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Crossing Fields

Anthroposophical End-Of-Life Care in Switzerland

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ABSTRACT

This article presents results of a qualitative study based on fieldwork and interviews in an anthroposophical hospital. From a practice-theoretical perspective, the paper discusses the interferences of medicine, religion, and spirituality in the field of anthroposophical end-of-life care. It describes the main practices conducted throughout the different stages of end-of-life care in this hospital and relates them to their rationalizations by medical actors as well as to basic anthroposophical concepts. Besides, the authors analyze power struggles between different actors displaying various dispositions concerning conventional and anthroposophical medicine, the latter integrating religious and spiritual aspects. The paper concludes by arguing that (1) there is a shift of relevance with regard to body-oriented and discursive practices in the course of anthroposophical end-of-life care, with a stronger emphasis on body-oriented practices at later stages. Moreover, (2) body-oriented practices, if rationalized in a religious way, serve as a resource not only for patients, but for staff members, too. Finally, (3) the contested issue of administering pain-killers and sedatives at the end of life in this hospital revealed that in many cases, nurses, despite their inferior position compared to physicians, succeeded in their wish to act in discordance with anthroposophical principles.

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1 INTRODUCTION[1]

In 2012, the Swiss people voted in favor of a popular petition to integrate anthroposophic[2] medicine, traditional Chinese medicine, homeopathy, neural therapy, and herbal medicine into the official list of services covered by obligatory health insurance. As a consequence, all expenses for these types of treatment will henceforth be covered, if they are provided or prescribed by trained physicians. This indicates a growing social acceptance of Complementary and Alternative Medicine (CAM)[3] in Switzerland as part of the established health-care system.[4]

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1 All the empirical data on anthroposophical end-of-life care used in this article come from a case study conducted by Barbara Zeugin within the broader context of a research project on Alternative Religiosity and its Consequences at the End of Life funded by the Swiss National Science Foundation (cp. www.nfp67.ch/en/projects/module-4-cultural-concepts-social-ideals/project-lueddeckens, July 4, 2018). We would like to convey our special thanks to all the managerial staff in the hospital where Zeugin conducted her fieldwork, to the leading internist, who introduced and mentored her, and to all employees and patients who welcomed her with open arms. Without their willingness to share their thoughts and experiences with her, this fieldwork would not have been possible. The research project was approved by the Kantonale Ethikkommission Zürich. Aside from the relevant literature, the few remarks in this article on conventional palliative care are based on Dorothea Lüddecken's fieldwork in a Swiss conventional palliative care unit conducted in 2016.

2 We decided to use the term "anthroposophic medicine" instead of "anthroposophical medicine" so as to acknowledge the most common emic language usage, in line with Kienle et al. (2006).

3 Gale and McHale's collection (2015) gives an overview of CAM, Jütte (1996) introduces the history of CAM, and Crawford (2003) discusses terminological issues.

4 The website of the Swiss Federal Office of Public Health provides information about all policies related to the incorporation of CAM into the public health sector (cp. www.bag.admin.ch/themen/gesundheitspolitik/03153/index.html?lang=de, July 4, 2018). Puustinen (2014) has criticized the incorporation of anthroposophical medicine into the Swiss health-care sector by claiming that its religious orientation is incompatible with the principles of natural science.

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Alongside these developments, the social sciences are also showing an increasing interest in CAM. Social scientists are either examining particular examples of CAM or else discussing its relationship to conventional medicine (cp. Jeserich 2010). Scholars in the Study of Religion, on the other hand, tend to scrutinize relationships between religion and medicine by referring mostly to discursive data material, that is, to written and oral data. Most of these studies discuss particular healing practices such as Ayurveda (cp. Koch 2006a, 2006b; Koch/Binder 2013; Lüddeckens 2018) or address the issue more generally (cp. Brown 2013; Koch 2015; Lüddeckens 2012, 2013). The latter approach often leads to the conclusion that, while CAM stems from specific religious traditions, it also forms an interface between religion and medicine. While this article agrees with this conclusion, it differs methodologically from these earlier studies, which restrict their analyses to the level of conceptualization by using only discursive data. Instead, this article attends not only to what people say but also to what they do, that is, to how they act.[5] Thus, the central focus is on the social practice of anthroposophical end-of-life care using one particular anthroposophical hospital as a case study.[6]

Adopting a practice-theoretical perspective on religion has proved to be a promising endeavor in recent research in the Study of Religion (cp. Echtler/Ukah 2016a; Utriainen 2013; Walthert 2014; Wood 2007; Wright/Rawls 2005). Within practice theory, Bourdieu's terms and concepts are quite prominent and allow not only varied sets of actions to be differentiated as specific to a certain group of people (habitus), but also their attribution to a specific realm (social field). Whereas scholars have already worked on the religious field (cp. Bourdieu 2000; Echtler/Ukah 2016b), this article deals with the intersection between it and the medical field.

This specific focus is due to the fact that anthroposophical end-of-life care unfolds in a particular historical, social, and institutional context that already indicates a position between (alternative) religion[7] and (convent-

5 Cp. Mezger 2018.

6 A communication-theoretical approach may represent another way of escaping a conceptualizing view of CAM (cp. Zeugin 2017).

7 The term "alternative religion" is used in this paper as an etic category. In general, practitioners of anthroposophic medicine do not consider themselves to belong to

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ional) medicine[8]. The practice of anthroposophical end-of-life care combines the basic principles of conventional medicine with alternative religious beliefs and practices, as anthroposophic medicine has aimed to counter-balance the one-sided notion of conventional medicine since its beginnings:

> "This is not an opposition against contemporary medicine working with scientifically acknowledged methods. We fully accept this medicine in her principles. And in our opinion what we offer should only be used by that practitioner of the art of medicine who can be considered a full physician according to these principles." (Steiner/Wegman 2014: 7)[9]

Anthroposophic medicine claims to undo the mechanistic and fragmentary conceptions of human beings that allegedly exist in contemporary conventional medicine by re-integrating "spiritual science" ("Geisteswissenschaft" in German) into medical practice. Steiner frequently used "Geisteswissenschaft" as a synonym of anthroposophy to highlight the aspect of spiritual science that goes along with the anthroposophical worldview. In this sense, "Geisteswissenschaft" means the aim and claim to describe "das Geistige", "the spiritual," exactly and methodically.[10]

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the realm of religion, nor to alternative religion. From an emic perspective, anthroposophy is seen at most as "spiritual".

8 We use "conventional medicine" in this paper as an etic category. German texts written by anthroposophical authors mainly use the term "Schulmedizin" or just "Medizin." Kienle, Kiene and Albonico use the term "scientific medicine", and remark that "Anthroposophic medicine considers itself to be an extension of scientific medicine" (2006: 4).

9 This translation and all following translations of texts originally in German are made by the authors of this article.

10 The English version of the official website of the "School of science" of the Anthroposophical Society at the Goetheanum explains: "In 1924 Rudolf Steiner developed a course of study based on meditative exercises that lead 'the spiritual in the human being to the spiritual in the universe.' This is the basis for the work of the School of Spiritual Science. It is also the background of the research, teaching, and training activities of the General Anthroposophical Section" (https://www.goetheanum.org/en/school-of-spiritual-science, March 8, 2018).

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According to the subtitle of Steiner and Wegman's *Grundlegendes für eine Erweiterung der Heilkunst nach geisteswissenschaftlichen Erkenntnissen* (1977), their motive for founding anthroposophic medicine consisted in the desire to extend the art of healing through spiritual knowledge ("Erweiterung der Heilkunst nach geisteswissenschaftlichen Erkenntnissen"). Thus, combining conventional medicine with anthroposophy and thus with alternative religious beliefs and practices was intended from the outset.

