CHAPTER 5

Is Killing Necessarily Murder? Moral Questions Surrounding Assisted Suicide and Death

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Although the key elements associated with assisted suicide have remained largely the same for the last two decades, the nature of the discussion within American society has changed dramatically. Twenty years ago discussions of assisted suicide were on the periphery of academic debate; today some of the most prominent scholars and legal experts in the United States are engaged in these discussions; interviews with political leaders two decades ago were rare and usually in non-prime time periods, whereas today, such debates among talking heads appear frequently on the twenty-four-hour-a-day cable networks; and issues that seemed uniquely American twenty years ago are now on the political agendas in a growing number of postindustrial countries. However, as much as the world appears to have changed, the main issue is still the central question: What is right and what is wrong and how do people in various societies determine the difference? In other words, the key issue is still a moral one.

However, before there is any further discussion of morality, it is necessary to explicitly state what I mean by assisted suicide. Assisted suicide, often termed physician-assisted suicide, is "making a means of suicide (such as a prescription for barbiturates) available to a patient who is otherwise physically capable of suicide and who subsequently acts on his or her own" (Quill, Cassel and Meier 1992:1381). This is different from voluntary euthanasia in which an individual actually administers the means of suicide or turns off the life support of a terminally ill individual.

As dramatic and important as much of this discussion in the United States and other industrial societies may be, it is interesting that it is taking place with two implied assumptions: (1) that this is the first time the issue of assisted suicide has been raised within advanced industrial societies, such as the United States; and (2) that twenty-first-century society is the first one that has ever had to face such a morally vexing dilemma. There are a variety of reasons for

these assumptions, but in general there appear to be two main causes for this widely held view. The first explanation derives from the obvious advances in medical technology that allow for the prolongation of life beyond anything that has existed before in our own society or in any other society at any other point in time. Although the technology may be unique, the situation is not, either historically or cross-culturally. As I will show, even though medical technology allows us to prolong life, the same dilemma faced people in our own society prior to the late twentieth century, as well as in other societies; it only happened at an earlier stage in the dying process.

The second explanation is broader and more complex and is not as easily countered. It is hubris—the belief that we cannot learn from other societies and cultures, certainly not cultures that are less technologically advanced than we are. If we did turn to these societies for help in answering our own perplexing questions, this would be tacit recognition that we are not morally more advanced and that we could learn from other populations, many of which we would regard as primitive or backward. I will address both of these assumptions in the remainder of this chapter as I first discuss the role of assisted suicide, death-accelerating behavior, and euthanasia in American society. I will continue by briefly considering a similar debate over these very same issues in nineteenth-century America, and conclude with a more detailed discussion of the nature of death-hastening behavior directed toward decrepit old people in many nonindustrial societies. It is my hope that this discussion will show that the ethical, moral, and legal questions that surround these issues are not unique to twenty-first-century American society, and that people at other times and in other societies have had to struggle with them just as we have.

AMERICAN SOCIETY

Given the changes that have occurred in the level of discussion about assisted suicide over the last two decades, it appears that the best way to organize a discussion of the role of assisted suicide in American society is to examine the changes that have occurred by decade: the 1980s, 1990s, and the 2000s. In this way, current beliefs, laws and behavior can be placed within both an historical perspective and a cultural context.

The 1980s

Three main events dominated the consideration of assisted suicide in the 1980s: (1) a 1984 New York Supreme Court ruling; (2) the case of Roswell Gilbert; and (3) the public outcry that followed statements by two prominent politicians that terminally ill people had a "duty to die." In 1984, the New York Supreme Court ruled that "a nursing home should not force-feed an eighty-five-year-old patient who was in poor health and had been fasting." The court decided that the man was "entitled to die of his own will [and] that the nursing home was not obliged to force-feed the man" (Hirsh 1985:9).

However, just across the Hudson River in New Jersey, an appellate court ruled that a hospital could not remove the nasogastric tube of an eighty-four-year-old man who wanted to die. In California, a hospitalized woman was prevented, through force-feeding, from starving herself to death (Hirsh 1985:10). Thus, in less than one year, three different courts in three different states had ruled differently in cases of terminally ill patients in nursing homes. Courtroom contradictions, however, were not limited to nursing home cases as, also in 1985, the issue that filled the tabloids was the Florida case of Roswell Gilbert, a seventy-six-year-old man who shot and killed his seventy-three-year-old wife who was suffering from Alzheimer's disease and osteoporosis. Gilbert was sentenced to twenty-five years to life for murder, even though an outcry was raised by a wide range of supporters and sympathizers. While Gilbert was sent to jail, two other men who violently killed close relatives went free. In an ironic twist, a seventy-nine-year-old man who shot and killed his wife, also suffering from Alzheimer's disease, had his case dismissed in the same courthouse in which Gilbert was sentenced.

