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# Introduction: Liminality and the Circle of Life in Modern Societies

Human life is defined by transitions that build a »Circle of Life« for every human being with a beginning and an end. These transitions are not only framed by political, social, cultural, societal and medical contexts, they also mark a frame for political, social and cultural spheres. They are thus subject to historical change. We would like to add some arguments as to the historicity of the »Circle of Life« and look especially at the transitions connected to the beginning and ending of human life, since they were (and are) often in the center of loud debates.

First of all, transitions at the beginning and the end of life were prolonged due to certain developments in the last centuries. This is important, because there is a crucial difference between life transitions themselves and the liminal stages accompanying them. Whereas in the latter, individuals find themselves at a threshold phase in an ambiguous condition, transitions tend to be marked by simplifying either/or-demarcations. There is a before and an after, one is either alive or dead. For centuries, that was more or less true; however, with biomedical and technological progress as well as cultural changes like secularization, these boundaries became blurred—and so did the understanding of »life« itself.

Life always has a beginning—birth or conception, depending on different perspectives—and an end, dying and death (however defined). Those experiences are common to all human beings and each of us experiences them in an individual way. However—and that is what makes the beginning and the end of life so special among other transitions and liminal stages in human life (such as childhood, coming of age, adulthood)—, although experienced by every being, no *communicable* experience and no exchange of experiences exists: all (human) beings transit those special phases at life's beginning and end, but no one can share his or her impressions with others, and communication is impossible during or after these transitions, leading to uncertainty and to an »ultimately individualized« experience.

Despite this lack of common experience and communication with a person in transition, every culture has developed approaches to cope, regulate and (try to) define these liminal stages of human life. Thus, different

perspectives evolved in every society—be it legal, cultural, theologically, social, etc. In historical research, those transitions at the beginning and the end of human life have often been analyzed in isolation from each other. Anthropologists and ethnologists, on the other hand, have been interpreting them as entangled practices for a long time, as envisioned in the concept of liminality and rites of passage by Arnold van Gennep[1] and Victor Turner.[2] In observing that cultures have different approaches to these phenomena, they argued that their functions depend on the specifics of a given society and its cultural beliefs and performances.

Since the Age of Enlightenment—and with the growing importance of what Michel Foucault called »biopower« or »biopolitics«[3]—, »life« has become a very important term; we can observe it today in debates on »life-work-balance« and the establishment of, theoretically and medically grounded, »Life Sciences«. Current debates on the characteristics and the definition of »life« differ from the philosophical considerations of Greek scholars during antiquity or religiously motivated debates in medieval or early Modern times. Even more, we can assume that thinking about liminal stages at life's beginning and end began in the moment when human beings began to recognize they were subjects to time and, ultimately, mortal—thus death being a part of the »Circle of Life«, not necessarily its end, since some religions consider transcendence to be possible, but a meaningful transition for sure. Neither philosophy nor religion nor science could give a holistic answer to the question of what »life« actually is that convinces everybody. Also, related fundamental questions like »Where do we come from?« and »Where are we going?« remain unsolved and are bothering every new generation in a (technologically and socially) changing world. This can be seen in modern societies where processes such as secularization, modernization, identification, and rationalization have a major impact on (religious) systems of belief as well as everyday life. Undoubtedly, these processes also have an impact on the meaning of liminality and rites of passage that are also subjects to public discourses, political decisions, and legal requirements.[4]

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1 Van Gennep, Arnold: The Rites of Passage, New York 1960.
2 Turner, Victor: The Ritual Process: Structure and Anti-Structure, New York 1995.
3 Foucault, Michel: The history of sexuality, vol. 1, New York 1978; Foucault, Michel, Bertani, Mauro, Ewald, François: Society must be defended. Lectures at the Collège de France, 1975-76, London & New York 2004.
4 See e.g. Bruce, Steve: God Is Dead. Secularization in the West. Oxford 2002.