From the perspective of the Study of Religion, anthroposophy can be categorized as a form of alternative religiosity, that is, as a contemporary religious phenomenon that in some ways represents an alternative to mainstream religions. The attribution of these forms of religion as alternatives points to the fact that alternative religions draw on sources that do not form part of the dominant canons of religious belief and practice (Knoblauch 2009: 104). Moreover, by referring to religiosity, the emphasis lies on individual rather than institutional forms of religion (cp. Luckmann 2005). In recent decades, alternative religious beliefs and practices have been widely diffused throughout society, with medicine and CAM leading the way (cp. Lüddeckens/Walthert 2010a, 2010b). Hence, the attribution of these forms of religion as "alternative" is increasingly losing its legitimacy. However, in contrast to other terms, it still has important advantages: unlike the terms "agnostic," "fuzzy," "popular religion" or "spirituality," "alternative" provides information about a form of religiosity's current position in the religious field.

The narrative of re-integrating "spiritual science," and therefore from an etic point of view (alternative) religion, into medicine is only plausible when the respective fields have already been subjected to processes of differentiation, as is true of conventional medicine and of caring for the terminally ill.[11] The continuing differentiation between religious and medical actors was strongly criticized (Kellehear 2007: 157), and, as a result, the conventional medical paradigm of palliative care developed as a counter-balance to the medicalization of dying and death (Walter 1994: 12–13). From its very beginning, (conventional) palliative care was not only informed by conventional medical care, it also included religion and spirituality ("spiritual care") in its treatment of the terminally ill and dying. This multidisciplinary approach to palliative care is often traced to Cicely Saunders and the hospice

11 Lüddeckens (this volume) examines the interrelatedness of CAM with religion and medicine using the concept of de-differentiation.

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movement (cp. Clark 2001; Wright/Clark 2012). In one of her lectures at Yale University in 1963, Saunders suggested introducing palliative care as a form of holistic care that involves the treatment of "physical, spiritual, and psychological discomfort" alike (Lutz 2011: 305).[12] By not simply delegating religious and/or spiritual care to actors within the established churches, concepts of palliative care hold everyone liable for caring for patients' religious and/or spiritual needs and they quite often make room for alternative religious practices and rationalizations.

2 THE ANTHROPOSOPHICAL MEDICAL SETTING

There is a broad range of academic publications about contemporary anthroposophic medicine from an insider's perspective. For example, Kienle et al. (2013) provide a general overview of anthroposophic medicine. In addition, there are more general publications by anthroposophical physicians, nurses, and therapists (cp. Bopp/Heine 2008; Fintelmann 2007; Kienle et al. 2006; Girke 2012; Glöckler 2010; Heusser 2011), as well as research articles on different methods of anthroposophic medicine (e.g., on the effectiveness of mistletoe therapy with cancer patients).[13] Heusser et al. (2006a, 2006b), von Dach (2001), and von Dach et al. (2009) focus specifically on end-of-life care. For accounts of the history of anthroposophic medicine, its origins and sources from an anthroposophical perspective, in particular the publications of the Ita Wegman Institute and of Peter Selg (2000a; 2000b), the head of the Ita Wegman Institute (http://www.wegmaninstitut.ch/, July 4, 2018) should be consulted.[14] There are only a few academic accounts from an outsider's

12 One outcome of this conceptualization is the official definition of the World Health Organization: "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". (www.who.int/cancer/palliative/definition/en, July 4, 2018)

13 A list of other English publications is to be found on the webpage of the medical section of the Goetheanum: www.medsektion-goetheanum.org/en/home/books.

14 Cp. Glöckler et al. 2011.

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perspective. Apart from book chapters on the history of anthroposophic medicine (Brügge 1984: 101–125; Jütte 1996: 237–261; Ullrich 2011: 158–165, Zander 2007: 1455–1578), scholarly discussions lack contemporary research on anthroposophic medicine from an etic point of view, although there are a few exceptions (Arman et al. 2008; Karschuck 2018; Ritchie 2001; Zeugin/Walthert 2016). To our knowledge, apart from Arman et al. (2008), who conducted qualitative interviews in a Swedish clinic, no qualitative study from a social scientific or Study of Religion perspective has ever been conducted in an anthroposophical hospital.[15]

Anthroposophic medicine[16] was founded by the physician Ita Wegman (1876–1943) and Rudolf Steiner (1861–1925).[17] Even though Steiner had already shown an interest in medical subjects in the first decades of the

15 Ritchie (2001) provides a qualitative study of the National Centre for Social Research, an independent social research institution. The study was funded by the Anthroposophic Medical Trust and printed by Weleda. In this study, which adopts an etic perspective, the authors investigate six practices and one residential unit in GB that offer anthroposophical treatment in addition to general practice. By means of interviews with patients and medical staff, as well as an analysis of medical records, the authors address the questions of how anthroposophical treatment is perceived by medical staff working in general practice, how it is organized and delivered, and what impact it has on patients in terms of patient responses and clinical effects (ibid: 4).

16 The following paragraphs are based on emic sources, exemplary monographs that fall entirely within the contemporary field of anthroposophic medicine (cp. Glöckler et al. 2011; Girke 2012), and the website of the medical section at the School of Spiritual Science, Goetheanum, in Dornach, Switzerland (www.medsektion-goetheanum.org/home/anthroposophische-medizin, July 4, 2018). Even though the field of anthroposophic medicine is indeed heterogeneous, these self-portraits should be considered accurate, despite the difference in actors. For an overview of the contemporary practice of anthroposophic medicine, see "Facts and Figures on Anthroposophic Medicine Worldwide", www.ivaa.info/fileadmin/editor/file/Facts_and_Figures_AM_WorldwideJuly 2012_Final_Public_Light.pdf, May 8, 2018.

17 On other influential actors in the development of anthroposophic medicine, cp. Zander 2007: 1542–1544. On the significance of Wegman, see "Grundlegendes" ibid: 1538–1540.

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twentieth century, the founding date is often located in the early 1920s, a decade that witnessed three events that had a lasting impact on anthroposophic medicine. First, Wegman and Steiner held medical courses for medical practitioners in Dornach, Switzerland (the centre of anthroposophy).[18] Secondly, Wegman founded the first anthroposophic hospital in Arlesheim, Switzerland, where medical research has been conducted ever since. Thirdly, in 1925, Wegman published the first monograph on anthroposophic medicine, written by herself and Steiner (Steiner/Wegman 1977).[19]

As mentioned above, Steiner and Wegman did not view anthroposophic medicine as being opposed to conventional medicine; rather, they conceptualized it as being in accordance with academic medical science and thus as an extension of conventional medicine, which anthroposophy complemented. Therefore, anthroposophic medicine is combined with conventional medical practices, each with their own rationalizations. This is why many anthroposophical medical actors favor the paradigmatic term "integrative medicine" (Glöckler et al. 2011: 564–567). While Steiner, Wegman, and others created new anthroposophical medical practices (e.g., rhythmic massage), they also adapted existing such practices to the medical setting (e.g., eurythmy therapy).[20] Since its beginnings, anthroposophic medicine has cared for the terminally ill, but it was not until recently that the conception of anthroposophical end-of-life care has emerged and received expression (cp. Girke 2012: 1051–1083; www.sterben.ch).

Within anthroposophic medicine, human beings are viewed as multi-layered. In his early works, Steiner mainly referred to an anthropology that consisted of seven bodies (2010: 19–36) and that goes back to theosophy. In the 1920s he started to elaborate an anthropology featuring four bodies (Zander 2007: 1495–1497). In this view, the human being consists of a fourfold body,

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18 https://www.goetheanum.org/en/, July 4, 2018.