The outcry over what many perceived as the inconsistency of state laws resulted in much activity over the last half of the 1980s as political leaders, editorialists, state legislatures, the American Medical Association, and the general public were confronted by the moral, ethical, legal, and religious issues surrounding euthanasia and assisted suicide. At the end of the decade, ex-Governor Richard Lamm of Colorado and ex-Senator Jacob Javits of New York raised the sensitive issue of the costs associated with the medical care of the terminally ill elderly and even suggested that terminally ill people may have the "duty to die." Although both politicians denied that they supported "mercy killing," both men called for a national debate on these topics and the development of national legislation that would "allow" the elderly to die when they desired. The challenge to debate these issues did not emerge on a national level as Lamm and Javits anticipated. Instead, the discussion was largely held at the level of individual states in both state legislatures and voting booths. The result was that by the beginning of the 1990s, thirty-six states had passed laws that explicitly prohibited assisted suicide, and in most of the other fourteen states, there was ambiguity as to the legal status of assisted suicide (Newman 1991).

The 1990s

A couple of brief examples illustrate this ambiguity quite nicely. In 1992, a referendum that would have legalized assisted suicide and voluntary euthanasia was narrowly defeated in the state of Washington. At almost the same time, the state legislature of Washington passed a law prohibiting assisted suicide, which was then declared unconstitutional in 1993 by a federal court because it interferes with individual liberty and privacy (Miller et al. 1994:120). In 1994, the people of Oregon approved by referendum "The Oregon Death with Dignity Act," which would, in very carefully defined situations, allow for assisted suicide. This law, although approved, could not be immediately enacted

because a federal court, in response to a petition from individuals living in Oregon who opposed the Act, ordered a stay. The United States Supreme Court eventually ruled favorably on the law's constitutionality, and it went into effect in 1997. However, also in 1997, the Supreme Court ruled unanimously that both the New York and Washington laws banning assisted suicide were constitutional. The impact of these rulings will be discussed in detail in the next section.

As the political and legal processes have failed in their attempts to clarify these vexing issues, several individuals have taken a more direct, hands-on approach. The most famous, or notorious, depending on your point of view, is Dr. Jack Kevorkian, a retired pathologist who has acted on his beliefs by "assisting" in over thirty suicides. "Assisting" is in quotations because there was much debate in the 1990s as to whether Dr. Kevorkian had undertaken assisted suicide or voluntary euthanasia. It was unclear whether in each and every case he had only provided a means of suicide, or whether he had crossed the line to voluntary euthanasia by actually administering the means of suicide, such as turning on a machine attached to intravenous tubes filled with barbiturates. Although the details were somewhat muddled, the state of Michigan passed specific laws on several occasions to prevent Dr. Kevorkian from "assisting" in a person's suicide. He continued to assist, was prosecuted on three separate occasions, and was acquitted each time, after which he returned to his "practice." On November 22, 1998, CBS's "60 Minutes" aired a videotape showing Kevorkian giving a lethal injection to Thomas Youk, 52, who suffered from Lou Gehrig's disease. This broadcast triggered intense debate. Two days later, Dr. Kevorkian was charged by Michigan prosecutors with first-degree murder, for violating the assisted suicide law and delivering a controlled substance without a license in the death of Youk. In April 1999, Dr. Kevorkian was convicted of second-degree murder and delivery of a controlled substance in the death of Youk, and a Michigan judge sentenced him to ten to twenty-five years in prison. On June 1, 2007, Dr. Kevorkian, at the age of seventy-nine, was paroled from state prison in Michigan. His parole prohibits him from providing care to anyone over age sixty-two, giving counseling on how to commit suicide, or being present at any suicide or euthanasia. However, in a series of interviews after his release, Kevorkian reiterated his belief in both the right of individuals to end their own lives and the right of physicians to assist in these suicides (*Philadelphia Inquirer*, May 31, 2007).

