Introduction

The contemporary medical field—including palliative care as a relatively new interdisciplinary approach to care for terminally ill and dying people—is characterized by its own guiding distinction between health and illness, which marks a barrier between medicine and non-medicine and structures the field of medicine itself (Vogd 2007, 2011). This results from the following three processes of differentiation, with particular consideration towards the end of life.

Medicalization, coined by Ivan Illich (1976), is best described as an extension of a medical mode of thought on problems that have not previously been under medical consideration. Medicalizing the end of life started in the late eighteenth century when physicians assumed power; until then ‘the clergyman had an established, largely uncontested place at the deathbed’ (Stolberg 2017: 70). The professionalization of the medical field in the nineteenth century made for different roles: various specialized medical professionals care for certain fragmented parts of patients’ bodies (Stichweh 2008). At the end of life, however, medical professionals try not to take a fragmented look on the terminally ill and dying, but rather a more holistic approach. Following Michel Foucault (2011), the institutionalization of the medical field has its roots in the seventeenth century and is marked by establishing and developing university hospitals bound to treating and researching illness. The institutionalization of caring for the terminally ill and dying dawned in the 1950s and led to the founding of hospices for the terminally ill and dying and palliative care units in hospitals, as well as to significant discussion about these developments.

In line with these processes, European palliative care grew out of the modern hospice movement that dates back to the 1960s, even though its origins are further back. Without insinuating a complete uniformity to all European countries’ palliative care policies and provisions, this chapter henceforth focuses on palliative care in Europe for two reasons. First, even if there exists a global palliative care movement (e.g. Centeno and Rhee 2019; Connor 2019; Harding et al. 2019), the policy and provision of palliative care vary a lot according to the welfare and healthcare system of any given state. As, unlike others, European countries are not facing basic problems in providing primary healthcare and emergency care, they are in the position to provide high quality palliative care. Such care ought to be provided to all people no matter...
where they receive care or what they suffer from. Terminally ill and dying patients may stay at home, reside in nursing homes, be hospitalized on different wards, or find a last home in a hospice or on a palliative care unit. There is also a differentiation between basic or specialist palliative care. Whereas basic (or general) palliative care is provided by primary and specialist caregivers in any location, specialist palliative caregivers require a more specific training, given that they attend ‘to the complex needs of patients with progressive chronic life-limiting conditions and their families and to give support to other services’ (Gómez-Batiste et al. 2019: 83), and is thus more likely to be provided in hospices, palliative care units, outpatient clinics, and possibly by mobile or support teams that either visit patients on various hospital wards or at home (Gamondi et al. 2013; Roth and Canedo 2019; Ryan and Johnston 2019). And second, the medical field in Europe is shaped by the dominance of conventional medicine and the concurrent subordination, yet growing relevance of, complementary and alternative medicine. In other countries, however, those different medical systems often co-occur quite differently (for examples, see Alavi, this volume, and Hsu, this volume).

By now, research on palliative care in Europe is well established. Palliative care is not only investigated within medical, historical, and social-scientific disciplines, it has developed into a research field on its own with professorships, conferences, and academic journals—Palliative Medicine, founded in 1989, and the European Journal of Palliative Care, founded in 1994, are prominent examples. All of them are connected by their recourse to the World Health Organization’s definition of palliative care, published in 2002:

Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. (World Health Organization 2002)

According to this, palliative care primarily aims at improving the quality of life at the end of life by treating pain as well as psychological, social, and spiritual needs. In addition, the WHO outlines another nine aims of palliative care. Whereas some are more practical (e.g. ‘palliative care provides relief from pain and other distressing symptoms’) or structural (e.g. ‘palliative care uses a team approach to address the needs of patients and their families’), others are more ideological. By stating that ‘palliative care affirms life and regards dying as a normal process’ and ‘intends neither to hasten or postpone death,’ palliative care firstly claims to provide holistic care, secondly implies distinct ideals of a good death, and thirdly objects to assisted dying. Whereas these core ideologies of European palliative care require no religious rationalizations, they render them possible. As a consequence, palliative care is a field in which medical and religious rationalizations may be entangled. One example of such an entanglement is anthroposophic palliative care.

