English translation by Jeff Martin of the transcript of a video:

https://www.youtube.com/watch?v=G11WUc0Ugcs

RUDOLF STEINER HAUS STUTTGART

Medizin in der Krise – Vortrag von Philipp Busche

“A lecture by Philipp Buche in German that was held on March 2021 in Stuttgart within the framework of the branch work of the Anthroposophical Society and was aimed at non-physicians. Philipp is an internist and gastroenterologist and head the Department of Internal Medicine at the Arlesheim Clinic in Switzerland. Together with Severin Pöchtrager he is responsible for their Corona ward.”

A Lecture from Philipp Busche

A concern for the human being is something that one can say should actually be the motive for our time, even if it is sometimes so difficult to keep in mind, with all the things that occupy us at the moment and that perhaps also affect us habitually. This is actually about concern for our neighbour, about concern for other human beings. I have been asked to tell you something about my experiences and perhaps about the questions, but also the insights, that motivate us when we care for and accompany patients in Arlesheim with Corona, with COVID-19. That is what I would like to do, and we are already looking back on a period of more than a year. I thought I would take you along a bit on our development path at the Department of Internal Medicine in Arlesheim over the last 12 or 13 months. I will use three patient cases as examples so that you can experience what such a pandemic actually means for the individual, for a team, for a clinic, for a society.

I will start with the first patient who came to us and was diagnosed with Corona. If you think back to the spring of 2020, suddenly Corona was in the media. They hadn't even agreed on a word yet, they hadn't even really agreed on a name yet, but everywhere there were reports of a new viral disease SARS-CoV-2. I have to be honest: Before this first patient came to us, it was just something completely abstract, something intellectual for me. I didn't really take it seriously at all. I thought, this is a problem in China, this is a problem over there. Then came the pictures from Italy, the corpses that you suddenly saw, the overcrowded intensive care units. But it all remained a bit distant, because if you only approach it in a nerve-sense way, if you only experience it in pictures, then it's very easy to develop the feeling: This actually has nothing to do with me.

It was totally healing for us in the clinic when we were able to encounter this disease properly for the first time. At that time, a 78-year-old patient came to us in the clinic and when she sat on the edge of the bed, you could see that she was slightly obese and in a very exhausted state. Then she told us how she came to the clinic. She was actually a woman who, at the age of 78, was quite healthy, had no significant previous illnesses, had managed her daily life on her own, and was fortunately well embedded in a network of acquaintances and family. She then developed symptoms where she said, "Now I have the flu" and that was nothing unusual for her at all. She usually got the flu once a year in January/February – feverish, and then it was fine again after a few days. It was different this time. She felt tired, she had aching limbs. That was all something she was familiar with, but what was different is that she didn't really get a fever. She had subfebrile temperatures and she realised that it didn't go away after a couple of days, but persisted. She already noticed: Something is strange. Now, at that time in Switzerland the media began to increasingly report about SARS-CoV-2, and also her family had already the feeling: Well, this could be something else, something new, unlike before. In any case, she also had a rheumatoid disease and was on immunosuppressive therapy. She didn't suffer much from it and tolerated it well, but the rheumatologist she contacted immediately said, "So if you have an infection now, we'll pause the medication." So, she went back home, stayed home and tried to take care of herself. Then she described that suddenly her sense of taste started to

change. The food no longer tasted good. Or she described very vividly that she could no longer brush her teeth because the toothpaste had a terrible taste. But she has always used the same toothpaste for the last 50 years. Then in addition to that, she couldn't smell properly anymore and she stopped eating properly; the terry cloth towels suddenly started to stink, even though she used the same detergent as in previous years, so she actually didn't really want to go to the bathroom anymore because those terry cloth towels were so unpleasant to her. The family then felt like, okay, this might be contagious. The patient was very concerned and didn't want to infect anyone and said, "From now on you don't visit me anymore. And also I won't go shopping anymore" and then the family and the neighbours started to put food in front of her door. But that led to the fact that she actually had no human contact for more than ten days. She got worse and worse, worse and worse, and then a daughter-in-law who lived further away, who is a nurse herself, noticed that something was wrong. She went to her mother-in-law, saw what a bad state she was in, masked herself so that everything was hygienic, packed her into the car and drove her to our clinic.

That is when the patient came to us in the clinic. She had already had the infection for about ten days. Then she arrived at our clinic and you could tell that the daughter-in-law and the patient were very, very scared. Remember how this pandemic started. Fear was something that was absolutely part of it in the media, in society, but also in every single person who somehow developed an infection, immediately there was fear. We actually never met COVID-19/SARS-CoV-2 without fear during the whole first wave. They were sitting there terrified that now this 78-year-old patient might have Corona. She then had a fever when she came to us, but not only did she have a fever, but by now she had shortness of breath. She also described this, that she was having a hard time breathing and an increased respiratory rate – so we were worried – mild nausea, but did not vomit, a little bit of diarrhoea, as we often see in these patients. The skin folds were standing out because she had taken in so little fluid that it was actually not enough for her own fluid balance and it was immediately clear that we were dealing with a seriously ill patient. When you auscultated her, i.e. when you listened to her with the stethoscope, you heard a crackling on the right and left side – we affectionately call it 'corona crackling' at the moment. Now, when you hear that, you know immediately that you are dealing with COVID.