19 This publication has now been translated online as "Fundamentals of Therapy: An Extension of the Art of Healing through Spiritual Knowledge" (cp. http://wn.rsarchive.org/Books/GA027/English/RSP1983/GA027_index.html, July 4, 2018).

20 Even though all these proprietary anthroposophic medical practices were more or less informed by anthroposophy, anthroposophy is not their only source. Some researchers, for example, have examined the connection between anthroposophic medicine and homeopathy (Jütte 1996: 237–261; Zander 2007: 1514–1522).

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the physical body (shape, anatomy, organs, and all the other material aspects), the etheric body (the source of life and growth that endows us with thinking skills), the astral body (the carrier of consciousness and feelings), and the I-organization or higher self. The fourth body constitutes the individuality of the person or his or her spirit, which ultimately transcends life (Steiner/Wegman 1977: 7–19). This conception of the human being is linked to a specific conception of the afterlife, as the I-organization or higher self will not only outlast death, it will be reincarnated (Steiner 2010: 37–59).

Steiner's notion of the four bodies is closely related to the concept of the threefold nature of the human organism that distinguishes the nerve-sense system, the metabolic-limb system, and the rhythmic system. An anthroposophical medical article advocating the need for "rhythm studies" (Hildebrandt 1997) illustrates the close link between the models of the threefold nature and the fourfold (or sevenfold) body, as well as their foundation in religious concepts. In Steiner's own words:

"The rhythmic element in the four bodies [aspects of the human being] was implanted in man over long, long periods.... And we would recognize the rhythm of our human aspects in the movements of the heavenly bodies, which make a complete system." (20 July 1923, Dornach)

"One day man will also apply his own rhythm to the world, when he has reached the divine level." (21 Dec. 1908, Berlin)[21]

3 PRACTICE THEORY: METHODOLOGY, METHODS, AND DATA

3.1 A Practice-Theoretical Approach

According to a practice-theoretical approach, the social is only accessible when it is carried out in action. This is in line with Theodore R. Schatzki's definition of social practices as a "temporally unfolding and spatially

21 The second quotation by Rudolf Steiner appears in his lecture "Über den Rhythmus der menschlichen Leiber", 1988: 158.

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dispersed nexus of doings and sayings. […] To say that the doings and sayings forming a practice constitute a nexus is to say that they are linked in certain ways" (1996: 89). Thus, social practices are constituted by the performance of doings and sayings and the existence of a coherent system of knowledge about the links between these doings and sayings. Accordingly, they can be heuristically distinguished in terms of a) their use of language and b) their knowledge structures:

a) Social practices that exhibit a high use of language might be labeled discursive practices in so far as they "[...] embrace different forms in which the world is meaningfully constructed in language or in other sign-systems" (Reckwitz 2002: 254). Social practices do not necessarily have to involve language or other sign systems and might thus be labeled body practices, or non-discursive practices. However, a closer look at social reality reveals that social practices are only rarely either solely discursive or non-discursive. Rather, they exhibit a greater or lesser orientation towards language or the body, being either more communication/language- (and less body-) oriented or more body- (and less communication/language-) oriented.

b) Social practices often build on the ability of actors to rationalize their actions reflexively. What Giddens calls the rationalization of action means that "actors—also routinely and for the most part without fuss—maintain a continuing 'theoretical understanding' of the grounds of their activity" (1984: 5). This form of knowledge is the most common one, yet it is often not "directly accessible to the consciousness of actors" (Giddens 1984: 4). Although, as social scientists, we examine this knowledge either through observation or by explicitly enquiring about it, the implicit motivation of action is not discursively accessible (Giddens 1984: 6, but constitutes the "implicit sense of what someone actually wants" (Reckwitz 2003: 293).

3.2 Data and Data Collection

Adopting a practice-theoretical view of anthroposophic medicine has an impact on one's methodological approach: this qualitative study first looked at what is happening on the ground and then asked the actors to rationalize their

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doings and sayings discursively.[22] Accordingly, this study combined the qualitative research methods of participant observation[23] and qualitative interviews.[24] Given that our main interest was in anthroposophic end-of-life care, the fieldwork focused on those hospital units that exhibited dying and death as crucial features, namely an oncological ambulatory and an oncology ward.

Zeugin actively participated in the field by means of a nursing internship and the job-shadowing of physicians, nurses, and therapists alike. This provided valuable insights into what happens behind closed doors (e.g., consultations between physicians and patients, appointments with therapists, anthroposophical medical treatments). Apart from participant observation, she blended in by experiencing certain anthroposophical medical practices herself, such as art therapy, rhythmic massage, poultices, and therapeutic eurythmy.[25] In addition, she conducted 25 interviews of an average duration of one hour with health professionals (nurses, physicians, therapists, social workers), pastors, and terminally ill and dying patients. Finally, she collected grey literature, online information, and internal documents.

3.3 An Anthroposophical Medical Hospital[26]

The anthroposophical hospital in which the fieldwork was conducted opened in the 1990s as a private clinic primarily providing anthroposophical medical

22 Even though, following Bourdieu (2005: 18–19), this is legitimate, we have to pay attention to the fact that such rationalizations—concepts, beliefs and values—and their verbal manifestations in discourses might not occur if it were not for us.

23 Apart from general guidelines about participant observation (cp. Spradley 1980; Emerson et al. 2001; Franke/Maske 2011), Zeugin considered the term "focused ethnography" coined by Hubert Knoblauch (2001, 2002, 2005) to be an important reference point.

24 In order to enhance the comparability of all the interviews, Zeugin designed a qualitative interview technique that combines elements of narrative interviews as conceived by Fritz Schütze (1983) and elements of problem-centered interviews suggested by Andreas Witzel (1985, 2000).

25 For a similar approach, cp. Langford 2002.

26 The following description is primarily based on the hospital's discursive self-portrayal in grey literature and on their website.

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treatment. In the late 1990s, the hospital was entered on the official list of hospitals, and since then it has been authorized and required to conduct primary health care, as well as emergency medical aid, like any other public health facility. Whereas its conventional medical treatment has always been covered by obligatory health insurance, formerly many anthroposophical medical treatments had to be financed by the patients themselves or by supplementary insurance. Only very recently, and as a result of the official recognition of anthroposophic medicine in 2009, has the hospital managed to introduce a lump-sum payment for anthroposophical treatments on a case-by-case basis.[27] Since then, the costs of anthroposophical medical practices have been covered by basic health insurance, provided that they are prescribed by a physician and are carried out for a patient on this financial basis.

A support association funded by donations and guided by members of the Anthroposophical Society bears some of the additional expenses associated with the hospital's orientation towards anthroposophic medicine from day one. For example, the support association pays for the employment of an anthroposophical nursing expert, who is responsible for training nurses in anthroposophical nursing, as they usually only have conventional training.

4 ANTHROPOSOPHICAL END-OF-LIFE CARE

As end-of-life care embraces more than just one's death bed, it is conducted at various stages of both conventional (Jonen-Thielemann 2012: 989–997) and anthroposophical end-of-life care. Corresponding to the anthroposophical concept of the end of life and to practice in the respective hospital, the following stages also cover the time after the death of the respective patient. The following description presents data from Zeugin's fieldwork in 2015.

4.1 Late Stage

At this time, most terminally ill patients are not permanently hospitalized, but are given outpatient treatment. Most conventional and anthroposophical curative treatments are reduced, and the provision of anthroposophical

27 Cp. http://apps.swissdrg.org/manual40/drgs/54771e6ce4b0887aa13fd25c?locale=de, June 4, 2018.

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medical treatment shifts away from oncological practices to relieving anthroposophical medical, nursing, and therapeutic practices.