This chapter portrays anthroposophic palliative care as a religiously substantiated embodiment of palliative care. After a brief introduction to the history on European palliative care, the aforementioned ideologies are illustrated. Thereafter, the chapter introduces anthroposophic medicine and palliative care and describes anthroposophic medical conceptions of the person and the afterlife. This is because the latter are of importance when it comes to illustrating how the claim to provide holistic care, distinct ideals of a good death, and an objection to assisted dying—against the background of anthroposophic palliative care—are medically and religiously rationalized.
A brief history of palliative care in Europe

From an etic perspective, the history of medicine (e.g. Ariès 1976; Stolberg 2017; Strange 2009), social sciences (e.g. Walter 1994; Kellehear 2007; Kemp 2014), and religious studies (e.g. Foley 2005; Garces-Foley 2013) have contributed to the recent historiography of caring for the terminally ill and the dying. There are no fewer emic accounts of this history, yet the boundaries between outsider and insider perspectives have become ambiguous since the emergence of palliative care as its own field of research (e.g. Clark 1998, 2001, 2007; Gómez-Batiste et al. 2019). Even if renowned scholars (e.g. Vanderpool 2015; Clark 2016; Stolberg 2017) have shown that the medical care of the terminally ill and dying by medically trained personnel is rooted in the early modern age, contemporary European palliative care mostly dates back to the so-called modern hospice movement. This movement was influenced by medical improvements and societal changes alike. Illness was better mastered by medicine than ever before, and dying and death became less of a societal taboo. In this atmosphere, hospices for the terminally ill and dying made for structural alternatives to hospitals—that were often not initiated by the authorities, but by ‘grass-roots community initiatives’ (Walter 1994: 88). Yet hospices not only constituted a structural alternative to the healthcare system, which, at the time, was viewed as technical, fragmentary, and mechanistic, they also featured new ideologies.

Cicely Saunders was one of the most prominent figures to promote these ideologies in the United Kingdom and beyond. In 1968, she established St. Christopher’s Hospice in London based on former discussions with a dying Jewish patient whom she met just after World War II about a place where he would be given ‘the time and space to make his own terms with an apparently unfulfilled and meaningless life’ (Saunders 2006: 280). This story not only constitutes a foundation myth for the modern hospice movement—with Cicely Saunders at its very core—but it also supplies a rationale for the inclusion of religion into the care for the dying and terminally ill (Clark 1998: 51). In accordance with this, several hospices were founded in Western Europe and North America as of the 1970s. While hospice care was slowly being transferred into all areas of healthcare throughout the 1980s and 1990s, critical voices were raised about the ‘routinization of hospice’ (James and Field 1992) and the ‘secularisation of an ideal’ (Bradshaw 1996). Regardless of when exactly this routinization and secularization of hospice began, the care for the terminally ill and dying seems to have lost at least some of its religious roots by around the time the WHO favoured the term palliative care over hospice care in its definitions of 1999 and 2002 (Foley 2005: 43). Whereas early hospices were often founded by religious communities or on Christian bases, more and more palliative care units were established in secular hospitals. Nevertheless, palliative care ideologies—such as the claim to provide holistic care, distinct ideals of a good death, and the objection to assisted dying—still allow for religious rationalizations.

Palliative care as holistic care

The notion of holism in European palliative care refers to the idea of individualized care for the whole person by a multi-professional team (Baldwin and Greenwood 2011; Brant 2017). These aspects of holistic care relate to Cicely Saunders’ concept of total pain, which underpins the WHO’s palliative care definition. Saunders differentiates between physical, mental, social, and spiritual pain, yet the latter does not necessarily have to be identified and labelled as such: ‘Few people today are likely to express their doubts and griefs in terms that are recognizably...
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religious’ (Saunders and Baines 1983: 62). Rather, spiritual pain is associated with feelings of ‘meaninglessness,’ which Saunders (1988) believes can be recognized through attentive listening. Principally, all members of the multi-professional team are required to tend to all four forms of pain, including the spiritual dimension, so as to acknowledge the wholeness of the terminally ill and dying. By doing so, the multi-professional team creates an ‘atmosphere of acceptance’ that allows for ‘forgiveness’ and ‘meaningfulness’ (Saunders and Baines 1983: 62–65).