For me, that was the moment when an abstract disease entity, which I had not yet met in any book – something I knew I had never encountered before – became an encounter with this disease entity, when I realized that this now sounds different from everything I had heard before from a lung. That fits with interstitial pneumonia, pneumonia where the lung framework gets ill, but it's quite typical of this disease that it makes this crackling sound. We didn't know that at the time because it was the first patient, but it immediately became familiar to the ear and all of our residents now know that if they have a patient on the emergency ward and they hear that, then the likelihood that the patient has Corona and is sick is higher than the result of the test, even if that's unremarkable. So, we can now meet this disease entity in the symptoms that this disease presents. We then did a swab test and it was positive. We still remember that the daughter-in-law was nervous, excited and anxious and immediately asked

whether it could be this new disease and when we then said, "Yes, the test is positive" – this took two days at that time – the next question was immediately, "Does my mother-in-law have to die?" This was something so unfamiliar, even as a clinical picture, but it came as a reflex after seeing all these disturbing and very touching images from Southern Europe. So, it was totally understandable. In the case of the patient, one rather had the feeling that she was much too weak to really worry about herself.

When I look back at us now in this situation, we were also uncertain. Of course, we knew formally how to put on our gloves and gown, but we didn't know whether the mask was the right one or whether we needed another mask. We had no experience at all with this clinical picture, also with regard to its infectiousness. The whole world had no experience. We were in a situation where the world population encountered a disease that they didn't know, that wasn't described, where there was no experience, where you don't just call your colleague and ask, "How do you do it?" So, we were uncertain ourselves and that is something that is very, very difficult for the patient-doctor relationship, if the therapeutic team itself does not convey full hope, confidence, security in what is being done. It was very important that during the first night, when the patient slept in the emergency ward, there was a nurse who had no worries at all, no fears at all, and who of course sat down with the patient with gloves and gowns and everything that goes with it and could simply hold her hand and say, "I'm here, we'll take care of you." The patient said that this was actually the moment when she experienced relief for the first time, when she had the feeling that she could go with it, that she could accept that she had this illness, and that she was given confidence that things would get better. She said later that it had scared her terribly. She didn't know what to expect and the diagnosis had really scared her.

The doctor who cared for her in the beginning was much like the nurse that first night. She took her time, sat by the bedside. As the head physician, I thanked this assistant doctor very much afterwards, because it takes presence of mind, courage and prudence to still have the calmness in a generally unsettled situation, to be completely involved with the other person, to be there, to be calm, to notice that the other person needs care and attention. The patient reports how important the initial contact with the doctor in the clinic was, which gave her confidence and courage. She reports what courage this gave her, and which could have carried her through the entire illness. This is perhaps a first motive for which one can wake up at a time when one is dealing with an illness for which one has no cure, that an encounter, an attitude can also have healing power. This is something that we as therapists, as doctors, always have at our disposal in the face of every illness, facing this powerlessness that we all experienced at the beginning as doctors, as a therapeutic team; that we don't know what the right therapy is. You can compensate for this to a certain extent by remembering the therapist is in you and by trusting that the patient will also bring along a therapist within her, with whom you can somehow work together.

She had been with us for a couple of days, had this pneumonia on both sides, heavy breathing, but she was stable. Then it was in the middle of March last year when we realised: Oh, the heart

rhythm is changing, she is getting arrhythmias and the blood oxygen is getting worse. Then we immediately understood: This patient is now exhausting her breathing. This is something that we see again and again in older people or in people who have been seriously ill with a lung disease for a long time, that the respiratory muscles become weaker and that even if you have held on for a long time, at some point your own strength is too little to supply the body with sufficient oxygen. These are the signs that the heart is reporting, that the blood oxygen is changing. I was on night duty that night and then I talked to the patient and she actually didn't want to be transferred when she came to us. That's why she came to us, she explicitly wanted to come to our clinic. Because of her previous history and her relationship to Anthroposophy, she wanted to come to us. But then it was clear that what she will need now, in terms of therapy, we couldn't provide. We are a small clinic in Arlesheim. We have about 100 beds. We have a monitoring ward, but we can't do artificial respiration. We have now treated 140 to 150 COVID patients. None of them have been intubated. I'll get to that later.

So, we couldn't offer this patient to increase and escalate her ventilatory therapy. We discussed that we would transfer her, and I felt as well that the patient had enough reserves to withstand ventilation in another hospital. She went along with that. That is, we transferred her to the intensive care unit in the reference center for COVID-19 at our local cantonal hospital, and we discussed this with the our colleagues there, and then she arrived there and now you have to imagine: First wave. All full of fear. The patients who arrived in the intensive care unit were all old, all had incredibly poor respiratory function, and there are still no therapeutic options. What did they offer her or what did they see? They saw that her breathing was insufficient, that she needed artificial respiration, and then recommended to the patient that, "we intubate you and put you on a ventilator." The patient said, "No, I don't want that. I want you to support me, I want you to help me, but I don't want to be intubated." She later said that this was not merely a recommendation, but a team of doctors wanted to convince her of this from their best medical knowledge. You can see that she did not feel free. But how beautifully she then further differentiated: There would have been much therapeutic will noticeable there. The only therapeutic option available to this intensive care unit at that moment was artificial respiration, and it was only understandable that a therapeutic team would then try to offer this therapeutic option to the patient as well. "I didn't want intubation, that was my decision. I'm 78 and I can also die, too. I had to fight intubation," she said. "I was threatened with death, but I persevered." But notice what kind of therapeutic will that takes when you go to an extreme like that as a physician in communicating out of helplessness because of a lack of options to do otherwise. I don't think we should judge that at all.