Therefore, despite the uncertainty and ambiguity in the above-mentioned fundamental question, legal debates about the »Right to Life«, sometimes »Life with Dignity« or even a »Right to Die with Dignity« gained influences in political, philosophical and ethical discussions in recent centuries. Indeed, in modern societies, negotiations between different interest and pressure groups—political elites, religious leaders, medical specialists, social workers, NGOs, etc.—aim to control the different liminal stages at the beginning and the end of a human's »Circle of Life«, despite their »in-betweeness« and uncertainty. Laws regarding prenatal testing, abortion and registration of newborns on the one hand, and provisions regarding palliative care, euthanasia, death criteria and burial rites on the other, regulate human lives in modern societies. Looking at laws on in vitro fertilization and cryonic procedures, one could even say that modern societies try to control human life prior to conception and after its end. Although part of everyday life, these transitions and liminal stages are subjects to highly theorized discussions led by circles of »experts«—including theologians, religious leaders, lawyers, medical staff, politicians, the mass media, etc.

To give just one example of the high level of theorization of those questions and the attempts to regulate them in modern societies: during the early 1980s, Irish politicians and society discussed the implementation of the state's obligation to »protect the life of the unborn« into the Constitution that was meant to outlaw abortion in the Republic once and for all.[5] However, this seemingly unambiguous aim caused tremendous debates, e.g., about the wording of such an amendment to the Constitution of the Republic, and lasted for almost three years in what proved to be only the first round of a longer struggle. Central to the discussions in the early 1980s was the question of how to define »unborn«[6] just as a heated debate on the brain death criteria illustrated the struggle to define »dead« at the same time.[7] Although used in unison by anti-abortion activists, what did »unborn« actually mean? Critical observers feared that using this, in

5 Earner-Byrne, Lindsey/Urquhart, Diane: The Irish Abortion Journey, 1920-2018. Cham 2018 (Genders and sexualities in history), chapter 5.

6 Mahon, Evelyn: Abortion Debates in Ireland: An Ongoing Issue, in: McBride, Dorothy E. (ed.): Abortion politics, women's movements, and the democratic state. A comparative study of state feminism. Oxford et al. (Gender and politics), pp. 157–179, here p. 160.

7 Belkin, Gary S.: Death before Dying, New York 2014; Barfield, Raymond: Brain Death, in: Bryant, Clifton D./Peck, Dennis L. (eds.): Encyclopedia of Death and the Human Experience, Los Angeles 2009, pp. 112–115.

their eyes, imprecise expression in the most important legal document of a society would lead to misuse and would not solve conflicts, but create new ones. Questions that arose also hinted at developments neither individual humans nor collectives, such as societies, could influence—such as miscarriages, or unsuccessful nidations, i.e., when the fertilized ovum did not nest in the uterus.

Similar examples are known from the Polish discourse on the introduction of a restrictive law on abortion—even a ban was discussed—in the early 1990s: as in the Irish case, »unborn human life« should be protected by the state from conception onwards. But how should the state, the doctors—let alone the couple—know precisely when conception actually occurred?[8] Similar questions were (and are) discussed regarding dying and the search for a distinct definition of »death« as the opposition to »life«, especially as technological progress provided modern medicine with new and better methods to sustain life.[9] One of the most prominent cases was the case of American Karen Ann Quinlan. The young woman, just 21 years old, had suffered a cardiac arrest following a visit to a bar in April 1975 and had fallen into a coma, because of which she developed apallic syndrome. When it became clear that the severe brain damage she suffered was irreversible, the parents requested that the ventilators be switched off. The doctors refused, and a legal battle ensued that lasted several months. After several courts dismissed the family's lawsuit, it took nearly a year before the New Jersey State Supreme Court ruled that the ventilators could be turned off. But when that ruling was implemented in May 1976, Quinlan began breathing on her own, contrary to most expectations that regarded her as being in fact dead. From then on, she was artificially fed and lived in a home requiring severe care. When Quinlan finally died in 1985, her body weight had dropped to 34 kilograms, with most media outlets agreeing that her life actually ended ten years ago and that keeping her body somehow »alive« for that long was in fact a (very expensive) folly.[10] These cases illustrate the unknown we are confronted with even in modern societies when looking at liminal stages at the beginning and the end of human life—despite or precisely because of all medical progress.