In this conception, spirituality as a universalized understanding of seeing one’s life as ‘meaningful,’ regardless of whether the patient classifies himself as ‘spiritual’ or ‘religious or none of them, is conceptualized rather broadly. This understanding is also prevalent in the broader medical field, where spirituality is mainly understood as ‘a broader term that may or may not encompass religion’ (Edwards et al. 2010: 753). In so doing, spirituality allows for the inclusion of all types of beliefs and practices, independent of the patients’ religious backgrounds (Saunders 2001).

Applying such a broad term of spirituality through equating it with ‘meaning-making’ and a ‘quest for meaning’ may blur what is often referred to as spiritual care. Arantzamendi et al. (2019), for example, subdivide this aspect of palliative care into a seemingly areligious, psychological emotional care and a religiously informed spiritual care. Emotional care tends to see ‘hope, anger, maintaining control and dignity, and meaning-making . . . as part of the process of coping with and adapting to the end of life’ (Arantzamendi et al. 2019: 822).

Even though ‘meaning-making’ is thought to help ‘achieve a sense of transcendence’ and the ‘quest for meaning’ builds on the patients’ personal identities, moral principles, and religious beliefs,’ they still classify this sort of care as emotional care. Spiritual care, on the other side, is based on the aforementioned broad definition of spirituality that centres around the fact that individuals ‘seek meaning, purpose and transcendence’ by looking at the ‘inner-most self,’ ‘surroundings,’ and ‘the beyond’ (Arantzamendi et al. 2019: 825).

In accordance with this theoretical differentiation in palliative care literature, spiritual pain, in practice, is usually addressed by the whole multi-professional team as a sort of emotional care, whereas more specific spiritual care interventions are mostly undertaken by healthcare chaplains that typically belong to one or another religious tradition and are consequently less broad and inclusive (Walter 1997).

Good death in palliative care

Even though ideals of a good death have existed throughout history and across socio-cultural contexts, they vary a lot—as Tony Walter writes: ‘Dominated by religion in the past and by medicine in the present: the idea of what constitutes a good death has changed in different cultures and societies throughout history’ (Walter 2003: 218). Whereas in the Middle Ages, ‘the aim was . . . to free the soul for entry into the afterlife’ (Round and Llewellyn 2016: 194), nowadays people focus less on what happens after death but rather on the process of dying. The idea of an afterlife has largely vanished behind that of personal growth in this life. Accordingly, it has become the individual’s task to control and optimize their process of dying, which devalues people whose dying appears to be un-active, unaware, unaccepting, unreconciled, or un-optimized (Streeck 2017). So as to acknowledge the fact that not each process of dying proceeds ideally, McNamara (2004) has coined the term good enough death.

On the level of ideals, a good death is a natural death. In contemporary European palliative care ideology, dying constitutes a part of life that has a value in itself for all parties involved: for the dying person who needs to sort things out and develop till the very end; for the relatives
who benefit from these undertakings and who witness a treasurable moment if they’re present at the actual moment of death; and for the caregivers who are able to learn from the terminally ill and dying about themselves, their own lifestyle, and life in general.

These ideals of a good death are surrounded by attributes like calm, quiet, freedom from symptoms and pain, consciousness, mental awareness, and dignity. A good death features a high level of self-determination and acceptance (Berger 2003; Chandler 2013). Richard Smith, former editor of the British Medical Journal, lists the following ‘principles of a Good Death’ from a fictive patient’s perspective:

To have choice and control over where death occurs; . . . To have access to any spiritual or emotional support required; . . . To be able to leave when it is time to go, and not to have life prolonged pointlessly.

(Smith 2000: 129)

Against all these attributes, features, and principles, there is little empirical data or knowledge on what constitutes a good death in practice (Kendall et al. 2007: 527); they are more likely ideals of care.