What was done? She was given non-invasive ventilation. They put a mask on her with positive pressure. This is actually a great procedure if you have water on your lungs, if you have severe pneumonia, if you have chronic bronchitis. That somewhat dilates the airways and you manage to provide more oxygen to the patient than just with nasal cannula where a little bit of oxygen comes. So actually, a good intermediate step. But now you have to imagine: The highest infectivity in this disease is the respiratory nasopharyngeal tract. Now just at this time the first studies also came from China, which showed that non-invasive ventilation or inhalation

spreads the pathogens in the room much more. So, what is the consequence from a hospital hygienist or from an infectious disease specialist? To say, of course, "We can no longer do this form of therapy." From one day to the next, it was decided in this cantonal hospital – understandably – "From tomorrow, no one will be given non-invasive ventilation. There will only be nasal cannula or tube." This patient, however, needed this non-invasive ventilation. But she just fell into the situation where therapy was no longer possible because of the fear of infecting the staff. Totally understandable. Nobody wants their nurses to be infected, especially not at that time. So, the therapy was omitted and so also for this patient, and because she was not artificially ventilated, did not want to be ventilated, she could no longer be treated non-invasively, was not allowed; she was then placed palliatively to die in the normal ward. So due to this social decision – which research then always brings about in concrete terms as a consequence – the patient is then transferred, she is in terrible shape, shortness of breath, 10 liters of oxygen via the mask, decides again against intubation and then says, "It was hardly bearable, this weakness, this shortness of breath. The staff was loving, however there was actually not much contact behind all the masks and protective gowns. There was a great respect for the infection." Incredible, right? In this emergency situation, how it can nevertheless illuminate and bring a positive aspect, not, "They didn't care" or "They didn't make any contact," but, "They understandably had respect for the disease and that's why they behaved the way they did."

I think this is very important: I can learn from this patient how to deal positively with phenomena and first try to understand what lies behind the attitude or action of the other person that I encounter, even if it doesn't suit or please me. I was in this cantonal hospital two or three weeks later, because there were simply 40 or 50 patients with COVID-19 there at that time and no one in our clinic. I wanted to learn about this disease. We had a good contact with the colleagues there and I then took part in a ward round. You have to imagine that: You go on rounds through 20 beds, see every patient, they all have the same clinical picture, they all get oxygen, but as a therapist you are not challenged at all, because as a doctor you have nothing to offer except to accompany, to look and to hope that things will get better. I experienced an unbelievable helplessness in the therapeutic team there. There is hardly anything that motivates one less to go to work than when one has the impression that one is going to work but cannot do one's job because one has nothing in one's hand with which to act.

So that was the situation a year ago. I think it's important to go back into that. There was a ban on visiting those patients at that time. This is also part of the pandemic, that we have to think about the importance of relationships and contact. This patient then tried to keep in touch with her daughters, with her family, over the phone, and that gave her strength. She reports, for example, that once she was apparently so ill that her consciousness was also impaired. She could have had the impression that an elephant was coming through the window and that first the elephants would have been saved and then the patients. You realise: She was so existentially ill that she could no longer qualitatively maintain her consciousness completely out of herself. Then she reports, after a few days she sat down with all her strength at the edge of the bed and spoke to her dear God. "If you want me to come, please let me come quickly,

because this situation is unbearable. If you want me to stay because I still have a job to do, please do it quickly too, because I can't take it anymore."

The following day things started to look up. The values improved. The doctors on the rounds were pleased that she was better, that her breathing was more stable again, that she needed less oxygen, and so it went on. Ten days later, twelve days later, she was so stable that the nurses were delighted to announce that she could now be transferred to rehab. That's what she did. Six months later, she still feels weak. When we talked to her on the phone to follow up, we asked her, "What helped you get better?" She said, "Yes, there is something that has helped me to stay healthy" and then she quoted a saying by Bonhoeffer: "Wonderfully sheltered by good powers, we confidently await what may come. God is with us in the evening and in the morning and certainly on every new day." That was already special for us when we heard it, perhaps also because we have a special ear for such questions of spirituality in medicine, in sickness and in health. But when we look back at this patient, what helped her, then certainly the oxygen, but also that individual people were free of fear, also that individual people took care, but also that she cultivated her own spirituality, which she affirmed herself in the sense of autogenesis, in the sense of keeping herself healthy and inwardly competent in dealing with the disease. I place this at the beginning because it leads us into a time of this pandemic where we as representatives of anthroposophic medicine, but as medicine in general, knew very little, had very little available, had very little experience and where therefore the patient in this course of the disease became all the more clear, because one notices that what happens in terms of development is so completely based on the patient and that, I find, is very tangible in this story.