The prosecutions and ultimate conviction of Dr. Kevorkian stimulated much debate about the extent and acceptability of assisted suicide in America. One study estimated that "(a)pproximately 6,000 deaths per day in the United States are said to be in some way planned or indirectly assisted" (Quill, Cassel, and Meier 1992:1381). This is a surprisingly large number of cases, but one must take into consideration that the 6,000 include people who die because of "the discontinuation or failure to start life-prolonging treatments," in addition to those individuals who die because of the administering of pain relieving medication in dosages sufficient to hasten death (Quill et al. 1992:1381). In fact,

there was sufficient discussion of the appropriate use of life-prolonging treatments within the medical profession in the 1990s to produce a "how-to" article. Angela Holder, writing in *Medical Economics*, advised physicians how to properly write "Do Not Resuscitate" (DNR) orders so that lawsuits are avoided. She suggested that the orders be explicit and that the family members and the patient be consulted, but the results of DNR orders are that elderly patients are allowed to die when they could technically be kept alive.

The attitudes of physicians toward assisted suicide is extremely variable, and even though the American Medical Association's Council on Ethical and Judicial Affairs has issued a report on "Decisions Near the End of Life" (Council of Ethical and Judicial Affairs, 1992:2229–33), there was far from a consensus in the 1990s as to the physician's role in suicides of terminally ill patients (Brody 1992; CeloCruz 1992). It is fair to say that the problems surrounding the desire of some terminally ill patients to actively end their lives had been "relatively unacknowledged and unexplored by the medical profession … (and that) … little is objectively known about the spectrum and prevalence of such requests or about the range of physicians' responses" (Quill et al. 1992:1380). Although it became clear that whatever position is finally taken by the American Medical Association, no physician would ever be compelled, as part of a treatment protocol, to assist in the suicide of a patient. However, there was a move in the 1990s toward a position that would support the right of a terminally ill patient to end their life and for physicians, by following very well-established guidelines, to assist in this action (Miller et al. 1994).

The Twenty-First Century

Although, at this writing, the new millennium is less than a decade old, there has been more activity and controversy centered on assisted suicide in this short period than during the past twenty years combined.It is impossible to go into detail about all of the various events that have occurred; Instead, I will concentrate on two examples that represent the larger trends concerning assisted suicide and conclude with a summary of where things stand today.

The first example is the demise of the Hemlock Society. The Hemlock Society, founded in 1980, was an international organization that advocated voluntary physician aid-in-dying for the terminally ill. At its peak in the mid-1990s, the Hemlock Society had over 46,000 dues-paying members and over 80,000 supporters in the United States alone. The Hemlock Society promulgated the belief that all terminally ill people should have the right to self-determination for all end-of-life decisions, and it put this belief into action through a program of education and research. Members of the Hemlock Society helped draft the Oregon assisted suicide law and provided much of the labor and financing for referenda in Oregon, Washington, Maine, Michigan, and California. However, by the beginning of the new century, membership had declined to less than 18,000. There were many reasons for the decline—including the growth of state level organizations with a focus on getting specific laws passed, and

internal divisions within the society—but perhaps the biggest reason came from its overall success. The Hemlock Society succeeded in putting the issue of "death-with-dignity" in front of the American public and into both state legislatures and the United States Congress. Even though the only legislative and court-backed success was in Oregon, assisted suicide was no longer a hidden topic, and therefore, the Hemlock Society had accomplished its main goal. Although the Hemlock Society closed its doors in 2003, there are now at least four organizations—Compassions and Choices, the Death with Dignity National Center, the Euthanasia Research and Guidance Organization, and the Final Exit Network—that have taken up the death-with-dignity mandate.

The second example that encapsulates the events of the last half-decade is the consequences of Oregon's Death with Dignity Law that was upheld by the United States Supreme Court in 1997. This edict allows individuals to end their lives through the use of prescription medication after their terminal diagnosis has been confirmed by two physicians. Nevertheless, the legislation has not been without controversy and legal challenges. In 2001, the Bush administration, with then Attorney General John Ashcroft taking the lead, challenged the law by threatening to prosecute physicians if they prescribed medication for "euthanasia." The challenge ended when, in January 2006, the United States Supreme Court ruled 6–3 that the Oregon law was not superseded by the federal government. Two interesting facts emerge from the consequences of the Oregon law. First, on average, fewer than thirty individuals chose to end their lives each year under the procedure outlined by the Oregon law; and the average number of such individuals has been declining in the last several years. In fact, since the enactment of the law in 1997, only 292 Oregonians have died under its provisions (Crary 2007). Thus, the "rush-to-suicide" that many commentators had predicted has not come to pass. Second, even with the success of the law, both legally and practically, no other state has followed Oregon's lead.