Palliative care approaches to assisted dying

The European palliative care field is characterized by an objection to assisted dying—an umbrella term for ‘(physician) assisted dying and suicide’ as well as ‘(voluntary) active euthanasia.’ The first term refers to the practice of physicians prescribing lethal drugs to a competent patient who then takes his or her own life and the latter refers to a physician both prescribing and administering a lethal drug to take a patient’s life (Fins and Bacchetta 1995). As of 2019, assisted dying is—in various forms—legal or legally tolerated in the following European countries: Belgium, The Netherlands, Luxembourg, and Switzerland (Chambaere and Bernheim 2019; Preston 2019). The withdrawal of treatment so as to not prolong life unnecessarily (Walter 1994: 152–156) and palliative sedation (Byock 2016: 369) are, however, widely accepted within the field of palliative care more broadly (e.g. Connor 2017: 204–216; Diamond et al. 2019).

The aversion towards assisted dying goes back to Cicely Saunders, who contributed various rationalizations for its avoidance. Medically spoken, the patient’s wish to die is seen as a reaction to an unaddressed anxiety or insufficient pain treatment: in sum, bad care. Accordingly, Saunders (1990) says, high quality palliative care could help to diminish patients’ wish to die. She further poses that ‘much may be gained by living until death comes’ (Saunders 2003: 20) and that suicide evoked a challenging grief for the bereaved. All this is based on her religious belief in an afterlife that would have comforting effects for both the dying and the bereaved.

Until the millennium, the palliative care field’s stance against assisted dying seemed rather unified (Walter 1994). Recent research, however, shows that these original positions are shifting towards a more favourably viewed view on assisted dying. While some caregivers still believe that ‘hastening’ death makes it impossible for the dying to ‘finish up their business,’ others argue that acting in accordance with one’s personal choice allows for a good death (Blaschke et al. 2019).

Even if many caregivers believe that assisted dying is unnecessary if good palliative care was provided, others acknowledge that even an excellent care practice cannot relieve all sorts of suffering (Blaschke et al. 2019). Accordingly, evermore caregivers argue that palliative care
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and assisted dying are not mutually exclusive (Barutta and Vollmann 2015). Most caregivers, ultimately, agree on the fact that being professionally involved in assisted dying has a negative impact on themselves (Blaschke et al. 2019). Bouthillier and Opatrny (2019), for example, have found that many more physicians were in favour of assisted dying being available to patients than were ready to prescribing or administering lethal drugs themselves.

Irrespective of these aforementioned shifts regarding the importance of self-determination, the interrelatedness of assisted dying and palliative care, and the impact of assisted dying on medical professionals, international palliative care organizations stand officially against assisted dying (Lima et al. 2017), while admitting that ‘patients requesting a lethal injection to end their suffering by the induction of death are a great challenge in palliative care’ (Radbruch et al. 2015: 11).

It is not surprising that hardly any religiously informed position against or for assisted dying is revealed in this discourse on assisted dying with the field of palliative care, given that medical publications are generally against publishing religious language and rationalizations, even if they are presented alongside scientific language and rationalizations. General research on assisted dying, however, is investigating the correlation of religious affiliation and attitudes towards assisted dying (Burdelette et al. 2005). What can be said is that while pro-assisted dying movements—such as ‘pro-choice,’ ‘right-to-die,’ and ‘death-with-dignity’ movements—argue without reference to religion, opponent groups, like the broader ‘pro-life’ movement, are often linked to religious communities that view assisted dying as an attack on the sanctity of life (Chambaere and Bernheim 2019).