When we in the clinic now look back after more than 100 patients and reflect on what we have actually learned about this disease, we realise that it has very different dimensions. One is the physical side, that someone no longer smells or tastes properly, that we hear this corona crackling or cracking, where we notice that the physical body is changing. But something that is just as much a part of this disease is the exhaustion and the weakness. These patients all report a lack of strength, which is much more than a simple tiredness, where you have the feeling that after sleeping once you are refreshed again. But a real weakness, where we have the impression that the life forces are existentially diseased. There are patients who actually have difficulties only on this dimension. They go through this infection and then this exhaustion remains. But for us, this means that we as physicians and as a therapeutic team must not only take care of the crackling, the pneumonia, the infiltrates, the shortness of breath, but we actually also need a therapeutic impulse to address this life level, to support the patients on the level of their life forces. This is just as much a part of the disease, just as much a part of the issue. If you look at the psychological dimension, then fear is clearly part of this disease. We have experienced this socially, we have experienced it globally, but we also experience it in the individual patients, also because breathlessness and anxiety have a great deal to do with each other. The two symptoms that immediately prompt doctors to act are pain and shortness of breath. This is related to the fact that this shortness of breath always touches on the existential question of, "Can I actually hold on to my soul/spirit here on earth?" So, the shortness of

breath, the dyspnea, the pain or difficulty in breathing is something that is directly accompanied by fear in the soul very, very often. So, these two dimensions, shortness of breath on the physical level, but anxiety on the psychological level, are very clearly related in COVID-19.

I'll come to the fourth dimension later with another patient. But we also learned that this disease has different phases. It took a while to see this. It took us a few more months to realized that this disease always starts in the nervous system. The first phase is always an attack of the mucous membranes in the head and the phenomena are actually nervous phenomena; loss of taste, loss of smell, headaches, lack of concentration. The disease actually starts here, and then – we also know this now – the virus moves further down in the next phase of this disease, which, however, not every patient has to go through. There are patients who have the first phase and then it's good, then they heal. But when it goes into the next phase – that would be phase **two,** so to speak – then the rhythmic system is seized and we either have an infection of the upper respiratory tract, a bronchitis, or, if it gets to the depths, the classic pneumonia, mostly with bilateral infiltrates, i.e., changes in both lungs. This is often the reason why pneumonia is so severe, because it is not limited to a small area, but often occurs on both sides. These are patients where you have to say that when you move from the first stage or first phase to the second, they become much sicker. Our patient came when this second phase had just begun and then went through this second phase in our clinic and in the cantonal hospital with a very severe pneumonia. The patients who really worry us are the patients who come in phase three. You know the risk factors, which are age, immunosuppression, all the clinical pictures that go with it, arterial hypertension, obesity, male gender. They don't actually have a classic continuation of infection now, so this is an infection where the virus moves from the top down deeper into the organism. The third phase is characterized by the fact that the body reacts and that this reaction is just as exuberant as actually the foreign influence by the virus is exuberant. Now the immune system reacts and we call that a cytokine storm, or actually an over-inflammation. There is an overreaction of the immune system. We notice the metabolism is excessively increased and now the patients are no longer actually suffering from the virus, but from the fact that the body is trying too hard to overcome it and in the process is additionally harming the organs. In extreme cases, this leads to sepsis, i.e., blood poisoning or an infection that is so severe that the circulation cannot be maintained and the internal organs are damaged and cease to function. These are then the patients who often stay in the ICU with long-term ventilation because the lungs are not functioning properly, with circulatory support. So, phase two and phase three are the phases where the metabolic system with its forces, with all that - I want to say - in the most choleric sense, the metabolism takes over and starts to produce an over-inflammation and thereby overtaxes the cardiovascular system. Our patient did not get to this phase. This is the phase in which one no longer tries to treat the infection, but to suppress the immune system by giving cortisone or – as we are currently learning in integrative medicine – where one notices that the therapeutic orientation must change, by treating with colchicum, because it is no longer a matter of overcoming the infection carrier, i.e., the germ, but of bringing the self-perpetuating inflammation back into a form. This is a completely different therapeutic approach and clinical picture.

If we look out into the world, what happened in the world at the time when this patient was with us? We had the first lockdown in March, and with a little bit of distance, I had the impression that this first Corona wave actually took hold of the whole world like a flu, and the world became a patient. The world society became a patient and was suddenly acutely ill. This included all the things that we normally know from an acute flu. We get infected, everybody gets agitated, and then there's a period of rest. We were all sent to bed, so to speak. You may remember that, especially in younger years, you get a feverish inflammation every now and then and then you go to bed for a few days and afterwards you often feel better than before. Often a viral infection, if it is overcome well, or a bacterial infection, if you overcome it well on your own, results in a different form of health than at the beginning. I had the impression that we, as a world population, were in such a situation for a moment. Suddenly the sky was blue again, nature was strong in a different way, family fathers and mothers had time for their children again. It was experienced more as a vacation than a lockdown. There were so many positive moments that suddenly became possible in this time in the social, in the ecological sense, that one had the impression: Okay, actually this doesn't do us any harm at all, if we are honest. We don't wish it on anyone, but a forced break for four weeks – the world is moving so fast anyway, so much too fast for all of us – thank you. There was a little bit of that. With all the worries, with all the uncertainty, there was also a side where you thought: Maybe it's our turn to stop, to take another look. But that was the first wave, that was in the spring of 2020. The world is acutely ill and you have the feeling: There’s a break, and then everything is different.

