

THE MAINTENANCE  
OF LIFE

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*Preventing Social Death through Euthanasia Talk and End-of-Life Care—  
Lessons from The Netherlands*  
Frances Norwood



# THE MAINTENANCE OF LIFE

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PREVENTING SOCIAL DEATH  
THROUGH EUTHANASIA TALK AND  
END-OF-LIFE CARE—  
LESSONS FROM THE NETHERLANDS

Frances Norwood

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*This is dedicated in loving memory to Frances H. Norwood and all the other mothers and fathers, sisters and brothers, wives and husbands who gave us something really special before they died.*



# CONTENTS

Figures and Tables	xi
Series Editors' Preface	xiii
Life and the Process of Death: Meanings and Endings <i>Andrew Strathern and Pamela J. Stewart</i>	
Preface	xxiii
Acknowledgments	xxv
Chapter 1 • That's Not My Wife	3
Social Death	6
A Study of Dutch End of Life	9
The Book	18
Part I • Euthanasia in Perspective	25
" <i>Slaap Lekker</i> " (Sleep Well)	25
Chapter 2 • Making a Discourse	29
" <i>Niks Meer Aan te Doen</i> " (Nothing More to Do)	33
An End-of-Life Discourse	41
A Practice Based in <i>Overleg</i> (Consultation)	42
A Collection of Statements	43
The Rules: Inclusions to Euthanasia Talk	47
The Rules: Exclusions to Euthanasia Talk	50
Social Losses and the Maintenance of Social Bonds	54
Falling from Culture	57
Assertions of Control: A Look at Dutch Responses to Social Loss and Social Death	65

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<b>Chapter 3 • Euthanasia in Historical and Cultural Perspective</b>	67
Connection to Suicide	75
Euthanasia and Assisted Dying in Historical Perspective	79
The Dutch Experience	79
The American Experience	94
Euthanasia and Assisted Dying in Cultural Perspective	108
The Dutch Experience	108
The American Experience	117
Euthanasia in Historical and Cultural Perspective	121
<b>Part II • Euthanasia Talk in The Netherlands</b>	123
<b>Chapter 4 • A Family Friend at the End: A <i>Huisarts</i> Perspective</b>	127
A Different Kind of General Practice	129
A Family Friend	132
The <i>Huisarts</i> Role	138
Making Death Beautiful: The Elements of Ideal Dutch Death	141
Maintaining Dutch Families through Euthanasia Talk	145
When <i>Huisartsen</i> Do Not Facilitate Ideal Death	148
A Friend of the Dutch Family and an Agent of the State	151
<b>Chapter 5 • Into the Garden: Euthanasia Talk and the Dying Individual</b>	155
Into the Garden	157
Making Death Ideal	164
Control at the End of Life	168
Maintaining Connection	170
Individuals Excluded	174
Window to the Garden	178
<b>Chapter 6 • A Family Matter: Euthanasia in Families and Homes</b>	183
“Already Gone”	186
A Family Matter	192



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Family and the State	194
Managing Memories and Maintaining the Family	198
When Euthanasia Talk Does Not Bring Ideal Death	201
Euthanasia in the Context of Home and Family	204
<b>Part III • Conclusion</b>	<b>207</b>
The Phone Rings	207
<b>Chapter 7 • Lessons from The Netherlands: A Comparison of Practices and Policies at the End of Dutch and American Life</b>	<b>215</b>
Lessons from The Netherlands	216
Consider Euthanasia Policy in Its Structural Context	217
Evaluate the Enduring Link between Euthanasia and Suicide	219
Create Space for Processing Death and Invoking an Ideal	223
Consider Assisted Dying in Cultural Context	226
Improving End-of-Life Care	227
Policy Implications	229
<b>Appendix A • List of Expert Interviews</b>	<b>233</b>
<b>Appendix B • <i>Dutch Termination of Life on Request and Assisted Suicide (Review Procedures) Act (2002)</i></b>	<b>237</b>
<b>Appendix C • <i>Oregon Death with Dignity Act (1997)</i></b>	<b>247</b>
Glossary	261
References	265
Index	283