Anthroposophic medicine and palliative care

Anthroposophic palliative care builds on the history and ideologies of European palliative care on the one hand and those of anthroposophic medicine on the other. Anthroposophic medicine goes back to Rudolf Steiner, founder of the anthroposophic movement, and Ita Wegman, who was both an anthroposophist and an academically trained physician. Steiner organized the first medical courses for anthroposophically interested medical staff in 1920 in Dornach (Switzerland), where he and Wegman presented several papers together. Wegman founded the first anthroposophic hospital in Arlesheim (Switzerland) with Steiner contributing to the everyday medical practice. Together, they published the first monograph on anthroposophic medicine in 1925, called The Fundamentals of Therapy—An Extension of the Art of Healing through Spiritual-Scientific Knowledge (Steiner and Wegman 1925). This title is programmatic: anthroposophic medicine views itself as not in conflict with conventional medicine, but as a spiritual extension of it, which corresponds with Steiner’s notion of Anthroposophy linking science and spirituality:

Under Anthroposophy I denote a scientific investigation of the spiritual world which, while cognizant of the limitations of mere physical science and ordinary mysticism, and before attempting to penetrate into the spiritual world, first develops in the soul faculties not yet evident in ordinary consciousness and science.

(Steiner 1929)

What started as a rather local phenomenon in the 1920s has spread all around the world, even though it still centres around Germany and Switzerland, with most of the approximately twenty-eight anthroposophic hospitals, hospital departments, and centres located in Western Europe (Kienle et al. 2006: 8). Apart from these institutional settings, there are physicians who
practise anthroposophic medicine as part of their daily routine as conventionally trained and officially acknowledged family practitioners, paediatricians, and so on.12

Ever since its foundation, anthroposophic medicine tended to the terminally ill and dying, as the transition from life to death is a central topic in Anthroposophy. Even so, the term anthroposophic palliative care is relatively new to the field of anthroposophic medicine (e.g. Girke 2016; Heusser 2006) and it was not until the twenty-first century that the emic term has been used by outsiders (e.g. Floriani 2016; Zeugin 2016, 2020, forthcoming; Zeugin et al. 2018).

Anthroposophic palliative care is performed by physicians, nurses, and therapists alike. Anthroposophic physicians first receive conventional medical training; anthroposophic medicine comes in as further specialized education, similar to oncology or palliative medicine. Anthroposophic nurses also are trained conventionally according to the prevalent training system and anthroposophic and palliative nursing come into play as further education either pursued personally or offered by the healthcare facility. In contrast, anthroposophic medical therapists such as eurythmy therapists,13 rhythmical massage therapists,14 or art and sculpture therapists15 are exclusively trained at anthroposophic educational institutions.

Anthroposophic medical conceptions of the person and the afterlife

Anthroposophic palliative caregivers share a certain set of conceptions that stems from an anthropology consisting of four bodies, often referred to as the fourfold human being.16 The physical body (or matter) is accessible to observation from the outside and features all ‘physicochemical properties, functions and structures’ (Heusser and Kienle 2009: 325). It is the carrier of the other bodies and hence, ‘it can only be perceived in isolation in the lifeless state’ (Längler and Seifert 2012: 30–31). The etheric body (life) is responsible for ‘growth . . . nutrition, [and] respiration’ (Heusser and Kienle 2009: 325), and it endows the human being with its self-healing forces and biological identity. ‘The etheric body can be perceived in the organized form of the physical body . . . and is expressed, for example, in the formation of the face’ (Längler and Seifert 2012: 31). The astral body (soul) represents the human being’s ‘consciousness, sensations, pain, lust, emotions, desires, instincts, [and] intentions’ (Heusser and Kienle 2009: 325). Thus, it is the carrier of feelings. Among other things, muscle tone, manner of breathing or speech, and countenance are visible expressions of the astral body on a physical level (Längler and Seifert 2012: 31). The ego-organization or ‘I’ (spirit) is the highest, most spiritual body of the human being. It is equal to the individuality and is the ‘vehicle of thinking and remembering’ (Längler and Seifert 2012: 31). The ego-organization is not visible and is believed to be perceptible only ‘via a substantive knowledge through the faculty of intuition’ (Längler and Seifert 2012: 31).17

Following this anthropology, illness is connected to an imbalance of these four bodies and ‘can have physical, etheric, emotional, or spiritual causes’ (Heusser 2016: 273). In reverse, health is not merely an absence of illness or a malfunctioning of the physical body, but a balance of all four bodies. To sustain or gain health, then, means to keep or bring matter, life, soul, and spirit in(to) harmony through anthroposophic medicine, because it is ‘not only aimed solely at physical interactions at a molecular level . . . but at differentiated effects of laws and forces in the realms of life, soul and spirit’ (Heusser 2016: 274).