Yes, and then came the summer and after our next patient came in October. A somewhat older woman, 82 years old, more of a nervous type, perhaps much less vigorous in terms of her resources, but still independent, quite an alert person, a participant in current events. When she came to us, she had a fever, and above all she had digestive problems with repeated vomiting and diarrhea. Then it was heard quite quickly, also on admission, that there were infiltrates; this crackling and cracking. We did a swab test. Now we were already professionals. Now we knew exactly how it all works and how to dress and equip ourselves, and had experienced a few patients. But in our canton, the rule was that all patients who came to us with Corona had to be sent to the reference center. There was only one hospital in the whole canton where all patients were treated with Corona and all other hospitals were supposed to be Corona-free. In this interim period after the lockdown, we changed a few things at our clinic. You have to imagine: This was not so easy for me. The whole world is doing a lockdown and we as a hospital clinic are told – while we hear all over the world that people are suffering, dying, that there are not enough intensive care places, not enough doctors, nurses – and we are now told as at the clinic, "From now on you don't do any more treatments. You have to close the internal medicine ward and your doctors have to be on call in case we need them in the reference hospital." While there were too few medical staff all over the world, I had to send my entire team home, to be on call. People are in our clinic because they like doing medicine. My colleagues, like me, we like coming to work. We like doing what we do. But what we don't like to do is, when the world is sick, stay home.

That was quite a weird situation, because we felt: We want to get involved, now we're really needed, and they say, "Yeah, wait, we'll call you then." But there was never a call. There was no need. The wave was not so high that we were needed. Together with the clinic management, we realized that this was not going to work. We wanted to be actively involved in the care of this pandemic. We then started talking to the crisis team. You have to imagine that a cantonal state of emergency was declared here, and the military took over hospital care and the coordination of supplies and everything. You can't imagine what that was like at the beginning – or maybe you can. There weren't enough gloves for the nurses, there weren't enough gowns, there wasn't enough of anything really. In this first wave, we started sewing gowns ourselves because we didn't know how many patients would come to us. But of course, it's incredibly nice for a team when suddenly the housekeeping staff, instead of cleaning the rooms, bring their sewing machines from home and then sit down and start sewing the old bed sheets into gowns. That also has a team-building quality, when you realise that the therapeutic team is being extended to housekeeping and everyone is working together. So there are also nice moments that are part and parcel of such a pandemic – absolutely. And now, in the meantime, we have spoken with this crisis team and with the other physicians, and we have said, "We want to be part of it. We dare to do that" and then they said, "Yes, but you don't have any ventilation places." So, we said, "That's right. Then we take all the patients who don't want ventilation, who don't need ventilation because they are not that ill, or for whom there is no ventilation place available because there are not enough." So, we said, "We will take care of all those patients for whom ventilation is not a therapeutic option either because of resources or because they say they don't want it for themselves."

Then the second wave came in October/November 2020 and during that time this patient also came to us. Now we were allowed to provide. Now we were allowed to keep people here. Now we were part of the cantonal crisis concept and had to take 25 or 50 Corona patients if needed. You have to imagine that: Our ward actually has 22 beds. So, we took on quite a lot when we said, "Well, we can also handle 50." We then made plans, as we sat down together for a few weeks. “We can redesign the day clinic and include the ward as well, and push in even more beds here." We were totally creative, but we wanted to cooperate. So, this one came as the first patient in the second wave, quite classically with these bilateral infiltrates and we immediately noticed: Okay, this is now Corona. She started it, so to speak, and as soon as she was there, patients started coming every day, and then there were more and more and more, and then all of a sudden, the other hospitals sent their patients directly to us, and then word got around: You can be treated at our clinic if you don't want to be ventilated. If you remember last fall, the first studies came out that ventilation was perhaps not always the best way in the first wave, that it is perhaps even better if people are not ventilated for as long as possible, because if they are ventilated, it is very difficult to wean them off ventilation again. Well, and then we had one, two, three, five, ten, 15, 20 to a maximum of 25 patients on the ward. That's a real challenge for a nursing team like this; changing clothes, organising equipment; a team which normally looks after 22 patients who don’t have to be isolated. We were actually totally overwhelmed – but creative. Because the team wanted to do it, ideas popped up all over the place about how we were going to deal with it.

A sub-assistant said "We could ask my students if they would help us." She sent a WhatsApp. Over the next few days, we had 25 requests from medical students, psychology students – it went on and on at the university – biology students, law students, all saying, "We can help out." We had more requests to help out than we had any need for. Suddenly every day there were one, two, three students from the university who we trained, who took care of the food, who helped, and the team was twice as big. We integrated rescue workers, all the people who wanted to help in some way. It was a huge hustle and bustle, and it was all done under maximum hygiene regulations. But it worked. At some point, there was a flow. In this entire second wave of 120 patients that we cared for, no one from the team was infected – not a single internal infection. So that was very important. And now the second wave; you made rounds just as you did at the beginning, but you didn't even know it then, and now you go from room to room and everywhere you see the same clinical picture: Corona, Corona, Corona, Corona, Corona. That sounds simple, but when you looked, Corona in patient one is completely different from Corona in patient two or patient three. One has a fever, the other has more of a cough, or there is the loss of the sense of taste. There are virtually no two patients where this disease progresses in the same way. This brought us, so to speak, the next realisation of how important the individuality is, which falls ill, for this disease pattern. That gave us incredible encouragement, because we realised: They all have the same disease, but they all have an individual course. This means that the individuality has a great power to shape the course of the disease. This has strengthened our therapeutic approach from the very beginning, which is not to focus on eliminating the virus, but to focus on supporting the host, i.e., the patient, in dealing with this virus. When you realise that the individuality gets involved anyway and individualises this course, then you realise that this is actually a relationship between the being of disease and the being of the patient, and if we can't treat the disease because we don't have a cure for it, then we are left with the patient to focus on. This is something that totally corresponds to our anthroposophic medicine, that we try to support the person, the patient, for whom we are caring – in his or her own being, in his or her own powers physically, mentally and spiritually – in such a way that the power to become healthy arises out of him or her.