This brings me to the brief summary of where things stand today in the United States on the issue of assisted suicide. Four states, Washington, New York, Michigan, and Florida, had bills introduced into their legislatures concerning assisted suicide in the late 1990s; none of the bills were enacted into law. Likewise, between 2000 and 2004, four additional state legislatures debated laws allowing some form of assisted suicide: California, Colorado, Hawaii, and Maine. Once again, none of the bills became law.

In contrast, forty states have specific laws that criminalize assisted suicide. Some of these laws have been challenged in court, and the Ninth U.S. Circuit Court of Appeals declared the Washington State law unconstitutional for violating the equal protection clause of the U.S. Constitution. However, as of now, it does not appear that much will change over the remaining years of this decade. Even if the Ninth Circuit Court's ruling is extended to other circuits and ultimately upheld by the Supreme Court, it does not appear that over the next several years any state, in addition to Oregon, will pass laws legalizing assisted suicide. This state of affairs in America is matched, to a large extent, in the rest of the postindustrial world. There are only three countries that legally allow assisted

suicide: Switzerland, Belgium and the Netherlands. In some other countries, most notably the Northern Territories of Australia, a specific province or state has legalized assisted suicide, but in the vast majority of countries, assisted suicide is illegal; and it appears that it will remain so for the foreseeable future.

HISTORICAL AND CROSS-CULTURAL PATTERNS

Historical Evidence

It is interesting to note that the controversy over whether it was moral for terminally ill individuals to take their own lives, what role, if any, should be played by physicians in such suicides, and whether active euthanasia should be allowed go back to at least Greek and Roman times (Carrick 1985). However, I am most interested in the similarity between the contemporary discussion of these issues in America and a comparable, intense debate in the mid- and late-nineteenth century, as a result of the discovery and use of anesthesia. Anesthesia, whether morphine, chloroform or ether, could not only alleviate pain, but, in sufficient dosages, end life. The debate became especially intense in 1872 when Samuel Williams, who was not a physician, published a book in England that argues it was the "duty of the medical attendant whenever so desired by the patient, to administer chloroform or such other anesthesia as may by-and-by supersede chloroform—so as to destroy consciousness at once, and put the sufferer to a quick and painless death" (Emanuel 1994:794). Publication of Williams's book generated considerable discussion on both sides of the Atlantic throughout the 1870s and 1890s. This discussion culminated in various attempts, both within the medical profession and within individual states, to codify various opinions into coherent policy and law. An editorial in the *Journal of the American Medical Association* in 1885 summarizes the position taken by the majority of physicians and certainly the medical establishment, arguing that the acceptance of Williams's position on euthanasia was really an attempt to make "the physician don the robes of an executioner" (Emanuel 1994:795). Responding to a growing demand for greater patients' rights, several state legislatures, in the 1890s, and for the first few years after the turn of the century, debated legislation that would have legalized some form of what today would be termed assisted suicide. None of these bills became law, and after the Ohio legislature rejected a bill in 1906 titled "An Act Concerning Administration of Drugs etc. to Mortally Injured and Diseased Persons," the clamor for patients' rights and euthanasia died down, only to reappear in the 1980s and 1990s.

Cross-Cultural Evidence

The previous discussion should help refute the assumption that this is the first time the issue of assisted suicide has been raised in American society. I will now turn my attention to refuting the second assumption, that we are the first society that has ever had to face such a morally vexing dilemma. To do

this I will turn to ethnographic data collected on a wide variety of nonindustrial societies and employ a methodology—holocultural analysis—that for the systematic analysis of data collected from a very carefully selected sample of these societies.[1] As noted in Sokolovsky's discussion of "covering up" among the Tiwi (Introduction this volume), much anecdotal information is available concerning the killing of particular individuals within nonindustrial societies. For example, almost everyone has heard stories about the old Eskimo woman who is set adrift on an ice floe or the elderly man left behind to die alone because he is no longer able to walk when his relatives move to a new location. Holocultural analysis, on the other hand, allows for the systematic analysis and interpretation of ethnographic material in order to more reliably reach conclusions on human behavior. My research used data drawn from the Human Relations Area Files, which is a compilation of ethnographic information on over 1,000 societies. However, I did not utilize all societies in the Files, but instead examined a sample of societies that have been selected for very specific reasons to ensure geographical distribution, as well as relative independence from each other. The sample is the Probability Sample Files (PSF) and is comprised of sixty nonindustrial societies (Naroll, Michik and Naroll 1976). The focus of the study was on the treatment directed toward the elderly in these societies.