For anthroposophic palliative care, the anthropology of the fourfold human being calls for the belief that death is not an end point but a transition to another form of existing: ‘In death, the “I”, the astral and the etheric bodies leave the physical behind’ (Girke 2016: 997). Dying thus appears as a dissolution of the human body. Correspondingly, dying is believed to be a
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process consisting of three stages: in the moment of physical death, life, soul, and spirit let go of matter, which conventional medicine takes as death. After this, the dead experience some sort of ‘retrospective memory’ that ‘resembles a tableau, or a panorama, woven out of all we have experienced during our past life’ (Steiner 1916). Over this ‘life panorama’—as it is often referred to—all memories rise up, yet they change their appearance given that they are re-experienced instead of rethought. This etheric death occurs over a period of three days and leads to the distribution of the etheric body into the world’s aether. Then, the astral body and ego-organization enter the ‘Kamaloka’—a place where the soul has to suffer from all desires it still has but is not able to satisfy. The astral death usually lasts one third of an actual lifetime and is characterized by re-living the whole life but in a different time order:

In Kamaloka a man (sic) lives through his whole life again, but backwards. . . . What is the point of this? The point is that he has to pause at every event and learn how to wean himself from his dependence on the physical and material. . . . And when he has lived through his life right back to the day of his birth, he can, in the words of the Bible, enter into the ‘kingdom of Heaven.’

(Steiner 1906)
The Bible’s ‘kingdom of Heaven,’ however, is not the endpoint of one’s individuality: once the ego-organization has entered the spiritual world, it is bound to be reborn; the time after death gradually transitions into the time previous to birth. Thus, anthroposophic medicine presumes that the human being’s individuality transcends death and reincarnates after a certain period of time (Selg 2005).

Ideologies of anthroposophic palliative care

Kellehear (2003) states that the structural preconditions allowing complementary and alternative medicine (CAM) to be employed in palliative care are based on the field’s ‘interdisciplinary imperative’ that allows the integration of a multitude of practitioners and practices into caring for the terminally ill and dying. Yet that alone is an insufficient explanation of how the rationalizations of CAM practices relate to palliative care. A short glance at the anthroposophic medical perspective on core palliative care ideology will show that the practice of conventional and anthroposophic palliative care are completely in line, yet the ideology of anthroposophic palliative care exceeds that of conventional palliative care because of its religious rationalization.

With regard to holistic care, anthroposophic palliative care strongly opposes a seemingly technical, fragmentary, and mechanistic care that reduces terminally ill and dying people to their physical pain or suffering. As pain and suffering are viewed as not only affecting the physical body, anthroposophic palliative care thus aims to incorporate psychological, social, and spiritual dimensions of pain and suffering. It assumes that the spiritual is a constitutional part of every human being and not merely a possible root of pain or a dimension of care. Accordingly, anthroposophic palliative care is performed by a multi-professional team (Ritchie et al. 2001: 39–40) including anthroposophic medical therapists—such as eurythmy, rhythmic massage, and art and sculpture therapists—who tend to all four bodies of the human being.

All these practitioners act in accordance with the anthroposophic anthropology of a four-fold human being that also affects how anthroposophic caregivers idealize a good death. Illness, dying, and death are not viewed as problems to be prevented, but integral components of life: even though illness may be tragic for patients and relatives alike, it’s also
‘an opportunity for learning and transformation’ (Arman et al. 2008: 258); dying is seen as a process in which ‘important development of the spirit is taking place’ (Varriale 2019: 15); and death is not taken for an endpoint, but a transition from this world into the next. Building on the belief that everything a human being experiences is predetermined through one’s past life/lives and in turn affects the future life/lives, illness, dying, and death are not futile. On the contrary, they are meaningful in as much as they hold learning opportunities that allow for spiritual growth. In this conception, a good death is more than just natural, self-determined, and accepted—the main topoi of a good death in conventional palliative care. In the anthroposophic setting, a natural death additionally means that, ideally, a dying patient is conscious and free of pain at the same time so as to go through the dying process fully aware and able to seize all possible learning opportunities (Girke 2016: 1020–1021). Self-determination aims at a very high level of patient autonomy that credits patients with active roles in therapy planning. And ultimately, accepting a terminal illness empowers a patient to transform hopelessness and futility into a stimulus for spiritual growth (Werner 2004).