The first patient demonstrated to a certain extent what it means to nurture and participate from one's own spirituality – in her case it was religiousness. In other words, we developed and standardised a therapy concept, which was then adapted again and again, where we said, "How do we do that? How do we support the patient in getting better if we don't treat the virus?" Then we took medications from phytotherapy, which we know, Echinacea, iron preparations, Pneumodoron 1 and 2, all substances that are supposed to help strengthen the patient's own inflammation competence. Very, very important are external applications. It didn't work for every patient every day with this flurry of activity and the resource shortages that we had for months. But again, and again we applied yarrow compresses to the lungs, thyme oil compresses, ginger compresses, mustard foot baths. Nursing has become a therapy. To be honest, we probably have to say that in this clinical picture, nursing is the much bigger doctor than we are with our medications, because of the effect of these external applications. In all the feedback that we have from our patients, they always talk about the effect of the

external application, how much better they could breathe, how much better the warmth equilibrium became, how much better they felt. So, a very big pillar: External applications. Then we were bold in a couple of places. For example, from the beginning we said, "We continue our therapies, respiratory therapy through the physiotherapists and eurythmy therapy." We developed exercises with them, we looked at what is technically possible, what is also possible in isolation, what is also possible when the patients cannot stand up. Our eurythmy therapists and our physiotherapists went to the patients every day – even if it was for ten minutes – and practiced with them, because this practice appeals so strongly to this individuality and gives support such that health forces are mobilised out of one's self.

Then we made a decision that was actually probably a no-go in Switzerland at the time. It doesn't sound that daring, but we decided that there would be no ban on visits. We allowed people to have their relatives come to visit. Not 20 at a time; one a day, but one every day. That sounds like a simple decision, but imagine you have 25 infectious patients, a nursing team that is overburdened to the maximum, six or eight students scurrying around, then doctors who are still coming and going the whole time, and then relatives. But the nursing staff had said that they will go along with it. Every member of the family has been trained on how to dress and equip properly. We made videos and showed them. So, it was an enormous effort. Nobody got infected. But I remember one patient who came to us with Corona pneumonia and she said, "Now, I was alone in my room in the nursing home for seven weeks and here I see my family again for the first time." Then she recovered and it was time to discharge her and she said "Nah, I don't want to go back to isolation. I'd rather die." The next day she had died. We don't know why, but it was coherent somehow with her biography. If you take it seriously that the only medicine we have – well we have many – but the only one where I would say that is the one that helps the best, is the patient himself. So, if it has to be about strengthening the individuality that falls ill, then social contact and being embedded in his – I say – social incarnation, being in contact with the people who support you, who are a piece of yourself – and that you can also meet this part – absolutely belongs in a health concept. So, we didn't do this to make people feel good or to be nice, but because we are really convinced – still are – that this has a therapeutic effect, whether I feel isolated or I am in relationship with what is essential to me.

This patient who was 82 years old also got really sick with severe pneumonia. We did not transfer her. With her, we then learned that saturation values, i.e., values of blood oxygen at a depth that we never thought we could tolerate, can be tolerated, and that the patients still manage this well. Something that has also become established by now, that one can become much more courageous if patients can endure poorer respiratory conditions before giving artificial respiration. This patient knew what she didn't want and knew how she wanted to go her own way. Something that sometimes totally helps when you become unsure yourself as a therapeutic team, when the patient then tells you what to do or how to proceed. That was the case with her to a certain extent. That gave us courage for all the other patients who came in, that we reacted much more carefully, perhaps sometimes more cautiously with invasive measures. You have to learn that first. Maybe one of the most important aspects for this

pandemic, that we as a world, as a medical movement worldwide began learning, is that we had nobody who knows better. There are many who might want to know better, but actually we were all learning. A learning medical community, that's something we're not so used to. We are a profession that thrives on knowledge, on knowing better, on knowing more, on knowing everything, and we were now in a situation where we didn't actually know anything and where every patient became a teacher. That's usually the case with patients, too, but we sometimes don't notice it that way. We are not so open. But this patient was one who opened our eyes in a very special way.

But if you think back now to the fall: A completely different situation than in the first wave. Not even a short acute illness, rest and then everything is fine again. We were actually already tired of it in the fall: Measures, restrictions, masks. Uncertainty; I think what came after fear was above all uncertainty. Uncertainty about what is right, what is the right way, which measures are the right ones, and then the polarisation began. In the Society of Anthroposophic Physicians in Germany, we have had resignations because we did not recommend vaccination. We also have resignations because we allow vaccination. We have resignations because we do not only quote Steiner. We have resignations because we quote Steiner too much. We had all this polarization. You get the feeling, whether it's about Corona or not, society is losing the center. So, the system that is now sickening globally – the rhythmic system – which is inflamed, which is weakened, which is challenged, seems to be losing some of its power socially as well.