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8 See chapter 6.

9 Marklan, Claire W. et al. (eds.): Life-Sustaining Technologies and the Elderly, Washington 1987.

10 Greiner, Florian: Dämonen in Weiß? Medizinkritik in der deutschen Zeitgeschichte, in: Historische Zeitschrift 315 (2022), No. 3, pp. 633–667, here pp. 639–641.

Thus, regulations regarding the different stages and transitions of human life do not appear ex nihilo in modern societies. They are instead the results of long-lasting discussions and were influenced by changes in discourse and values among elites, ›average‹ members of society, technological innovations and advances in medicine and sciences—to name just a few. Thus, these questions and their implications are constantly being renegotiated, for example, with regard to the protection of unborn life and the issues of transplantation medicine. Although human life inherits a variety of different transitions and liminal stages, the beginning and the end of life are regularly debated in a particularly highly emotional and unforgiving tone. In the last decades, discussions have become increasingly heated, as recently demonstrated by the abortion debate in Poland[11] or the controversy over euthanasia and assisted suicide in Germany.[12] This vehemence cannot be understood without analyzing the historical shifts that characterized birth and death in the nineteenth and, especially, twentieth centuries. Initially, this impacted general conditions and processes, as can be seen with particular clarity in the development of the settings in which birth and death occurred: while only about 5% of all births in industrial societies took place in hospitals at the turn of the twentieth century, by 1970 almost all of them did—home births, which had been common in the past, became an exotic exception within a very short time. And whereas in 1900, 80% of all people died at home, the ratio fell to around 25% in the last third of the twentieth century—with almost 70% of the population now dying in medical institutions, where less than 10% of all deaths had occurred at the beginning of the twentieth century.[13]

Behind this development lay the consequences of increasing medicalization, as well as the transformation of family structures, the growth of the welfare state and new treatment options made possible by medical technology. As a result, care for women in childbirth did indeed improve, as did treatment of the critically ill; infant and maternal mortality rates fell, while at the same time life expectancy for the elderly increased. Nevertheless, although the institutionalization of birth and death ultimately

11 Zok, Michael: (K)Ein ›Kompromiss‹? Der Konflikt um die Neuregulierung des Schwangerschaftsabbruchs in Polen in den 1980er/1990er Jahren, in: Ariadne. Forum für Frauen- und Geschlechtergeschichte (77) 2021, pp. 164–182.

12 See Greiner, Florian: Die Entdeckung des Sterbens. Das menschliche Lebensende in den beiden deutschen Staaten nach 1945, München 2023, pp. 222–224.

13 Greiner, Entdeckung, pp. 27–57.

was the result of an improved health care that allowed more and more people to participate in the benefits of medical progress, it has been increasingly seen as a grievance since the 1960s. For example, in the last third of the twentieth century, the models of »home birth« and »home death« alike flourished and spread rapidly with their encouragement of home births and dying at home, respectively. In terms of personnel, structure and content, there were close points of contact between the actors and interest groups at the beginning and end of life. Naturalness became a major buzzword, and the efforts quickly took on the character of a movement, claiming for itself nothing less than the preservation of human dignity. In the 1970s, for example, a »Natural Birth Movement« emerged, which categorically rejected hospital deliveries according to a »feminist critiques of the medical management of labour«, followed shortly by a »Natural Death Movement«.[14] Its founding father, the English social activist Nicholas Albery, claimed that he first had the idea for the »Natural Death Centre«, which he later established, in the mid-1970s, when his pregnant wife gave birth to their child in a haystack.[15] Among other things, the agenda contained compulsory public speaking about death and improvements in end-of-life care, as well as the promotion of »Do-It-Yourself« funerals using inexpensive and environmentally friendly coffins made of recycled materials.[16] In both cases, the focus was on appeals for a return to naturalness. This entailed a rigid rejection of medical interventions at the beginning and end of life and an active, self-determined control and planning of births as well as of one's own dying process—which, at the same time, was supposed to mark the basis for understanding human life.