Assisted dying therefore appears to be the opposite of a natural, self-determined, and accepted process of dying. At first glance, anthroposophic palliative caregivers and researchers’ arguments against assisted dying resemble those of conventional palliative care publications and associations, as they agree that patients’ wishes for assisted dying are a result of bad care. A closer look, however, reveals that the anthroposophic palliative care field’s objection to assisted dying goes beyond medical reasoning. Heusser (2003) states that belief in individual, yet non-spiritual decision-making (in favour of assisted dying) is not consistent from an anthroposophic point of view given that the ego-organization, which is the most spiritual body of the human being, is responsible for decision-making in the first place. Schopper (2003) argues that dying, illness, and death are highly fruitful when considered anthroposophically: dying is a transition, illness a spiritual experience, and death a new birth. Thus, a patient’s death wish displays hidden spiritual needs that ought to be tended to. And Helwig (2003) highlights that, even if assisted dying is legal in the place of a particular anthroposophic health facility, these facilities do not comply with patient requests for this service and advise patients to go elsewhere.

All of these rationalizations draw on one or another statement of Rudolf Steiner on suicide: ‘When someone commits suicide he has identified his ego with the physical body. For this reason, the longing for the physical body is all the more intense. It seems to him that he is like a hollow tree, like someone who has lost his ego’ (Steiner 1905). Accordingly, committing suicide—and assisted dying is seen as exactly that—is believed to impact the developments after physical death, since the letting go of the physical body turns out to be harder for those who have taken their own life. As a consequence, they would not just suffer in ‘Kamaloka’ for a third of a lifetime but for the whole span. This, however, is not to be seen as punishment, but as a necessary part of the human being’s spiritual growth (Herzog 2003).

Conclusion

From the foregoing, it follows that conventional and anthroposophic palliative care are in line when it comes to the common set of ideologies, including the claim to provide holistic care, distinct ideals of a good death, and an objection to assisted dying. Anthroposophic palliative care, however, exceeds these ideologies by supplementing medical reasoning with a religious rationale that strongly builds on an anthropology that includes transcendent aspects of the human being. This analysis coincides with the field’s own evaluation of the ‘surplus’ of anthroposophic palliative care: whereas anthroposophist palliative caregivers depict both
conventional and anthroposophic palliative care as counter-movements to the highly specialized and materialistic paradigm of biomedicine, they believe that anthroposophic palliative care may serve as the ‘rescuing angel’ that re-integrates ‘spirituality’ into medicine (Bopp 2010).

This chapter has shown how conventional medical rationalizations of core palliative care ideologies entangle themselves with religious rationalizations against the background of anthroposophic palliative care. As such, anthroposophic palliative care has proven to be a religiously substantiated embodiment of palliative care and has thus served as an example for the entanglement of medical and religious rationalizations. Given that the modern hospice movement was founded by Cicely Saunders on a Christian basis, other religious rationalizations are no less expectable in the field of contemporary European palliative care, especially when they enter it by means of CAM (Kellehear 2003).