Society is polarising. That's the whole fall, the whole winter, an extreme increase in polarisation. And one has the feeling, where one stands, where one speaks, where one is in contact, it is becoming more and more narrow. And if I look at it with a bit of distance, at what is now taking place socially and what is then also taking place to a certain extent with these patients, we are actually going from an acute phase of an acute infection into a chronic disease. Chronic inflammations are always characterised by the fact that they sclerotise, that they solidify. When I drive here to Germany from Switzerland, where the outdoor cafés and restaurants reopened on Monday, I notice the extent to which a society allows itself to become sclerotic varies from country to country. But you can see what's happened: We're getting stuck. We no longer manage to just dissolve this and take the next step. Things don't just disappear again, and it takes a completely different approach. With an acute illness, you have the feeling that you'll get through it and then it'll be over again. With a chronic illness, it's not about making it go away. Chronic is something that you don't make go away, but that you accompany. It's a relationship that doesn't end again, but where it's about learning how everyone has their right place in the relationship, where you have to rearrange yourself. If you now look at this therapeutically and see: Okay, let's assume that we as a global society are chronically ill right now, then as a doctor you can also try to sense, “What does this do to people?” Unlike an acute illness, I have the impression that a chronic illness very quickly raises the question: What is actually essential? If someone has a chronic joint disease, a chronic heart disease, a chronic intestinal disease, the question comes up very quickly: Why? In the case of cancer, perhaps the question at the beginning is: Why me? At some point it becomes the question: Why? When you work with people, when people work together, then perhaps it also becomes the question:

What for? But actually, to a much greater extent, a chronic illness situation leads to the question of meaning, to the question of what is essential, and then you realise that this is no longer something that can be answered from the outside, but where everyone is challenged as an individual to find his or her own answer.

I have the impression that this is where we are now: From a physical crisis at the beginning, where it was about intensive care beds, about ventilation yes or no, body bags, coffins, we were completely physically oriented. Then since last fall a mental-social crisis has become polarised. We are no longer where we were. We have long been in a crisis of meaning as a society. We are looking for orientation. We ask ourselves: What is the next step? I see people, especially younger people, who are still facing the question of the future in a completely different way, asking themselves: Where are we going? How are we going to get ahead? The world – viewed positively – is now hungry for new ideas. People are looking for utopias, looking for visions, because they realise that the way the world is developing now is not the way it should develop, we can't go on like this, it won't work. I have the impression that with all that is now being demanded of us, with all that is now difficult, that is tight, that does not feel right, where we realise that we are not only physically in a pandemic, we are also mentally in a pandemic. There's also a mental contagion that's taking place. We now need a spiritual contagion for good ideas, for visions of the future, for utopias that lead us in a direction that we may only suspect, that we have yet to sense.

The third patient is 30 years old, he was an inpatient with us about three weeks ago and had Corona in January with loss of taste, loss of smell, a little fever, a little bronchitis and then good again. And now muscle pain, lack of concentration, and so much so that he can no longer go for a walk or climb his stairs. Corona is long gone. The test when he comes to us in the ward is negative. He is a person who tends to panic a bit, who actually should or wanted to come for clarification because of this, and who is now suffering from something that is currently beginning to be called Long COVID Syndrome or Post COVID Syndrome, where we realize: Just because COVID is over, COVID is not necessarily always over. Again, something where we are quite questioning: How can it be that a viral disease still causes symptoms three months, eleven months, twelve months after infection? We now assume that about 20 percent of patients who are symptomatically ill retain residual symptoms. This means that we are dealing with a completely new phenomenon in medicine, and while in the case of COVID we do at least have some symptoms for which there are diagnostic results – we as physicians always feel quite comfortable when we can say, "There's a crackle, and in the X-ray or in the computer tomography I can also see that there's something different," – we are now dealing with patients where our conventional test procedures, ECG, laboratory, CT, are actually useless. This 30-year-old person is incapable of working, is actually incapable of everyday life due to weakness and muscle pain, without us finding any tangible test results. Anyone who has looked at the last Zeit issue will have noticed that there is now also initial research and it is suspected that there is something similar to a chronic fatigue syndrome after COVID, i.e., a chronic exhaustion – put quite simply – and it seems to be the case that in some of the patients not all the viruses disappear and some of the viruses still trigger illness. In another part of the patients with Long-

COVID it seems that the immune system has not managed to completely eliminate these viruses. That is, there remain fragments that can affect the organs, and in a third part it seems to be simply that in this reaction of the immune system auto-antibodies arise, so actually an autoimmune disease remains, which can then lead to various complaints.

If we now look at this anthroposophically with our humanistic view, then we notice: This is actually not one syndrome, but we are dealing with four groups that we have come to know at the moment. There are patients who have gone through COVID and report lack of concentration, headaches, neurological complaints, where one has the impression that it is the whole nerve-sensory system that is impaired. Probably most of the patients, or a large part of the patients, notice that the rhythmic system has not fully recovered: Cardiovascular, but especially respiratory. A colleague of mine, with whom I have worked a lot in the last few years – who is actually a healthy working woman – is herself still so impaired that she can no longer go jogging, that she can't even manage the two floors in her own house, and one notices that this impairment of the rhythmic system is something persistent, becoming chronic. Second group: Lungs and circulation. A third group, which is simply exhausted, which do not regain their strength. And then a fourth group, like this patient, where we have the impression that something is wrong with the limb system. Pain, weakness, lack of strength, but not in the sense of exhaustion, but really having no strength for everyday things.