Some of the body-oriented practices stay the same throughout all stages, but others are reduced,[28] and some vary over time and are attributed with different meanings, such as body wash care. No matter whether body-oriented practices lost importance or were continued, all options were usually rationalized by referring to anthroposophical concepts.

In reducing body-oriented practices, the argument was mostly based on the belief that too much touching prevents patients from "letting go" and accordingly from dying. This is expressed in the following quote from a rhythmic massage therapist:

> "I've often experienced that patients who always loved rhythmic massage and who wanted to have it every day got to the point where every single touch was too much. And they say: No, I don't want that anymore. And mostly, this happens right before they really cross the threshold. Maybe because everything that is forced on the physical body from the outside reconnects them to it. That there is this feeling of letting go of their physical body." (Heike, rhythmic massage therapist, 8 June 2015)[29]

The remaining body-oriented practices were often explicitly rationalized using anthroposophical concepts, again with the importance of "letting go". The conception of letting go is found in Girke (2012: 1053), one of the very few accounts of end-of-life care written from an anthroposophical point of view. In this work, "letting go" is strongly linked to an alternative religious conception of the human being, as Girke refers to the fourfold articulation of

28 According to the observations of Lüddeckens during her fieldwork in a conventional medical palliative care unit, the reduction in body-oriented practices is not specific to the anthroposophical setting: in conventional palliative care wards body-oriented practices, such as hygienic measures, also lose importance.

29 Original wording: "Ich hab noch oft erlebt, dass [...] Klienten, die es (rhythmic massage, BZ) immer geLIEBT haben und die JEden Tag gerne das wollten, dass es einen Punkt gibt, wo (.) jenste Berührung wie ihnen zu viel ist. Und die sagen dann, NEIN, ich will nicht mehr. Und das ist dann oft (-) kurz bevor sie wirklich über die Schwelle gehen. (-) [...] Vielleicht weil (.) alles, was da von Aussen auf den (-) Leib kommt, [Hm=hm] ja wieder ähm (1) sie mehr verbindet mit dem. Dass da dieses Gefühl ist, dass [...] sie lösen sich ja grad aus dem Leib."

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the body by using it as an explanation for what is happening throughout the process of dying. For example:

"In death, the I, the astral and the etheric body detach from the physical organization. […] A […] manner of crossing a threshold between life and death concerns the consciousness and hence the nerve-sense system. Patients grow increasingly tired, which is associated with the separation of the fourfold body throughout the dying process." (Girke 2012: 1054, 1058)[30]

This anthroposophical perception of "letting go", first of the patients' physical body at the time of death, then of their etheric body during the following 72 hours, and finally after this time of their astral body, was also found in the hospital in this case study:

"In anthroposophy, there is the crossing of a threshold and afterwards the (transcendent) bodies let go of each other. [...] And after three days all that remains is the [...] corpse, right? And all the other bodies step by step let go of this physicality." (Lothar, physician, 30 April 2015)[31]

One example of this rationalization of a body-oriented practice is the conviction that certain directed ways of touching support patients in "letting go:"

We often perform the so-called pentagram embrocation. They really address the human being as a whole, in his or her individuality. And they strongly lead the person

30 Original wording: "Im Tod verlassen das Ich, der astralische und der Ätherleib die physische Organisation." (Girke 2012: 1054) "Eine [...] Form des Überschreitens der Schwelle betrifft das Bewusstsein und das Nerven-Sinnes-System. Es entwickelt sich zunehmend eine Müdigkeit, die mit der Lösung der Wesensglieder im Sterbeprozess zusammenhängt" (Girke 2012: 1058).

31 Original wording: "Aus der Anthroposophie heraus gibt es ein SCHWELlenübertritt und danach [Hm=hm] lösen sich die verschiedenen Wesensglieder [...] ab. [...] Nach (.) drei Tagen ist dann nur noch der [...] Leichnam vorhanden, oder? [Hm=hm] Und die (-) äh anderen Wesensglieder (-) lösen sich in SCHRITten aus dieser Leiblichkeit [Hm=hm] heraus."

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back to his or her real self, so as to facilitate the letting go when it comes to dying. (Heike, rhythmic massage therapist, 8 June 2015)[32]

While in this case, the embrocations are conceptualized as reassuring the wholeness and individuality of the patient as a precondition for "letting go", the next example instead emphasizes the calming effects of certain practices:

"Someone who has difficulties in letting go needs to get his underarms washed quite coldly. […] It calms and supports letting go." (Manuela, nurse, 22 May 2015)[33]

In this view, the process of "letting go" is facilitated by nurses acting calmly and silently, and deliberately touching, thus performing body care in a certain way.

From an anthroposophical perspective, one aspect of the person will transcend death. This aspect is referred to most often as the soul, the spiritual dimension, or the I, as anthroposophists would say, and just as frequently it is linked to the idea of reincarnation. The notion of "letting go" is also found in conventional medical palliative care contexts as one of its own core semantics. However, here it is merely a matter of the patient's need to let go of life: "As death nears, many people feel a lessening of their desire to live longer."[34] In the anthroposophical context, in contrast, "letting go" is clearly linked to conceptions of human beings and the afterlife.

At this stage, discursive practices that actively involve the patients are reduced, whereas discursive practices among the health professionals themselves increase slightly, rationalizing the body-oriented practices, as we will see in the following examples. An important discursive practice is the nursing case discussions, which are held weekly, last thirty minutes, and occur

32 "Wir [...] machen dann manchmal auch die sogenannten [...] Pentagramm-Einreibungen. [...] Die wirklich dann auch (1) den Menschen ganz stark in seiner Gesamtheit (-) ansprechen, in seiner Individualität. Äh und ihn noch mal ganz stark zu sich führen, sodass manchmal das (-) äh Rauslösen dann, wenns (-) äh ins Sterben geht, [Hm=hm] leichter fällt."

33 All interview quotations and observation logs are translated by Barbara Zeugin. Original wording: "Öpper, wo Müeh hät zum losla, wo lang hät, (-) d Underärm chüel wäsche. [...] Es tuet beruhige und helfe LOSla, ja."

34 www.caregiver.org/advanced-illness-holding-on-letting-go, July 4, 2018.

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under the premise that internal and oncology nurses are physically copresent. Additionally, the performance of this social practice builds on formal guidelines aimed primarily at the rationalization of action by producing a theoretical description of the fourfold articulation of the body. At the same time, these guidelines offer instructions for action by referring to the nurses' experiences of work and providing a list with features of each element of the fourfold body that guides them in their observations and their treatment of the patients. In preparation for the discussion of each case, one of the nurses is asked to fill in a table with her observations. The performance of the nursing case discussion is the anthroposophical nursing expert's responsibility, whereas the presenting nurse varies each time. In Zeugin's observations, the discussion unfolds as follows. While all the nurses sit in the nurses' station, one nurse describes a patient who is being somewhat "problematic" by using a guideline table of the fourfold bodies as a template for her presentation. In this table, the four bodies are adapted to the medical setting: the physical body is linked to visible, easily determinable aspects such as age, gender, and symptoms; the etheric body carries information about respiration, body heat, nutrition, and expulsion, as well as creativity, habits, and everyday rhythms; the astral body is to be found in the patient's experience and communication of pain and mood, as well as thinking, feeling, and wanting; and the last body, the ego or "I" of the human being, is exemplified as a patient's profession, all sorts of biographical information, and indications of self-awareness, e.g., regarding the finiteness of his or her being. After this presentation, the other nurses add their own observations. Finally, possible nursing interventions are discussed by making use of a conception of anthroposophical nursing called the "twelve gestures of care" in nursing.[35] The twelve gestures, such as Hüllen/or "grounding" and Harmonisieren or "harmonizing," are different objectives that can be achieved by several different nursing practices. In the case of a female who refused to eat in accordance with the results of her measuring each food item with a pendulum, the interventions included the following: sending in the (anthroposophist) nutritionist to discuss a balanced diet; the affection and love of nurses spending time with her; and a footbath

35 This conception was developed by Rolf Heine on the basis of Steiner's belief in the twelve "senses" (cp. www.vfap.de/anthroposophische-pflege, July 4, 2018). The last sense, the "Ich-Sinn," is based on the ego of the fourfold body concept; cp. von Dach 2008.

