA	Maroli
34	Iluru Mihu	50+	Female	1960s	Voluntary	Leprosy (Chedi)	Mihundo
35	Dandrime Lingi	50+	Male	1970s		NA	Awahali
36	KoremeLingi	50+	Male	1960s	Voluntary	Epilepsy (Emo)	Awahali

Source: Field work (2007-2010)

Appendix - II

Key Informants interviewed listed below:

- A. Jinje Mega, Female, age 70+, Debiya Mili, Female, age 70+, Ango Mimi, Male, age-80+, Andro Elapra, Male, age 65+, Akusi Kechee, Female, age 60+, Timiya Mihu, Female, age 40+ of Ashali village, Lower Dibang Valley, AP.
- B. Diko Miwu, Male, age 70+, Emuko Miwu, Male, age 50+ of Maroli Village, Dibang Valley District, AP.
- C. Sipa Melo, Male, age 45+ of Aleney village, Dibang Valley District, AP.
- D. Kichu Lingi, Female, age 100+ of Abali Village, Lower Dibang Valley, AP.
- E. Gula Lingi, Male, age 70+, Mikhita Mene, Female, age 60+ of Iduli Village, Lower Dibang Valley, AP.
- F. Anoko Mega, Male, age 50+ of Cheta Village, Lower Dibang Valley, AP.
- G. Omane Mito, Male, age 60+, Yiene Meto, Male, age 50+, Dalukha Mene, Male, age 50+ of Mayu Village, Lower Dibang Valley, AP.