## FIGURES AND TABLES

Figure 2.1 Five Stages of Euthanasia Talk	44
Figure 3.1 Percentage of Persons who Initiated Concrete Requests and Died Euthanasia/PAS Deaths in The Netherlands versus Percentage of Persons who Initiated Prescription Requests and Died Physician-Assisted Deaths in Oregon, USA	103
Figure 4.1 Number of Euthanasia Deaths Performed by Study <i>Huisartsen</i> Compared to Years in Practice	143
Figure 5.1 Number of Patients Planning to Die at Home versus in an Institution	165
Figure 5.2 Main Illness of Patients with Euthanasia Requests	175
Figure 5.3 Age Range of Persons with and without Euthanasia Requests	176
Figure 6.1 Reasons for Canceling a Euthanasia Request	198
Table 2.1 Percentage and Number of Euthanasia and Physician-Assisted Suicide (PAS) Deaths in The Netherlands, 1990–2005	30
Table 3.1 Euthanasia and Other Medical Behavior That Potentially Shortens Life (MBPSL) as a Percentage of All Deaths in The Netherlands, 1990–2005	87
Table 3.2 Percentage and Number of Physician-Assisted Deaths (PAD) in Oregon, 1998–2007	102
Table 4.1 <i>Huisartsen</i> Characteristics, Study Sample versus Population	129

Table 4.2 <i>Huisartsen</i> : General Figures	131
Table 5.1 Characteristics of 25 Patients with and without Euthanasia Requests	180

## SERIES EDITORS' PREFACE

# LIFE AND THE PROCESS OF DEATH: MEANINGS AND ENDINGS

*Andrew Strathern and Pamela J. Stewart<sup>1</sup>*

Frances Norwood's deeply thoughtful exploration of euthanasia and related practices in the Netherlands induces us to contemplate how death, the final event in any individual life, is, can be, or should be, dealt with in circumstances when curing sickness or indefinitely prolonging that life are not perceived options. The end of life, like the beginning of it, is always potentially difficult, even traumatic, for the network of kin and friends as well as for the dying person. Its meaning must be very different in contexts where cosmological visions imply an afterlife from those in which such visions are attenuated or absent. And attitudes to euthanasia, as well as to suicide, must vary with cosmology also (for an example from the Pacific see Stewart and Strathern 2003). If life is a gift from an omnipotent God, it may be argued that only that God can determine when it should end, and it can thus be expressed in phrases of acceptance such as "It was his/her time", or "an act of God". So, too, with life's beginnings, in conception and parturition. Abortion and euthanasia stand logically in similar spaces of indeterminacy or disapproval, depending on the prevailing cosmology. The Christian doctrinal background in many places, including the Netherlands, would lead to such a presupposition. And in addition to religion the state and its authority over people are likely to be involved. For reasons that must have to do with deeply held

predispositions, abortion (under specific circumstances) may be permitted in practice by the state whereas euthanasia is not. At the end of life an adult person has long been enmeshed in the politico-legal structures of the state, their identities and potentialities categorized, filed, and put into place.

Their death, then, may be thought of as belonging more to the state than the termination of life prior to a birth. But, with progressive secularization and rationalization of practices, the state may come to embrace, and at the same time circumscribe practices previously tabooed by custom or religion. The term euthanasia itself implies something that is “good”, from its Greek roots, “well-dying” (parallel with “well-being, we might say). The term also carries an echo of the concept of “the good death”, defined differently in different culture-historical ways, but sometimes implying a peaceful end, without undue suffering, of a person surrounded by sympathetic kin and friends, who will also give the person, once passed away, a “good funeral”.

Issues of terminal care may be involved. When should care become palliative rather than an aggressive attempt to cure a condition? The voluntary choice of a person to move from hospital to home or hospice is a mark of a decision to let life go. Euthanasia, in concept, takes this move one step further, by making death a matter of personal agency rather than a passive acceptance of events that must be considered beyond one’s control and allowed to take their course. A decision of a person who feels that their life is effectively at an end simply to die without any artificial assistance at all is sometimes portrayed in works of art, and is not classified as euthanasia, although it is that person’s active effort to achieve a good death as they see it. A person may be kept in a nursing home for a long time and remain passively in existence until some minor condition may end their life. They may have willed this or even looked forward to the end, signaling this by an unwillingness to interact much even with kin, or by choosing which kin to interact with and which not as a mark of their continuing agency. When they finally pass away, perhaps in sleep, the event is likely to be described as “a blessing in disguise”.