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in water containing rosemary in order to "ground her" because she seems too "spiritually minded": "She is so spiritually minded. […] She aspires to overcome her trauma so as to not have to go through it again in her next incarnation" (Nadja, nurse, 18 May 2015).[36]

Another discursive practice is the inter-professional biographical work[37] case discussion. Biographical work constitutes a crucial part of anthroposophic medicine, as of end-of-life care. According to the biographical counsellor, she first conducts a conversation with a patient to learn about his or her life story. This conversation follows the pattern of seven-year cycles ascribed to Rudolf Steiner. This pattern is again used throughout the biographical work-case discussion, as in the case of a 55-year-old woman with leukaemia. In this case, biographical work discussions brought together the attending physician, the key nurse, a physiotherapist, and a social worker, as well as representatives of all anthroposophical therapies. To begin with, they shared their initial impressions of the patient's current state. The physician said that she had recently delivered some computer tomography results and that the patient didn't behave normally: "She hugged me. I don't like that, but I didn't say anything. I think she is really longing for closeness" (Elisabeth, physician, 22 April 2015). The nurse adds that the patient seems very sensitive: "She reacted strongly to physical contact when I applied a rhythmic embrocation; it really exposed her emotions so strongly that I had to give her some tranquilizer" (Nora, nurse, 22 April 2015). Afterwards, the biographical counsellor retold the woman's life story in accordance with the pattern of seven-year cycles. Finally, the health professionals discussed what they had been listening to and concluded that the patient clearly lacked a basic sense of trust in her first seven years and that she had always cared more for others than for herself. From this the physician deduced the following need for action: "Anthroposophically speaking, her higher self needs shelter, warmth and protection. […] I'd recommend some nice warm poultices" (Elisabeth, physician, 22 April 2015).

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36 Original wording: "Sie ist so vergeistigt. […] Sie strebt an, ihr Trauma zu bewältigen, damit sie das los ist und das nicht noch einmal machen muss, wenn sie inkarniert wird."

37 "Biographical work" is an anthroposophical extension of conventional psychology complemented by the anthroposophical theory of reincarnation and anthroposophical anthropology; cp. Ritchie 2001: 78ff.; Burkhard 2002.

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In both examples, body-practices involving the patient, such as a footbath and poultices, are the consequence of a discursive practice among healthcare professionals.[38]

4.2 Final Stage

On the physical plane, the body starts shutting down and curative medical treatments become completely irrelevant. Even though the physicians are still engaged in both conventional and anthroposophical medical care, they withdraw from the sickbed, leaving nurses to be more present. Once a cure is definitely no longer an option and discursive abilities decline, body-oriented practices gain more and more momentum, such as rhythmic massage.

According to Margarethe Hauschka (1978), who was an assistant to Wegman, the founder of rhythmic massage, this form of massage combines Swedish massage techniques with anthroposophical spiritual science. Anthroposophical anthropology and the conception of the threefold nature of the human organism (nerve-sense system, metabolic-limb system, rhythmic system) are the main official rationalizations of this formalized set of practices (cp. Hauschka 1978: 92–100; see also above). Rhythmic massage, as its name suggests, is primarily aimed at the rhythmic system.

Whereas different practices of rhythmic massage are performed at several stages, the so-called *embrocation* is of great significance when it comes to patients who are very close to death.[39] In her fieldwork, Zeugin found that the pentagram embrocation is embedded in a wider scope of action. The following account is based on her own experience of a rhythmic massage therapist carrying out pentagram embrocation on her for illustrative purposes. While sitting on the massage table, the therapist explained that pentagram embrocation requires a subsequent rest of about twenty minutes to produce its effect fully. She further explained that this effect consists in bringing all parts of the body back together and making the patient "whole" again. The massage therapist fetched a piece of paper and, while drawing a pentagram, she continued her explanation as follows. The embrocation stems from

38 In the second case, however, the discussion among the healthcare professionals was preceded by a biographical conversation with the patient.

39 Cp. von Dach (2001), Pflege an der Grenze des Seins, pp. 36 f.; also Layer 2006: 110-116.

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Leonardo, but thanks to anthroposophy this picture was assigned to the etheric body, where the energy flow is positioned. As rhythmic massage operates at this level, blocked energy can be set free by indicating five essential points. According to what she had said in a previous interview, she aims to bring all the bodies together by pointing to these five positions on the physical body in the correct sequence. After the treatment, she started a conversation that led from the illnesses of the etheric body to the *Tibetan Book of the Dead*.

With regard to this therapeutic practice, a conventional medical rationalization of action is missing altogether: there is no reference to the relief of pain or any other distressing symptom, as required by the definition of palliative care, but it is primarily aimed at the patient letting go of her body and life in order to prepare for the afterlife.[40] The link to the "Tibetan Book of the Dead", a book that is widely popular for its content about support for the souls in the process of dying and their transition to the afterlife, even strengthened this aim.

This rationalization of action, i.e. letting go of the body and preparation for an afterlife, is part of the discursive knowledge of all health professionals in the hospital of Zeugin's fieldwork.[41] It comes into effect in the communication with the particular patient, provided that the latter can still be addressed and is conscious. Otherwise this body-oriented practice can be performed without any use of language.

4.3 Terminal Stage

Due to the increasing loss of agency that develops in the terminal stage, anthroposophical physicians and therapists noticeably back away from the death bed, leaving it mainly to the nurses to provide all sorts of primary and end-of-life care. Nurses now become more autonomous and independent

40 See the "Therapeutic Rational" of massages with regard to the findings in the study of Ritchie: "Through achieving balance in physical functions, the therapist is able to influence and connect with the other 'higher' levels to promote greater balance and connection between them. Massage mainly works through the physical and etheric (or life forces) level which can then strengthen the soul (emotional) and spiritual levels (ego organisation)" (2001: 72).

41 For the Lucas Clinik in Arlesheim (CH), cp. von Dach 2001: 36 f.

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from the physicians' instructions and surveillance. Often, they perform self-directed "little somethings", as one of the nurses explained:

> "For me, the anthroposophical aspects just go with caring for the terminally ill. […] Not pampering them, but to give them a little treat—in another way." (Larissa, nurse, 26 March 2015)[42]

A prevalent and thus almost institutionalized instance of little somethings is the social practice of installing a rose-quartz lamp in patients' rooms. The lamps are not installed until the patient's death is foreseeable, yet from then onward they are lit permanently. While some nurses simply highlight the practice's aesthetic value, others argue that it supports the patient in letting go by providing a nice, warm, quiet ambience.

Furthermore, nurses increasingly relocate their doings and sayings towards a set of practices that are often referred to as "being with" when the dying process progresses.[43] Practices of "being with" are carried out so as to still be doing something, even though medically nothing can be done anymore. "Being with" comprises a multitude of practices, such as sitting at the patient's bedside, decorating his or her room, singing a song, narrating a story, holding the dying person's hand, and so on. Even family members are instructed just "to be with" their dying relatives in order—at least this is how the saying goes—to facilitate the process of letting go and thus promote dying. Hence, "being with" is strongly linked to conceptions of a good death, the human being, and the afterlife in the form of the metaphor of letting go.