What clearly emerges is the instructional character of the movement, which aimed at human self-optimization. A natural birth and a natural death marked the sense-making objectives of human life, for which the individual had to prepare oneself systematically. For example, Albery described death as a kind of school leaving qualification (»Death as graduation«), following a well-known quote by Elisabeth Kübler-Ross, in which

14 Bourke, Joanna: Becoming the ›Natural‹ Mother in Britain and North America: Power, Emotions and the Labour of Childbirth Between 1947 and 1967, in: Past & Present 246 (2020), pp. 92–114, here p. 96.

15 Albery, Nicholas/Elliot, Gil/Elliot, Joseph: The Natural Death Handbook, London 1993, pp. 7–13.

16 ibid., pp. 117–151.

the process preceding death was likened to the decisive learning period of schooltime.[17]

Now one might object that the movements mentioned were short-lived, exotic and of minor significance. This is true, but only superficially, as we would like to illustrate with an example—and here we limit ourselves to the end of life. The Natural Death Movement was closely related to the hospice and palliative movement, which shared many of its core demands—especially for a well-prepared death in the comfort of one's own home—and which, at the end of the twentieth century, not only gained international acceptance in modern societies in terms of health policy, but even rose to become a cultural norm. The ideal type of dying and a »good death« are, in fact, almost identical. Until today, the death of the American aviation pioneer Charles Lindbergh is often invoked as a shining example in thantology and hospice circles.[18] After being diagnosed with cancer, Lindbergh lived actively for another two years and accepted treatment but rejected an unavailing »prolongation of suffering«. He arranged his last affairs, bid farewell to his family, and organized the funeral and memorial service himself, arranging it according to his own ideas, before finally dying »peacefully« in Hawaii in the summer of 1974, a death that, according to his wishes, had been just as »natural« as his birth.

Since the 1960s, various actors have been trying vigorously to influence liminal stages at the beginning and end of life for different reasons. First of all, we should not overlook the fact that optimized medical care did not always represent a real improvement but in some cases actually created new deficiencies, as became especially obvious at the beginning and end of life. The horrific images of impersonal assembly-line deliveries and dying patients shunted off to storerooms in large hospitals are manifestations of this. But much more was at stake, specifically the very basic problems of providing meaning and sense, which triggered new insecurities. Behind the demand for more naturalness at the beginning and end of life, for example, was the argument that modern-day man had lost former certainties, even securities, in these two liminal phases, despite or precisely because of all progress. This referred to the consequences of individualization processes as well as to those that had the power of interpretation and here, of course, especially to the dwindling importance

17 Albery/Elliot/Elliot, Death, p. 12.

18 DeSpelder, Lynne Ann/Strickland, Albert Lee: The Last Dance. Encountering Death and Dying, 2nd ed., Boston 1987, pp. 489–493.

of the churches. Already in the course of the nineteenth century, doctors had increasingly replaced clergymen at sickbeds;[19] in modern societies, trends toward scientification and secularization at the beginning and end of life went hand in hand. Nevertheless, this development is less linear than it might seem at first glance. So, today, it is possible to observe a continuing influence of churches and religious interpretation patterns in all questions pertaining to the »Circle of Life«.[20] However, this was not apparent to contemporaries. Their diagnosis was different: the unsolved riddles of modernity surrounding life and death unsettled people, especially where previous ritualized certainties based on religion had been lost. The demands for more humanity, familiarity and solidarity at the beginning and end of life were a direct reaction to this. They are also an expression of that peculiar interplay between tendencies toward both individualization and group formation which—as Frank Bösch recently remarked—is so typical for contemporary history.[21]

## Structure of the Book

In this volume, we focus on the liminal stages at the beginning and the end of human life and contextualize them with related (on-going) debates and discourses. Because we are interested in the social, cultural, and legal processes that aim at regulating the beginning and the end of human life up to the present time, we concentrate on the late nineteenth and the entire twentieth and twenty-first centuries. As the liminal stages at the beginning and the end of the »Circle of Life« are so central to the discussions in modern societies, we decided to follow this »natural cycle« and look first at processes and discussions about life's beginning (chapter 2–6) and afterwards concerning death and dying.