Notes
1 The distinction of illness, disease, and sickness is an important topic of medical anthropology (e.g. Young 1982) and medical sociology (e.g. Atkinson 1995: 21–25). In their understanding, illness varies historically and culturally, which is why in the following illness and ill are used as main terms.
2 One significant point of this discussion is the fact that most people would want to die at home, whereas research shows that in Europe, dying in hospital and nursing homes is far more common (Robinson et al. 2006). Kellehear (2017), on the other side, deems the institutionalisation of dying a ‘myth,’ given that the social understanding of dying implicates more than just the final stage of dying.
3 For a glance at legal aspects of palliative care, see Lombard (2018) and Meisel (2016).
5 Cicely Saunders’ person and her achievements for the modern hospice movement are well documented (e.g. Clark 2018; Hartley 2014). Saunders (1978) herself presents an early account on the main ideologies of palliative care in Europe.
7 Etymologically, the ideals of a good death can be derived from either ‘dying well, that is, painlessly and easily’ or ‘dying beautifully or in an ideal or exemplary way’ (Kellehear 2007: 90).
8 One following thought from this is that the legalisation of assisted dying should only happen if palliative care is widely available and of high quality (e.g. Blaschke et al. 2019).
9 Whereas Glöckler (2004), Glöckler et al. (2011), Kienle et al. (2013), and Längler and Seifert (2012) offer compact introductions to anthroposophic medicine, Kienle et al. (2006) review all available research that has been conducted within the field of anthroposophic medicine. Glöckler and Heine (2016) inform one about organizational aspects of anthroposophic medicine and Zuck (2012) discusses its legal framework.
11 Accordingly, anthroposophic medicine increasingly views itself as integrative to conventional medicine (e.g. Kienle et al. 2013; 2016).
12 The legal status of anthroposophic medicine and its integration into national healthcare varies a lot. In Switzerland, for example, anthroposophic medicine is one of the five CAM methods that were integrated into national healthcare due to a national petition. As of 2017, anthroposophic medicine is covered by compulsory health insurance given that it is provided or directed by an acknowledged physician (Zeugin 2020).
13 Eurythmy is an anthroposophical expressive art and movement therapy that was founded in 1912 and transferred into anthroposophic medicine after 1921 by Rudolf Steiner (Zeugin forthcoming). The main aim of eurythmy therapy is to ‘increase awareness of the body, the self and ultimately the surrounding environment’ (Ritchie et al. 2001: 73). Eurythmy therapy is based on the gestural letters of the eurythmic alphabet. These gestures are believed to have their own meaning and effects (e.g.
the vowel ‘I’ stands for self-assertion) and are thus, on diagnostic bases, ‘gradually built up into a sequence’ (Ritchie et al. 2001: 73).

14 Rhythmical massage therapy is an anthroposophic medical therapy that stems from classical Swedish massage and was adapted to the anthroposophic setting by Ita Wegman and Margarethe Hauschka (1978) as of the 1920s (Zeugin 2020). Rhythmical massage therapy ‘is a body massage where the focus is on generating a general balance to the ‘system’ as a whole’ (Ritchie et al. 2001: 6) by ‘encouraging the body’s own natural healing capacities’ (Ritchie et al. 2001: 70).

15 Anthroposophic art and sculpture therapy is conducted as individual or group therapy and uses ‘watercolours, pigments made from natural plant colours, pastels, charcoal, pencils and clay’ (Ritchie et al. 2001: 81). Often, anthroposophist art and sculpture therapists refer to Goethe’s colour theory and ascribe a distinct meaning and effect to every colour—for example, red stands for euphoria and the power of transformation (Zeugin 2020).

16 The fourfold human being is not the only anthroposophic anthropology. Rudolf Steiner also taught a threefold anthropology—body, soul, and spirit—and a sevenfold anthropology that differentiates the ego-organisation further into a spirit-self, a life-spirit, and a spirit-man (Steiner 1906). However, the fourfold human being is the anthropology most adapted to illness, dying, and death, and thus the most prominent in anthroposophic medicine. Alternative terms are the fourfold structure of the human organism (e.g. Längler and Seifert 2012) or the fourfold image of [the human] (e.g. Heusser 2016).

17 For an illustration of how to use the anthropology as a means of diagnosis, see McKeen (2016).

18 Given that assisted dying is a rather prominent topic in the media in Germany and Switzerland, from which the anthroposophic movement historically stems, most of the following emic accounts on assisted dying are in German.

Bibliography


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