1

Definitions

Although the study examined all types of behavior, the most surprising and potentially important finding was that nonsupportive treatment, especially the killing, abandonment, and forsaking of the elderly, was widespread. In order to describe these life-threatening behaviors in a coherent manner, I coined the term "death-hastening behavior," which is a broader concept than gerontocide or gericide, and includes killing, abandoning, and forsaking of the elderly; it is defined as nonsupportive treatment that leads directly to the death of aged individuals. Four brief examples from the literature analyzed illustrate the type of data found in the Human Relations Area Files and the scope of the death-hastening concept.

Killing

Chukchee—reindeer-herding people who speak a Paleo-Siberian language and live in northeastern Siberia, principally on the Chukotsk Peninsula.

Few old Chuchi die a natural death. When an old person takes ill and becomes a burden to his surroundings, he or she asks one of the nearest relatives to be killed. The oldest son or daughter or son-in-law stabs the old one in the heart with a knife (Sverdrup 1938:133).

Abandoning

Lau—a horticultural and fishing people who speak a Malayo-Polynesian language and live in the Lau Islands off southern Fiji in the central Pacific Ocean.

Informants on Fulanga said that when the tui naro (headman) of the Vandra clan became old and feeble, he was taken to Taluma Islet in the lagoon and abandoned there in a cave filled with skeletal remains of old people who died there after having left the community (Thompson 1940:10).

Forsaking—Denial of Food

Bororo—a horticultural people who speak a Ge language and live in the Amazonian forest of Central Brazil.

It is the same for the old people; after a hunt or successful fishing trip, they are brought a piece of meat or a few fish. But also they sometimes are forgotten. The indigent person is then reduced to going without a meal and all night long, alone, utters ritual lamentations (Levi-Strauss 1936:276).

Forsaking—Denial of All Support

Yakut—Yak herders who speak a Turkic language and live in north-central Siberia in the former Soviet Union.

The position of older people who were decrepit and no longer able to work was also difficult. Little care was shown for them; they were given little to eat and were poorly clothed, sometimes even reduced to complete destitution (Tokarev and Gurvich 1964:277). Aged people are not in favor; they are beaten by their own children and are often forced to leave their dwellings and to beg from house to house (Jochelson 1933:134).

Each of these behaviors leads directly to the death of the elderly within the particular society. The example of killing is self-evident—the elderly are not left to die, but rather are dispatched directly by members of the social group. The abandoning example is also fairly clear-cut, and ranged from the elderly who are physically removed from a permanent community, to societal members leaving the elderly behind as the group moves to a different location The two examples of forsaking behavior show some of the range of this behavior. Forsaking is the broadest of the three behaviors and includes the denial of sufficient food, medical care, clothing, and shelter (see Barker this volume for specific examples of this category).

These behaviors contrast with supportive treatment, which is defined as the active support of the elderly including the provision of food, shelter, medical care, and transportation. Supportive treatment is more than the expression of deference or respect and must be accompanied by tangible actions that aid in the survival of the elderly individual. Behavior that falls between supportive and death-hastening is, for the present study, defined as nonsupportive, nonthreatening behavior, and includes such behavior as insulting the elderly, requiring them to give up certain property, and removing them from their normal residence. These behaviors can be unpleasant and may even have long-term detrimental effects on the well-being of the old person, but they do not directly threaten his or her life. Thus, nonthreatening behavior can be viewed as transitional between

supportive and death-hastening, and may eventually lead to death. A definitional problem was raised by the type of data analyzed: how is elder suicide to be categorized? If an old person asks his sons to kill him, if an old woman wanders away from camp in order to die, or if an elderly individual gives away all of his or her possessions and then wanders from village to village, eventually to die of neglect and exposure, are these examples of suicide, and perhaps even assisted suicide, rather than death-hastening? To avoid the development of numerous coding categories that would prove too difficult and confusing to employ, the decision was made to include such behavior in the existing categories of killing, abandoning, and forsaking. The issue as to who initiates the death-hastening behavior is considered as each of the particular categories is discussed.

Findings

Data concerning the treatment of the elderly were available for forty-one of the sixty societies in the Probability Sample Files. In twenty-one of these societies, a slight majority, at least one type of death-hastening behavior was present (see Table 5.1). While twelve societies directed only support toward the aged, almost an equal number (eleven) displayed both death-hastening and supportive actions toward their elders. Examining the data more closely, ten societies have a single form of death-hastening behavior, while eleven societies have a combination of behaviors. Killing is the most frequent means of hastening the death of old people; it occurs in fourteen of the twenty-one societies. Forsaking is found in nine of the societies, and old people are abandoned in eight societies. The most frequent combination of behaviors, to both kill and abandon the elderly within the same social group, occurs in five instances. A combination of forsaking and killing is present in four societies, and forsaking and abandoning are present in only a single society. Interestingly, there is no difference in the treatment directed toward older males and older females.