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19 Abel, Emily K.: The Inevitable Hour. A History of Caring for Dying Patients in America, Baltimore 2013; Nolte, Karen: Todkrank. Sterbebegleitung im 19. Jahrhundert: Medizin, Krankenpflege und Religion, Göttingen 2016.

20 See Greiner, Florian: Säkulares Sterben? Die Kirchen und das Lebensende in der Bundesrepublik Deutschland nach 1945, in: Vierteljahrshefte für Zeitgeschichte 47 (2019), No. 2, pp. 181–207.

21 Bösch, Frank: Arbeit, Freizeit, Schlaf. Alltagspraktiken als Perspektive der bundesdeutschen Zeitgeschichte, in: Bajohr, Frank et al. (eds.): Mehr als eine Erzählung. Zeitgeschichtliche Perspektiven auf die Bundesrepublik, Göttingen 2016, pp. 301–313, here p. 313.

In their chapter, Christoph Egen, Cornelia Weiß, Christoph Gutenbrunner and Anne Ostermann situate recent debates on pre-natal diagnosis (PND) and its ambiguities, which were at the center of the debates about its ethical implications, especially in (Western) German discourse, in a long-term context. The authors highlight the (historical) dilemmas concerning health since the Age of Enlightenment and look at the effects of medicalization on (prenatal) life. They show the changing meaning of »health« understood not only as a desirable condition, but also as a »right« as well as a »duty to society« and highly individualized prevention in the late twentieth century. However, medicalization was met with resistance in history, just as PND and preimplantation genetic diagnosis (PGD) are today.

Wiebke Lisner takes a step back (chronically) and shows how difficult it was to determine whether a woman was pregnant or not in times before pregnancy tests were invented. Her chapter focuses on midwives who were accused of having conducted abortions before and/or during the Nazi occupation of Poland. Set in a highly nationalist and racist setting, the court proceedings aimed at limiting (ethnic German) women's »subversive agency« (Isabel Heinemann), but also showed a lack of unambiguousness. However, those midwives (had) acted not according to the rules of the German occupiers but instead in accordance with the norms of their local (pre-war) environment.

The next chapter also traces totalitarian politics concerning reproductive rights. Marina Bantiou takes a look at one of the most repressive reproductive regimes: late socialist Romania. Connected to a said »demographic crisis«, the country run by dictator Nicolae Ceausescu introduced an almost total ban on abortions—with a few exceptions. Banitou analyzes the efforts to control procreation by law and administrative means, including mandatory gynecological testing, spying, and denunciation. The chapter puts an emphasis on the massive side-effects that were not intended by the legislation and hit women instead of »protecting unborn life« and positively stimulating demography. Illegal abortions, female extramortality, and a growing number of abandoned children were characteristic of the Communist-Romanian efforts to control the beginning of human lives and survived the transition to democracy.

However, the Romanian experience did not represent all totalitarian Communist regimes. In her chapter on reproductive rights in the German Democratic Republic (GDR), Luisa Klatte shows the non-linear developments in the reproductive regime of the Sozialistische Einheitspartei

Deutschlands (SED), leading to a liberal but still pro-natalist approach. Because its pharmacological industry was one of the most advanced among the state-socialist countries, new methods—especially the introduction and general availability of the hormonal pill, called »Wunschkindpille« (›pill for a dream child‹)—, but also changes in discourse opened opportunities for women to consciously decide when and whether to have children. However, German unification led again to a questioning of women's decision-making and reproductive rights.