During the terminal stage, practices and their rationalizations are even more detached: the latter are not discursively communicated in contact with the patients, but only in interprofessional conversations or in exchanges with the researcher.

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42 Original wording: "Und für mich ghört das Anthroposophische dänn eifach au dezue. [...] Nöd verhätschlä, aber (.) ähm (1) eifach nomal öppis chlises Guets tue, uf än anderi Wiis."

43 Cp. Zeugin/Walthert 2016.

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4.4 After Death

Once a patient has died, there is still work for the physicians and nurses to do until the state funeral office takes over. After a physician has issued a death certificate, the nurses are in charge of most post-mortem care practices, that is, going through the formalities, dealing with family members, and burning incense in the patient's room. It is common practice to let the deceased patients rest for some hours before preparing them for the laying out. Usually one nurse prepares the deceased without the bereaved being present and performs individual actions like closing the deceased's eyes and washing and clothing him or her quietly without moving the body unnecessarily. The latter aspect accords with two differing rationalizations of action, one saying that things are done like this out of sheer respect, the other that the souls need to let go of their bodies and thus need quiet.[44]

The deceased are laid out in the in-house mortuary for three days. This temporal determination is in line with Rudolf Steiner's conception of a panorama of the past life that follows death and lasts around two to three days. Whereas the physical body leaves the person at the time of death, the etheric body splits off during this subsequent period (Steiner 2001: 140).

"There is a period of rest, and in it, the bodies […] let go of their physicality. I believe we overestimate ourselves if we believe we have a great impact on this process of letting go. It is connected, is connected to the person's biography, right? […] Well, I believe there is this frame, and we do not strictly lay out the deceased's body for three days, but if possible." (Lothar, physician, 30 April 2015)[45]

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44 Both kinds of rationalizations can be found in conventional palliative care contexts as well. However, in most cases, the deceased are prepared for their "departure" within short time of their death and incense is only burnt if a staff member chooses to do so as an individual.

45 Original wording: "Es gibt eine bestimmte Ruhephase, (.) in der (.) diese Leiblichkeit (.) sich [...] lösen kann. Und ich glaub, wir überschätzen uns, wenn wir glauben, dass wir in diesen Ablösungsprozess (.) viel bewirken können. [Ok] Es hängt das hängt mit der Biographie dieses Menschen zusammen, [Ja] oder? [...] Also ähm (3) ich glaub, (2) es gibt den Rahmen, wir machen es auch nicht prinzipiell so, dass wir Menschen dann drei Tage aufbahren."

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As these words from a physician in a leading position indicate, laying out the deceased for three days is rationalized by means of the notion of letting go of the various bodies, i.e. as an anthroposophical practice. However, whereas he considers this action as supporting the process of letting go, to him it is not necessarily a precondition.[46] This stance is in line with actual practice in the hospital, which is also influenced by economic and other practical considerations resulting from its designation as a public hospital: whereas laying out the body for three days is the usual practice, the duration may be reduced, or it may not take place at all when there are more deceased than rooms for laying out, or when the deceased or his relatives do not approve of it. However, if possible the practice is performed in its original form.

In addition, all health professionals are invited to participate in a collective farewell ritual that is primarily targeted at the health professionals themselves, though the deceased's family is invited too. The deceased is laid out in the middle of the small room, specifically reserved for this purpose. The room is decorated with candles and flowers, and the attendees surround the coffin. The actual farewell ritual starts with a gong being sounded, and two tunes are chosen and performed by the health professionals.[47] After the singing, the physician provides the deceased's biography, focusing on the description and interpretation of his or her dying process and the health professionals' share in it. Depending on the physician's personal assessment of the religiousness of the deceased, he may say the Lord's Prayer. The ending of the ceremony is again marked by the same songs. This stage, where the medical staff are still involved, is marked by religious ritualistic practices and other discursive practices, all of them in line with anthroposophical rationalizations.

During the successive stages of anthroposophical end-of-life care, from the late stage till the terminal stage, body-oriented practices in relation to discursive practices in contact with the patient gain momentum. However,

46 He pointed out that the separation of the four bodies also takes place when people die a painful death and cannot be laid out, for example, when they are buried alive in an earthquake.

47 The first canon, "Dona Nobis Pacem" ("Give us peace"), originates from the last words of the Roman Catholic mass of Agnus Dei; the second tune, "Harmonie der Sterne" ("Harmony of the stars"), by the German songwriter Werner Gneist, explicitly concerns God, creation, and the meaning of life.

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death seems to be the turning point, where body-oriented practices with regard to the deceased patient are reduced decisively, while discursive practices with anthroposophical rationalizations among the healthcare professionals become central. At this stage, the difference between anthroposophic care as including care for the deceased and conventional medical care which ends when the patient has passed away is most obvious.

5 RELIGIOUS RATIONALIZATION IN END-OF-LIFE CARE

As the description above indicates, it is a distinctive feature of anthroposophic medicine that it provides religious rationalizations that enable healthcare professionals to maintain their agency even if medical rationalizations do not support further actions.

In conventional palliative care, less and less action is carried out over the course of the dying process.[48] This is due to the fact that many conventional medical practices are no longer of effect and communication becomes more difficult, with patients losing their communication skills or their consciousness. However, in the case of the anthroposophical medical care in our case study, health professionals continue providing care by focusing their action on more body-oriented practices, as we have seen above.

While some more communication-oriented medical practices, such as psychotherapeutic interventions ("biographical work"), end completely, others vary over time and become more body-oriented: eurythmy therapy,[49] for example, becomes more passive and has fewer communicative instructions as death approaches, as patients are not required to engage in physical activities by themselves anymore; rather, the eurythmy therapist conducts the

48 Cp. Zeugin/Walthert (2016) for an account of the relocation of action against the backdrop of hospice end-of-life care.

49 Eurythmy is an anthroposophical expressive art and movement therapy. "The therapeutic rationale" of eurythmy therapy appears in the findings of Ritchie as follows: "As with all treatments, the overall therapeutic rationale and subsequent processes are very much dependent on the individual patient and relate to a key principle of developing the potential of the person" (2001: 76).

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physical activities for them either by moving the patient's body parts or by taking over the exercise completely and performing it herself.

By means of such non-discursive practices, the health professionals reclaim agency, which seems to decline increasingly in the face of death. Even when it appears that nothing can be done anymore because the patient is going to die anyway, this allows health professionals to still do something for their patients and not just stand by idly.

A typical rationalization of eurhythmy therapy is as follows: "Unconsciously experienced states of restlessness decrease and give way to a peaceful state of mind. All these are important means in order to commit oneself to the next steps and the new spiritual space connected to death."[50]

Emphasis on these body-oriented practices is backed up by way of rationalization based on an anthroposophical understanding of the dying process. With regard to the various activities in the different stages mentioned above, the healthcare professionals often refer to explanations pertaining to anthroposophical concepts such as the pattern of the seven-year cycles, the fourfold body, and the departure and reincarnation of the soul.