In all or most of these cases the actions of care-givers and visitors are bound up with the idea of compassion. Medicines are administered to alleviate pain or induce sleep. The person's agency and experience become constrained. It is in circumstances like this or when such circumstances are already envisioned or anticipated that discussions about the eventuality of death are likely to reach into people's consciousness. Until then, a patient may be expected to, or may expect to, fight for life, a fight which begins as a fight to get well, to be cured, and may continue as a self-sustaining fight for each succeeding day of existence itself.

Frances Norwood has looked into these issues and processes in both the Netherlands and the U.S.A. Her carefully constructed investigation is also in part framed by her own reflexive subjectivity in relation to the deaths of her own kin, with an increment of empathy resulting from her own experience. The duality of the anthropologist as observer ("subject") and the people she studies as observed ("object") is here definitively transcended. (An even more striking example of this process can be found when an anthropologist discusses and analyzes their own experience with a particular condition, such as Emily Martin (2007) has done in her book on bipolar disorder, in the course of discussing the same topic in a broader fashion.) Norwood explicitly lets us see in her own life some of the concerns that others see and she has studied in theirs, that is, the experience of the deaths of kin or associates. It is the more compelling because of the inevitability and universality of the experiential issues involved.

From her detailed empirical studies in the Netherlands, Norwood brings forward to our attention two surprising results and one informative factor for making comparisons. The first surprising result is that "euthanasia" is often talked about as a possibility which can occupy the attention of a patient and their social network for a period of time without issuing in an actual decision to carry it out or the final implementation of an act of voluntarily ending the life in question. During this time the life of the person can also be reviewed and reflected on, over and above the possible struggle and pain of daily survival, precisely because of the poten-

tiality of setting a date for the death itself. The process can also be shared rather than one that is only introspective. This gives us the second surprising result, that talk about euthanasia may be seen as having a palliative function, even prolonging life while discussion about it goes on, and keeping the patient alive enough to think about what their life has meant and continues to mean and the circumstances in which they would or would not be content to die. Euthanasia talk is therefore as much about life as it is about death.

A further point—and this is the informative factor referred to above—is that the general medical practitioners (*huisartsen* in Dutch) in the Netherlands play a close, sympathetic, and mediating role between the state, the patient, and family and kin in the process of euthanasia talk. The role is authorized by the state, and the doctor will eventually play an active part if the patient decides to go through with the procedure of voluntary death. This places a large responsibility on the doctor, which is fulfilled exactly by the house visits, the lengthy discussions, and the whole process of careful deliberative discussion (*overleg* in Dutch) which Norwood remarks is characteristic of Dutch social culture generally. Given the stereotypical patterns of segmental, single-stranded, impersonal, and routinized interaction with primary care physicians in many contexts in the U.S.A., the model of the caring practitioner who makes home visits and gets to know people well seems to be a very valuable one to keep in mind as also potentially beneficial outside of the contexts Norwood is discussing concerning euthanasia.

The reference to euthanasia talk as a kind of palliative care, in which doctor, patient, and social network co-operate reminds one of the functions of hospice care in many places where euthanasia as such would not be legally permitted. From *The Irish Times* Weekend Review section for Saturday, December 13, 2008 (published in The Republic of Ireland) we culled a lead article with the title “Living and dying with dignity”. The article foregrounds the breadth of functions of hospices run by the Irish Hospice Foundation, with the aim of offering “more people comfort, friendship and a second home when they need it most” (loc. cit., p. 1). One patient is prominently quoted as saying: “I had been under the illusion that the



hospice was a place to die, but it's not. They make it so pleasant and make you feel like somebody cares" (ibid.). The same article reports a first national survey in Ireland conducted in 2004, in which 67% of people wished to die in their homes, without pain, conscious of those around them and with their "loved ones", i.e. kin or friends (ibid.). Yet, it goes on, in practice two thirds of the approximately 30,000 people who die each year in Ireland are in hospitals at the time of death (ibid.).

Here we interpret further the implications of the newspaper article discussed above. Efforts to increase the numbers of hospices and to expand their range of services are clearly designed, we suggest, to close the evident gap between people's ideal wishes and the limitations of what hospitals can do. Hospices are in between hospital and home. They can provide some professional medication, and they can also be more like a home. In a very broad sense, then, they provide both assisted living and assistance with dying. If to die at home is an ideal, for some people, we may note, euthanasia allows this to happen in a planned way. The patient is not whisked away in an ambulance for heroic surgery or medication, but may quietly prepare or be prepared to die.