Importantly, in all but one society in which multiple forms of death-hastening occur, supportive or nonthreatening treatment is also found. The most common pattern is for the killing, forsaking, and abandoning to be present with supportive treatment. Intuitively, it would appear to be emotionally, cognitively, and behaviorally inconsistent for such extremes of treatment—killing and support—to be present in the same society. This is resolved by answering the following questions: Who is to be supported? Who is to be denied food? Who is to be killed? A cultural contradiction is apparently avoided simply by directing different treatments toward different categories of the elderly within a given society (Barker this volume). The criteria upon which this differentiation is based are complex and will be discussed in detail in the analysis/discussion section.

The data on death-hastening provided additional details concerning the forsaking and killing of the elderly. In five of the nine societies is which old people are forsaken, there is total nonsupport. The elderly are denied food, shelter, and treatment for illness. Most often, as the previous examples show, the elderly are driven from their homes and forced to either beg or scrounge for food. Interestingly,

Table 5.1
Treatments in Nonindustrial Societies

Treatment	Number of Societies	Percent
Only Support	12	29
Support and Nonthreatening	4	10
Only Nonthreatening	4	10
Only Death-Hastening	6	14
Death-hastening and Nonthreatening	4	10
Death-hastening and Support	11	27
Total	41	100

societies in which the elderly are specifically denied sufficient or "desirable" food tend to be horticultural societies, whereas those that practice total forsaking tend to rely on hunting, fishing, or animal husbandry. The existence of relatively frequent "hunger seasons" in horticultural societies appear to result in the elderly being denied food, or only being provided with foods that are low in nutritional value or not easily chewed and digested (Fortes 1978:9; Ogbu 1973:319–23). Even though these "hunger seasons" appear to occur more frequently than is commonly presumed, it is usually only by chance that a researcher is in a community during a period of a severe food shortage. Thus, the forsaking of the elderly through the denial of sufficient food or the substitution of undesirable food is perhaps underrepresented in the available ethnographic literature.

Details concerning the killing of the elderly are generally lacking in the ethnographic material. An outsider is just not going to easily collect specific information on the killing of societal members, regardless of the age of the people being killed. The available data, though, do indicate several interesting patterns. The elderly are killed violently: beaten to death (three societies), buried alive (three societies), stabbed (two societies), or strangled (one society); and no difference based on sex was uncovered. The decision to kill the elderly individual was made, in all but one instance, within the family. The common procedure was for the children and the elderly individual to decide jointly that the time was "right to die." In two societies, the elderly individual appears to decide on his or her own when it is the proper time to die. Among the Yanoama, a South American shifting horticultural society, the decision is removed from the family and placed in the hands of the village leaders. The actual killing of the old person is also a family affair. In six of the seven societies on which data were available, a son, usually the eldest, kills his parent. Once again there is no variation based on sex.

Analysis/Discussion

The findings presented above answer three of the main questions posed earlier. The killing of the elderly does occur in other societies, and when killing, forsaking, and abandoning are combined into the broad category of

death-hastening, the elderly are dispatched in 50 percent of the societies with data in the PSF. The sex of the individual does not appear to make a difference since both males and females have their deaths hastened. Children, after consultation with their parents, make the decision, and sons carry out the actual killing. Three questions still remain to be answered: Why are old people killed, forsaken, or abandoned? In what type of societies is death-hastening found? How does this behavior compare to the killing of the elderly in our society?

Death-hastening is directed toward individuals who have passed from being active and productive to being inactive and nonproductive members of the social group. This transformation of the elderly from intact to decrepit has long been recognized within the anthropological literature, but the connection between it and death-hastening behavior has only recently been systematically analyzed (Rivers 1926; Simmons 1945, 1960; Maxwell, Silverman and Maxwell 1982; Glascock 1982; Kiemo 2004.). Leo Simmons perhaps best described the results associated with the transformation when he stated: "Among all people a point is reached in aging at which any further usefulness appears to be over, and the incumbent is regarded as a living liability. 'Senility' may be a suitable label for this. Other terms among primitive people are the 'overaged,' the 'useless stage,' the 'sleeping period,' the 'age grade of the dying' and the 'already dead' (1960:87). Thus, at least two categories of the elderly exist in nonindustrial societies: "normal old age" (the intact) and the "already dead" (the decrepit). In the most simple terms, it is when people are defined as decrepit that they have their deaths hastened.