In these explanations, particular emphasis is placed on the notion of "letting go": Throughout the dying process, people have to let go not only of their lives, but of their bodies too. This notion is used to rationalize the body care, rhythmic massage, the "little somethings" such as the rose quartz lamp, and even the effort to avoid moving the body immediately after death. This kind of religious rationalization enables health professionals to continue providing care without focusing their actions on healing and without restricting their focus on the physical existence of their patients. Instead, the idea of easing the separation of the bodies and the soul's transition into the afterlife gains importance. As already noted, this relates to a specific conception of human beings and the afterlife, as well as showing that the health professionals in the anthroposophical hospital feel accountable for this kind of religious or spiritual care. It is this rationalization of action that distinguishes the

50 http://www.sterben.ch/Heileurythmie.81.0.html, February 7, 2018. Original wording: "Auch unbewusste Unruhezustände lassen nach und weichen einer **friedvollen Seelenstimmung**. Das alles sind wichtige Hilfen, um sich auf die nächsten Schritte und den neuen geistigen Raum einzulassen, der mit dem Tod verbunden ist."

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practice of anthroposophical end-of-life care from conventional medical settings, where end-of-life care might also feature a transition from communicative to more bodily-oriented practices, yet without this very specific anthroposophical rationalization. Therefore, in this setting, where religion and medicine intersect, reference to the religious dimension provides a fundamental basis for how therapeutic practices are rationalized.

These examples illustrate the ways in which actors in anthroposophic end-of-life care, unlike those in conventional medicine, act according to the rules not only of the medical field but also of the alternative religious field of anthroposophy, showing how they gain agency by means of this double orientation.

The body-oriented practices, like the poultices and the footbath in the examples given above, are in most cases conducted because of instructions from the interprofessional nursing case and biographical work discussions. In most cases, the nurses did not rationalize these practices with anthroposophical concepts in contact with the patients. The first patient will probably never know that she was given a footbath so as to "be grounded" as a supportive measure with regard to her future reincarnation, any more than the second patient will know that the poultices will protect her "higher self". In the stages in which the discursive practices are reduced there is consequently less communication about religion. However, religion is practiced by means of footbaths, poultices, the ways of performing body care, and so on.

6 POWER STRUGGLES

According to Bourdieu, fields are internally structured by actors' struggles for power.[51] The valid set of rules of acting and of the distribution of power are the main bones of contention between leading actors who hold a monopoly of power and novices or oppressed actors who are trying to gain power (Bourdieu 2014: 107). In the case of end-of-life care in our case study, the rules of both conventional and anthroposophic medicine are at stake. There are practices based on conventional medical dispositions and others based on

51 For a short but concise explanation of Bourdieu's conceptualization of field, (symbolic) power, and forms of capital as manifest in habitus, material goods, and institutionalized forms, see Rageth this volume.

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anthroposophical dispositions and situations where struggles over the validity of different sets of rules occur. The actors involved embody a conventional medical habitus and an anthroposophical habitus to different degrees. Moreover, they have different degrees of symbolic power with regard to their anthroposophical expertise and institutional status.

Thus, the question of how, under these specific circumstances, the respective power struggles can be understood arises.[52] Most of the actors' struggles over power have to do with the fact that the actors orient themselves to the set of rules of more than one social field. While all actors play by the main set of rules of anthroposophical end-of-life care, they relate differently to conventional medicine and anthroposophy respectively. Even though in our case the anthroposophical medical treatment is provided by physicians, nurses, and therapists alike, a nurse who mainly refers to the conventional medical set of rules is likely to perform fewer anthroposophical medical practices and to rationalize them in a less anthroposophical manner than a nurse who relates more to anthroposophy, such as the anthroposophical nursing expert.

All nurses are trained in conventional medical nursing, yet, apart from the in-house training, they have hardly any education in anthroposophical nursing. Accordingly, they are most likely to relate to the set of rules for conventional medicine in cases where the two fields are in conflict.

In contrast to the nurses, the physicians all have a general interest in CAM, and more than half of those who engage in end-of-life care have degrees in anthroposophic medicine in addition to their conventional medical education. The nurses and physicians who have this kind of double training occupy powerful positions within their own occupational groups, as well as throughout the hospital. For example, all attending physicians on the hospital management board are trained in anthroposophic medicine and are well-known practitioners of it. Therapists, finally, are greatly involved in acting on anthroposophical principles, as they have all been trained by an anthroposophical institution and are also likely to relate to anthroposophy,

52 As Bourdieu explains: "The struggles which take place within the field are about the monopoly of the legitimate authority (specific authority) which is characteristic of the field in question, which means, ultimately, the conservation of the structure of the distribution of the specific capital" (1995: 73).

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irrespective of their professional engagement in the medical setting.[53] Physicians, therapists, and the anthroposophical nursing expert, socialized within the anthroposophical field, consequently tend to act in a respective habitus and prefer anthroposophical practices in cases of conflict.

The continuing power struggle of the actors involved in the practice of anthroposophical end-of-life care may be illustrated by attempts made by the anthroposophical nursing expert to control the doings and sayings of nurses in caring for the terminally ill and dying. By means of the nursing case discussions, the anthroposophical nursing expert tried to impose a collective nursing habitus by directing it towards the anthroposophical set of rules. That she was allowed to do this reflects the fact that she was accorded greater power than the regular nurses. This further demonstrates that the hospital's management and the supporting foundation—leading actors—who have not assigned a conventional medical nurse to administer further training are upholding the anthroposophical set of rules in doing so.

However, the nursing expert's influence on the nurses remains limited in so far as in most cases the nurses do not transfer the anthroposophical dispositions taught in the actual case discussions to other cases. Furthermore, it must be noted that the practice of the nurses is informed by anthroposophical dispositions only when they consider it not to be in conflict with conventional medical practice, despite the instructions of the anthroposophical nursing expert. This way of acting is in line with Bourdieu, who argues that the intentional communication and teaching of any habitus is exceptional and bound to fail (1997: 165–169). The reasons for this are twofold. First, the incorporation of objective structures involves a lengthy process of implicit learning, which for most nurses took place in the realm of conventional nursing, not in anthroposophical care. Secondly, those forms of habitus are the most effective that are not informed by intention. Due to their socialization within conventional nursing, the nurses implicitly acquired learning about certain norms that led to certain dispositions with regard to practices. In contrast to this implicit learning, the intentional teaching of the nursing expert is less influential in conflict situations, as the crucial example below will demonstrate.

53 A last group of actors are the terminally ill and dying patients themselves. Due to the article's terms of reference, however, they will not be dealt with specifically here.

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The practice of administering pain-killers and sedatives at the end of life poses a problem for anthroposophical end-of-life care. While many nurses openly argued in favor of this practice, anthroposophical physicians tended to be reluctant to follow it, while the hospital management did not participate in any explicit discourse on the matter. One important rationalization for the physicians' reluctance is the emphasis on the patient having a clear mind so as to have an opportunity for transformation and inner growth and to be able to extract experience until the very end, which is gainful for the afterlife.[54] Therefore, as patients should be able to experience this transitional period consciously, anthroposophical medical care tries to avoid the use of sedating painkillers: "The aim is to pass away with the least required pain medication and a mind as conscious as possible" (Lothar, physician, 30 April 2015).[55] In this context, it important to realize that the anthroposophical physicians shared the anthroposophical view that dying is not something to be prevented at all costs and that death is not dreadful. On the contrary, the time of death appears as a significant and wonderful moment in an anthroposophical view (Steiner 1980: 327–328). Another rationalization articulated in the hospital where Zeugin's fieldwork was conducted consisted in the conviction that the

54 This rationalization, expressed by the physicians in our case study, is in accordance with anthroposophic medical theory. Cp. Floriani 2016: 99–100; Girke 2012: 1062–1064, Glöckler 2008: 471–472; Karschuck 2018: 136–144.