The same section of *The Irish Times* featured on its back page (p. 16) a brief report, called "the television story of the week", in a documentary film of the "assisted suicide" (loc. cit., p. 16) of a person who was suffering from motor neuron disease. The theme of "dignity" is replayed here in a different context, since the clinic in Switzerland where the event took place is the "Dignitas Clinic" in Switzerland (ibid.). The film was reported to have shown the patient drinking a lethal dose of barbiturates through a straw, falling asleep, and dying within half an hour. The newspaper reporter writes: "He died in peace, in the presence of his wife" and "with a Swiss doctor and with the film crew" whom the dying person "had invited to witness his parting" (p. 16). The piece ends with "I hope he has found the peace he sought", a secular echo of the liturgical *requiescat in pace*, without its original cosmological implications of the dead waiting in peace for the second coming. The search for peace is clearly a theme shared by these two articles at front and

back of *The Irish Times* Weekend Review. Dividing them is the question of the avowed and legitimate means of how such peace may be obtained.

Interest in a case like this reported in *The Irish Times* is transnational. We (AJS and PJS) were in Taiwan on research in December of 2008, and we read another account of this case, reported directly from London, which appeared in *The China Post*, a local newspaper there in Taiwan. This report noted that a British television network came under criticism in the U.K. for screening the film. It notes that “this was the first time British television has shown someone committing assisted suicide” (*The China Post*, Thursday December 11th 2008, p. 2). The man whose death was depicted, who was 59 and partly paralyzed from his condition, had been a University Professor, the report says, and had wanted the film made so that people could see how such a death could be comfortable. He gave as his reason for wishing to die that otherwise he would continue to suffer and to inflict suffering on his family (*ibid.*). Anti-euthanasia activists, however, declared that it was irresponsible to show the film because to do so would be “euthanasia voyeurism” and “would create a false impression of a growing demand for assisted suicide in Britain” (*ibid.*). It would also strengthen pressures felt by people about imposing on “loved ones [kin], carers or a society that is short of resources”, a campaign group called “Care Not Killing” declared (*ibid.*). Such reports indicate clearly how controversial the subject is; they also show that it is of great and international public interest. To some extent the issue becomes more difficult with the secularization of society, which opens the way to such debate. To some extent, also, it is due to the ability of medicine to keep people alive or artificially alive. One way and another, the question of whether a person can legitimately be the instrument of ending their own life remains a matter of considerable concern in those countries with relatively long life expectancy figures and relatively advanced medical capacities. Dignity does seem to be a central matter in the debates. The Netherlands rule regarding euthanasia is constructed with this matter in focus. The person who, exercising their free will, has decided to end their own life, is

in a structural position analogous to that explored by Giorgio Agamben in his book *Homo Sacer* (1998), a person who cannot legitimately be sacrificed but whose killing also cannot necessarily be punished (Agamben 1998: 81); provided it is carried out in a prescribed way, we might add. Suicide or assisted suicide may be regarded as within the zone of taboo; or simply in the zone of the liminal, on the margins of legitimacy. All of these characterizations reflect the complex feelings that surround the topic and relate it to the overall mystery and liminality of the cycle of life and death, intimately related as well as in a sense opposed, often studied by anthropologists in conjunction with ideas about spirits, ghosts, and the “otherworld” that frames the life-span of the person in society. Attitudes toward death are bound to vary enormously according to ideas of this otherworld of spirits. “Gone to a better place” becomes available as a euphemism in a cosmographic world with an image of a “Heaven” in it. In the same religious world the saying “The wages of Sin is death” hints of the opposite of Heaven, Hell. Where such notions are less strong, or absent, focus is likely to be on the circumstances of death itself, whether it is peaceful or troubled and the like. Still, the idea of a journey can be present, wherever the destination is thought to be. Thus, a funeral well attended by kin and friends may be described as having effected “a good send-off” for the dead person.

Since birth and death, as well as other cyclical events, are tied in with kin relations, the roles of kinsfolk are likely to be crucial. The place of such kin in debates about how terminal illness is to be handled and whether a person can die “at home” is always likely to be significant. In nuclear family situations this burden is quite likely to fall on spouses; or on adult children. The extent of the obligations of such care-givers is by the nature of the relationships involved likely to be difficult to measure, since such obligations are open-ended, universal, and at the same time subject to agreements between those involved. At any rate, as with so much of contemporary life which is not conceptualized as belonging to the realm of kinship as such, in practice kin ties and kin networks tend to be

involved in decisions about life and death, and it is within the domains of kinship that the cyclicity of life and death is played out.