In fourteen of the sixteen PSF societies in which a distinction is made between the intact and the decrepit elderly, some form of death-hastening behavior is present. In the majority of these cases, as Barker shows (Part VI this volume), both supportive and death-hastening treatments occur. The evidence clearly indicates that the intact elderly are supported and the decrepit elderly are killed, abandoned, or forsaken. This dichotomization of treatment can be most easily seen in several ethnographic studies. D. Lee Guemple's research among the Eskimo documents well the change in behavior that accompanies the redefinition of an elderly individual as decrepit as his or her health declines: "They [the aged] suffer a marked reduction in both respect and affection when they are no longer able to make a useful contribution. As they grow older and are increasingly immobilized by age, disease, and the like, they are transformed into neglected dependents without influence and without consideration. In short, old age has become a crisis" (1969:69). At this point, "the practical bent of the "Eskimo asserts itself forcefully. To alleviate the burden of infirmity, the old people are done away with" (Guemple 1969:69).

Finally, research in New Guinea and its neighboring islands shows the transition from intact to decrepit and the resultant change in behavior. "Van Baal reports that the Marind Amin elderly are respected and well treated as long as they are in good health. When they become helpless and senescent they may be buried alive by their children" (Counts and Counts 1985a:13). Research among the Kaliai of New Britain conducted by Dorothy and David Counts provides an example of an elderly man who, because he was suffering from physical disabilities

and declining mental acuity, had, in the eyes of his sons, lived too long. The sons, therefore, conducted final mortuary ceremonies, distributed property, and essentially defined their father as socially dead (Counts and Counts 1985b:145).

Although drawn from widely different societies, the previous examples show that death-hastening behavior is directed toward a specific type of elderly individual—the decrepit who have experienced actual or perceived changes in their health to the degree that they are no longer able to contribute to the well-being of the social group. This inexorable journey is traveled by males and females alike, but there is some evidence in the ethnographic literature that females begin the journey at a slightly later age than males.[2]

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Thus, death-hastening behavior is directed toward the decrepit elderly, but is this behavior found equally in all nonindustrial societies? To answer this question, a series of variables selected from the Ethnographic Atlas were correlated with the killing, forsaking, and abandoning of the elderly (Murdock 1967). The results indicate that death-hastening tends to be present in societies that: (1) are located in areas with harsh climates, in particular, desert and tundra environments, (2) have no horticultural activity or only shifting horticulture in which grain crops predominate, and (3) lack systems of social stratification. Societies that lack death-hastening and instead have only supportive treatment tend to: (1) be located in areas with temperate climates, (2) have intensive agriculture, (3) have a system of social stratification, and (4) have a belief in active high gods. In other words, death-hastening tends to occur in societies that can be characterized as simple—hunting and gathering, pastoral and shifting horticultural—while societies with exclusively supportive treatment are more economically complex—sedentary agricultural.

Although death-hastening behavior tends to be found in more technologically simple societies, it is common for this treatment to be present in conjunction with support of older people and to be directed toward only the decrepit elderly. Likewise, the supportive behavior found in more technologically advanced societies can vary depending upon internal conditions, such as social stratification, residential location, and gender. In many ways it is more desirable to be old in Pygmy society, even if one faces being abandoned and killed, than in some advanced agricultural societies. As long as they are intact, older Pygmies can look forward to respect and supportive treatment, receiving the most desirable foods in an environment that provides abundantly for the general population. In advanced agricultural societies, even though supportive treatment for the elderly is present, it must be put in the context of often harsh environmental and societal conditions; isolated residences, frequent food shortages, and exploitive state political systems can put the elderly in jeopardy even if they are generally supported.

CONCLUSION

The discussion of the cross-cultural material on death-hastening should refute the second assumption that we are the first society that has ever had to face such a morally vexing dilemma as assisted suicide. Death-hastening is a

common occurrence in nonindustrial societies, and people in these societies have had to make decisions concerning the decrepit or terminally ill elderly that are morally complicated and emotionally painful. I want to continue with the comparison by briefly analyzing the way in which the killing, abandoning, and forsaking of the elderly in these nonindustrial societies compares to assisted suicide in American culture. I also want to consider how we can learn from the similarities and differences that exist between these behavioral responses in nonindustrial and American society as we struggle to reach some type of societal consensus on what has become a significant moral dilemma. There are some clear similarities between death-hastening and assisted suicide:

1. The behaviors are directed toward people, often old, who have experienced a decline in physical or mental health and who are often terminally ill:
2. These individuals are considered burdens to themselves, their families, and to the community;
3. The decision to hasten death is difficult and involves family members, the stricken individual and often other members of the social group, such as physicians in American society, political and/or religious figures in nonindustrial societies.