55 Original wording: "Also das Ziel ist schon, [...] mit möglichst wenig (.) SCHMERzmittel bei möglichst grossem Bewusstsein diesen Schritt zu gehen." The same physician explained further that many patients appreciated a state of painlessness: "It is as if their pain is receding and their spiritual life gains freedom" (Lothar, physician, 30.4.2015); original wording: "Der Schmerz tritt wie in den HINtergrund [Ja] und damit ist mein Geistesleben eigentlich freier". The goal to administer as few painkillers as possible is in accordance with von Dach 2001: 34–37. Floriani (2016) refers to Bott (1996) here: "According to the anthroposophic approach, humans are on a path of spiritual evolution, wherein disease can play a central role in their terrestrial fates as part of a process of transformation and inner cures, with particular transformative power during the process of dying. In other words, disease is understood as means of transformation and spiritual development" (ibid: 99–100). For anthroposophical concepts, cp. Girke 2010; 2012: 426, 1052–3.

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dying need fewer painkillers in order to ease their pain, as they are already letting go of their bodies during the dying process.[56]

Nurses, on the other hand, mostly preferred to administer pain-killers and sedatives and used conventional medical rationalizations in doing so, concentrating on the physical needs and psychological conditions of their patients. By emphasizing their greater presence at the dying patients' sick-beds, they claimed to know their patients' wishes and needs, leading them to argue for the benefits of the conventional medical treatment of administering pain-killers and sedatives.

The anthroposophical physicians were powerful actors within this anthroposophical hospital because they acquired more symbolic power than other health professionals: they were officially in charge of implementing anthroposophy in the hospital, and they had both conventional and anthroposophical medical degrees and titles that equipped them with institutionalized cultural capital (cp. Bourdieu 1986). The nurses, by contrast, had less institutionalized capital and symbolic power than the physicians who administer and supervise their actions. From their positions of symbolic power, the latter tried to control the practice of anthroposophical end-of-life care by rationalizing it in an anthroposophical manner.

However, although the nurses possess less symbolic power than the anthoposophical physicians, in many cases they prevailed. A close look at the actual practice indicates that although, at a rough guess, the administration of pain-killers and sedatives is still less common in this anthroposophical hospital than in conventional medical health facilities, it is still more common than anthroposophic medical actors intend. Their symbolic power ultimately seems less than originally anticipated. Thus, when it comes to the practice of administering pain-killers and sedatives within the practice of anthroposophical end-of-life care, it is the anthroposophical physicians in this case who are the "oppressed actors," most probably because they orient themselves towards the alternative religious field instead of the conventional medical (or economic) field.

The reasons for this finding are threefold. First, the nurses tried to act in conflicting situations in accordance with their own habitus, which was the conventional medical one. Secondly, they were closer to the patients at the crucial time during the terminal stage once the physicians had more or less

56 Cp. Girke 2012: 1061.

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backed away from the death bed. Thirdly, the hospital management ultimately turns the scales, even when it does not adopt a position on this issue discursively. Rather, as representatives of the hospital, its members are held responsible for its management and viability. In their doings and sayings, moreover, conventional medical and economic rationalizations go hand in hand: being governed by the public health sector's standards and the economic habitus according to which time is money, they quite inadvertently prefer the administration of pain-killers and sedatives because it is less time-consuming than any anthroposophical end-of-life care practice and also accords with the prevailing rules and regulations.

7 CONCLUSION

Anthroposophical end-of-life care belongs to both fields: from an emic perspective anthroposophic medicine complements conventional medicine with spiritual knowledge, while from an etic perspective it pursues medical as well as spiritual and religious goals. This study, based on fieldwork in an anthroposophical hospital, has provided three main insights about social practices in the intersection between the religious and the medical fields.

First, in the course of anthroposophical end-of-life care, body-oriented practices that are rationalized by anthroposophical religious concepts gain momentum in relation to discursive practices in contact with the patients. After death, discursive practices among healthcare professionals gain in importance, while body-oriented practices with regard to the deceased lose in importance.

Secondly, by rationalizing their actions in a religious (anthroposophical) way amongst themselves, healthcare professionals not only explain their actions, they also regain agency in the face of a terminal illness backed up by the institution. Body-oriented practices with anthroposophical rationalizations therefore serve as a resource not only for patients but for staff members too, enabling the latter to support their patients even when, from a conventional medical point of view, nothing can be done anymore. From an anthroposophical perspective, not only does the physical body have to be taken care of but other non-empirical bodies also have to be taken into account. One of the main references in this regard is the notion that patients need to let go of their various bodies throughout the dying process and beyond death and are

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in need of support. Other rationalizations are the support of the souls' preparation for the afterlife by taking care of the transcendent bodies and transcendent aspects of the dying patients.

It is important to note that, in the later stages of end-of-life care, anthroposophical rationalizations occur in inter-professional communication, or in communication with the researcher, and only rarely in communication with the patients. Nevertheless, even though religion might not be a topic of staff-patient conversations, it is still practiced in the form of massages, baths, poultices, so-called "little somethings," and further body-oriented practices.

Thirdly, the examples in this study have shed light on the social context within which anthroposophical end-of-life care is carried out. The healthcare professionals are constantly contending with each other over the distribution of power and the appropriate set of rules to follow. Yet, anthroposophical end-of-life care-providers are not only contending with each other over their respective social positions within a particular social field, they are also struggling over the different fields of (conventional) medicine and (alternative) religion. It is the anthroposophical foundation of anthroposophical end-of-life care that causes its actors to become involved in additional work and expense, as they not only act in accordance with the conventional medical field, but also orient themselves towards anthroposophy's own set of rules. Whereas this mostly occurs without problems, the need to play by two different set of rules at the same time makes the practice of anthroposophical end-of-life care liable to conflict.[57]

As we have seen, those physicians and nurses who are also trained in anthroposophic medicine generally have a higher social status. This does not mean, however, that they are more powerful in practice. As indicated by the practice of administering pain-killers and sedatives, the actions of nurses are determined rather by the habitus they have acquired in their conventional medical training than by the influence of the anthroposophically trained nursing expert or physicians, notwithstanding her or their higher social position.

Given that the hospital in question is an anthroposophical institution, one might have expected that in cases of conflict medical treatment would be in

57 This is all the more the case when it comes to discursive practices, such as an open discussion about administrating painkillers and sedatives, because discourses require greater explanation and thus more easily uncover conflicting issues and demands for autonomy.

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line with anthroposophical principles. In that case, in the example of pain-killers and sedatives at the end of life, the position of the anthroposophical physicians would prevail. This is especially the case since anthroposophical physicians have more symbolic power than nurses because of their institutional position and their anthroposophical expertise. However, Zeugin's fieldwork revealed that in many cases the nurses successfully negotiated with the physicians in charge in favor of giving pain-killers and sedatives. Hence, often the nurses' position was implemented at the bedside.

We argue that there are three explanations for this:

a) Nurses are closer to the patients in terms of time, body care, and emotional contact during the last stages of life. This might be even more the case in anthroposophical end-of-life care because more body-oriented care practices are performed in this period, as we have outlined above.

b) Nurses tend to act according to their conventional medical habitus in cases of conflict between anthroposophical and conventional medical practices and their respective rationalizations.

c) The hospital's management, including the most influential physicians, who are anthroposophically oriented, has to keep the financial conditions of the hospital in mind. However, the financial challenges are rooted partly in the hospital's specialization in anthroposophic medicine, which goes along with additional remedies and technical facilities, as well as the greater expenditure of time involved in care. Examples are the applying of a poultice or a rhythmic embrocation instead of administering pain-killers and sedatives at the end of life.

Thus, the anthroposophical hospital in question stands between the demands of the public health sector, its patients' needs and demands, the caregivers' attendance, and the anthroposophical orientation of its supporting foundation. All these interests mingle when it comes to anthroposophical end-of-life care, as they are apparently not located within the boundaries of any one social field.

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