While the developments in the GDR led to a specific liberal reproductive regime, Michael Zok looks at a unique Polish phenomenon during Communist rule (and afterwards): the strong position of the Catholic Church and its impact on discourses on life's beginning. He shows how the »in-betweenness« and uncertainty about prenatal life were neglected in the Catholic discourse in Poland. Instead, Catholics saw (and see) it solemnly as the first—and not even special—phase of human life. Moreover, the chapter highlights how historical and cultural developments shaped the discourses on liminal stages in very particular ways. In the Polish case, the experience and remembrance of genocide and (totalitarian) foreign rule influenced the debates about the »protection of unborn life« as well as euthanasia.

Thorsten Benkel explores liminal states as irritations of knowledge. He discusses the dichotomy of life and death, using Antoine de Saint-Exupéry's disappearance and posthumous fame to illustrate the ambiguity between physical death and cultural survival. In examining the concept of »social death«, Benkel shows that, vice versa, individuals can become socially invisible despite their physical existence, as seen with marginalized groups and legal declarations of death. The disappearance of Flight MH370 and its passengers is used to highlight the blurred boundaries between life and death, emphasizing that intermediate states challenge clear distinctions between existence and non-existence. Borderline states, such as near-death experiences, cryonics, and post-mortem digital avatars, reveal the ambiguity in determining the end of life.

Julia Dornhöfer, too, is focusing on the challenges individuals and societies face in defining boundaries between life and death. Living wills provide a legal document that promises a planned passage in end-of-life situations as well as an active engagement with death and dying. She argues that although public discourse has increased since the mid-twentieth century, death-denying strategies remain in place, particularly within families. The chapter thus highlights the importance of addressing these

taboos and improving communication about end-of-life wishes to create more meaningful living wills and optimize palliative care in general.

Anna Bauer highlights the differentiation and specialization in multi-professional palliative care. With modern societies being characterized by extensive organizational structures, it calls for high specialization and a deeply interconnected »circle of life«. Within the dying process, Bauer is tracing a paradigm shift from the »closed awareness context«, where patients were kept unaware of their imminent death, to an »open awareness context« promoting informed and autonomous decision-making. Furthermore, the evolution of end-of-life care is discussed, involving multi-professional teams addressing physical, spiritual, social, and psychological pain. This division of labor results in a fragmented view of the patient rather than a unified one. The concept of »death brokering« is distributed among various professionals, creating a complex, multi-faceted organizational system with various contradictions and dependencies.

In discussing the history of euthanasia, assisted suicide and withdrawal of treatment in India, Boopathi P is able to show that the cultural and religious background of a society determines the way the end of life is handled medically and legally. While in most Western countries as well as the former Eastern bloc, at least passive euthanasia has become commonplace and ethically possible in the last third of the twentieth century, it was only in 2011, when India's Supreme Court finally legalized it following the prominent Aruna Shanbaug case, sparking nationwide debates. The verdict sanctioned passive euthanasia and introduced living wills, balancing modern medical practices with traditional beliefs. Legal discourse has thus shifted from religious to constitutional considerations.

Drawing on a completely different case study, namely Switzerland, Eric Franklin shows how and why the small European country pioneered in the institutionalization of assisted suicide, a concept that gained acceptance in the late 1970s and was implemented in the 1980s. The legal framework has its roots in the late nineteenth century, emphasizing honor over shame, with the debate being influenced by criminologists Carl Stooss and Emil Zürcher. Article 115 of the Swiss Criminal Code, passed in 1938, already allowed altruistic assisted suicide without selfish motives. After the Second World War, the concept of honor transitioned to dignity, aligning with human rights principles. In the 1970s, movements advocating for self-determined dying emerged, leading to legal precedents expanding eligibility for assisted suicide, including for mental suffering. The notion of dignity now underpins the right to assisted suicide.

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