Dr. Norwood's study explores these and many other matters with great detail and ethnographic insight. Her book contributes deeply both to applied topics in medical anthropology and to a philosophical anthropology of life and death. Indeed she shows that these two topical arenas are closely connected, since basic philosophical ideas and cognitive schemata, expressed in relational or secular terms, create the contexts in which arguments about euthanasia are fought out. Dr. Norwood recommends that the Netherlands approach to these arguments can fruitfully be considered in other contexts, such as those in the U.S.A. Her work makes a most interesting contribution to discussions in Medical Anthropology and we are very pleased to include it within the Medical Anthropology Series of books with Carolina Academic Press.

Cromie Burn Research Unit, University of Pittsburgh  
February 2009  
PJS and AJS

## Note

(1) Prof. Pamela J. Stewart (Strathern) and Prof. Andrew Strathern are a husband and wife research team in the Department of Anthropology, University of Pittsburgh, and are, respectively, Visiting Research Fellow and Visiting Professor, Department of Anthropology, University of Durham, England. They are also Research Associates in the Research Institute of Irish and Scottish Studies, University of Aberdeen, Scotland, and have been Visiting Research Fellows at the Institute of Ethnology, Academia Sinica, Taipei, Taiwan during parts of 2002, 2003, 2004, 2005, 2006, 2007, and 2008. They have published over 35 books and over 175 articles on their research in the Pacific, Asia (mainly Taiwan), and Europe (primarily Scotland and Ireland). Their most recent co-authored books include *Witchcraft, Sorcery, Rumors, and Gossip* (Cambridge Uni-

versity Press, 2004); and *Self and Group: Kinship in Action* (in preparation with Prentice Hall). Their recent co-edited books include *Exchange and Sacrifice* (Carolina Academic Press, 2008) and *Religious and Ritual Change: Cosmologies and Histories* (Carolina Academic Press, 2009).

Their most recent research is on the topics of Cosmological Landscapes, Religious Conversion, Ritual Studies, and Political Peace-making.

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## PREFACE

This is a book about how people die today. When I mention to people I meet that I study death and dying, I invariably get one of two responses. Sometimes the person opens up with a heartfelt story of the death of a loved one or the person shys away from the topic with a comment like, “Isn’t that depressing?” and nonverbal cues that tell me that they really don’t want to know the answer to the question. The answer is yes, death is depressing, but there is also something beautiful and life-affirming about witnessing the passing of a human life. Studying with people who were dying and with people who cared for them taught me something about death, and about life. Death is hard and by witnessing it so intimately, I came to a new understanding of how valuable life is and I learned a little bit more about myself and what I want from life.

This book is about the day-to-day experience of death in a culture that has experimented with some new ways of supporting modern death. This book is for anyone interested in learning more about death in another culture in order to gain some insight into life and death where you live. This book is written for persons who are dying and for the family members who care for them. It is for healthcare professionals, bioethicists, policymakers, anthropologists and other social scientists interested in learning how to make a better way at the end of life.

This book is also intended for those on both sides of the euthanasia and assisted suicide debates. Most chapters begin with an extended excerpt of someone’s experience, highlighted by italics in the text. Based on in-depth interviews and observations with patients, family members, and healthcare practitioners, these excerpts

provide readers, who both support and oppose assisted dying policies, information about how assisted dying occurs on a day-to-day basis. They include direct quotes from taped interviews with participants (marked in the text by quotations) and paraphrased quotes and observations gained from fieldnotes taken during or immediately following an event and often double-checked by interviews with participants following an event. While individual names have been changed, the stories—the events, the people, and the locations—are real.



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Thank you to my mother for inspiring me to seek and to my father for inspiring me to study and learn. Thank you to the *huisartsen* who bravely offered to have an American anthropologist in tow. Finally, thank you to all the families who participated in this study who opened their homes and their lives to me when they had such precious little time left together. This project has received funding through grants from the University of California-San Francisco, University of California-Berkeley, the American Association for Netherlandic Studies, and the Netherland-America Foundation. Any mistakes in this text are my own.

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