There are, however, some significant differences between the behaviors found in American and nonindustrial societies.

First, examples of overt, direct killing of the elderly in America are still relatively rare enough to produce sensational responses in news reports. However, as discussed previously, approximately 6,000 deaths per day in the United States appear likely to be in some way planned or indirectly assisted by the joint decision of family and medical personnel through the discontinuation of or failure to initiate life support, or overmedication. Thus, there is an important difference in American society between dramatic, overt assisted suicide (i.e., Dr. Kevorkian), and more subtle, covert assisted suicides (i.e., discontinuing life support). The behaviors present in many nonindustrial societies—killing, abandoning, and forsaking—although emotionally demanding, resemble the less dramatic covert behavior found in American society. There appear to be some definite reasons for this response to death-hastening. Death-hastening is part of the culture of these nonindustrial societies; children have personally experienced the death of close relatives, and as they age they may be called upon to hasten the death of one of their parents, and they in turn may ask their children to do the same. As a result, death-hastening is open and socially approved in nonindustrial societies. In contrast, the covert nature of the vast majority of assisted suicides in American society indicates that there is not a society-wide acceptance of this behavior, and consequently it must be kept under cover and not open to discussion.

Second, the people who decide and undertake assisted suicide or death-hastening are quite different in the two types of societies. In nonindustrial societies, the decisions are made by the family, often with open discussions with the older person. As Maxwell et al. state, "Gerontocide is usually a family

affair" (1982:77). The decision is made by family members and usually carried out by a son. In American society, it is often unclear as to who decides—children, spouse, the terminally ill person, medical staff, courts of law, or some combination. Most often, the decisions appear to be made on an ad hoc basis, with the family brought in at the last minute and the stricken individual often not consulted at all. As the earlier examples of recent legal cases in America show, when the decision is made and implemented by a single person or undertaken in an overt fashion, the consequences can be severe—people can be charged with premeditated murder. Thus, it is not surprising that people, especially hospital and nursing home administrators and physicians, are reluctant to openly take responsibility for aiding in the termination of life to the point that decisions regarding the discontinuing of life support can end up in courts of law. Social sanctions in the form of prosecution and lawsuits are applied inconsistently, with the result being that most assisted suicide is done covertly and then covered up. In contrast, death-hastening in nonindustrial societies is open and direct and people are willing to take responsibility because the rules are known and accepted by the social group.

Perhaps the most significant difference between assisted suicide and death-hastening is the respective levels of technological sophistication of the two types of societies in which the behaviors are found. As has been shown, death-hastening is most prevalent in societies with simple subsistence/technological systems: hunting and gathering, pastoral, or shifting horticultural. Even though the issues surrounding the killing, abandoning, and forsaking are similar to those found in our society, the technological ability to maintain life is significantly different. In addition, the need for the social groups in these technologically simple societies to move frequently produces a threat to decrepit individuals as does the inability of most of these societies to store sufficient quantities of food to allow all members to survive severe food shortages.

American society is the most technologically sophisticated society that has ever existed. We have the ability not only to maintain life, but also to prolong life beyond the point many people think is reasonable. We are able to provide physically incapacitated individuals with many technological marvels, allowing these individuals to live, if not a productive life, one that certainly extends beyond that even imagined by members of nonindustrial societies. Yet we inarguably assist the deaths of large numbers of individuals every day and then struggle over the moral, ethical, and legal questions revolving around these actions. We search for a societal consensus that seems to be further away today than a decade ago.

NOTES

1. For a more complete discussion of the methodology employed, please refer to Glascock and Feinman 1980, 1981.

2. In certain nonindustrial societies, especially foraging and horticultural, women are often defined as "old" at a later chronological age than men. This is the result of people

in these societies employing a definition of elderly/old based on a change in the tasks that a person can accomplish. Once a person can no longer accomplish normal adult tasks, for example, hunting for men and gathering for women in foraging societies, he or she is defined as old, regardless of the individual's chronological age. In fact, it is rare in these societies for people to be aware of their "age" or the number of years they have lived. Since in foraging societies gathering is generally less strenuous than hunting, a woman will be able to undertake normal adult tasks at an older chronological age than a man. Thus, women tend to be defined as "old" at a later chronological age than men.