We started a therapy with this patient with different medicines, where we had the impression that this could help him, but all this did not help. Then we reflected on that and thought: Okay, what is our picture? What is the problem? The picture we developed in the team is that perhaps this initial infectious disease – similar to this whole pandemic – has become chronic and has become a chronic problem. Then we said: Okay, what would we actually wish for the patient? We would actually wish for him that it becomes acute again and then that he really overcomes it. That's where the idea came from: We create fever. That's what we did. We talked to him and said, "Can we do mistletoe therapy with you? We have never done that with post-COVID syndrome, but we would like to try and use an off-label course with you." We did. He had a fever of 39 degrees over three days. That doesn't make you feel good. That's stimulant therapy. It is good if someone does it who knows how it works with oncological patients or fibromyalgia patients. It has to be done by someone who knows how to do it. Then you do it, you accompany it, you have to explain it well to the patient so that he knows that he feels like he has the flu for three days and after the three days it will be fine. That's what we did and now we have called him again after about three weeks: He can go for a walk again, he can manage his stairs again, the pain is better – it's still not completely good – and he asked if he could come back as an inpatient now, so that we could do this for the second time, so that it deepens and solidifies.

So, we realise that Corona is a multi-layered problem, a multi-dimensional problem, a problem where you realise that on every level of our being illness can show itself, illness can manifest itself. It's actually a beautiful situation: It takes a therapeutic creativity to confront it. For me and my whole team, I can say that we are extremely grateful to anthroposophic medicine,

because we were never helpless therapeutically. We had no idea what the right way was, but we had an unbelievably large treasure that we could make available to the patients in order to get into a process at all, in order to look for what could be the right way for the person, for the patient, because we try a medicine that is not pathogenetically oriented, but salutogenetically, that tries to always aim at the health forces of the individual person, and they are right in every illness, if one addresses them. In this respect, we could at least apply what we had learned from other infectious diseases and try to make it available to the patients in this disease situation.

This went so far that our colleagues from the cantonal hospital asked us what else could be done and that we helped and shared; just as they taught us at some point to use cortisone in the third phase of thrombosis prophylaxis, because so many people get clots in this strong infection. This is where you realise that something like this can also overcome polarisation if you manage to stay in conversation with each other and if you realise that the conversation is not about you, but you are oriented towards caring for people. This is something that every doctor, every therapist understands: To put the person in the center and to care for him or her. I would sometimes wish that we as a world population would manage this better, that in all that we talk about, what we argue about, where we disagree, that we reflect again and again: Who is actually the one we have to take care of and how do we do that best? Perhaps we can do this here in such a circle, that we briefly reflect and ask: If we take this seriously, that from this crisis, which perhaps began physically, which has taken on a soul-social dimension, which is now perhaps already in a stage where it asks for meaning, where one can say, we also have a spiritual crisis, because we have to search for our inner orientation, review it or find it anew. Perhaps we can then ask ourselves personally: How are we doing at this threshold, where we have to somehow listen to the future anew, where we have to search for the future anew, where we have to listen to the future anew, perhaps to some extent.

I thus have the impression that what we are experiencing are global events that we also know from our own search at the threshold. We experience mockery, we experience arrogance, we experience that we find know-it-all-ness in the social sphere at a place where there should actually be reverence, where there should be restraint, where there should be modesty in judgment, because we encounter something that we cannot yet know. We experience fear, anxiety and we realise that we are challenged in our own courage, in the courage to think something new, to do something new, to experience something new and we experience in the social realm again and again consequences of hatred, where actually care and loving attention should be, because one puts one’s own ego more in the center than the other. To a certain extent, this crisis, because it has become chronic, also leads us to the threshold of the spiritual world with the question is: Where is the meaning that guides me into the future? With the artist Josef Beuys, the mysteries took place at the train station. I have always understood it in this way: Because man meets man there, I and I, and where I and I are, there is a spiritual world and there a spiritual world can be recognised. Maybe that's why the train station is the place for the modern mysteries. Mystery medicine, I believe – if we want to live mystery medicine, if we want to practice it in a hospital, in a department, in a practice, in a patient-doctor encounter – then we have to do it a bit Michaelic. It's not enough to know the right thing to do, which

we're not doing at the moment anyway. It is not enough to think the right thing, to feel the right thing, but we must wilfully strive to care for the other person. We must take action for what is good, for what the individual needs, what we individualise for their individual situation. One of Rudolf Steiner's central meditations for young physicians asks the question: How do I find the good? It is not the question: How do I find what is right? The question, "How do I find the right thing?" is one that can be answered in general terms. The patient-doctor relationship always involves the question: How do I find the good for the individual person who entrusts himself to me, whom I care about because he has asked me for help? This good can only be treated individually and if this pandemic teaches us one thing, it is that we should take the focus away from the disease to the host, that we need to focus on the person.

I think with all the questions that move us today – vaccinate yes/no, is the vaccine good, is the vaccine bad – you can handle all that intellectually. You can also say "so and so is right". In concrete terms, it doesn't have to be right, but it has to be good for the person who has the question whether to be vaccinated or not, because he decides for himself: This is my way. This is how I understand anthroposophic medicine, that we have the task – and I believe that this is actually a general medical task, a general medical task that we manage from all that we know, from all that we have recognised as correct – to focus on what is good in the individual situation and to work with it. In this respect, I think that the mystery medicine for the future that is taking place in the hospital or everywhere where people meet therapeutically, is something where one wants to work for this good in a very Michaelic way. That is the answer in this meditation, that it says, "In thinking I do not find the good. In feeling I can perceive it, but it does not exist when I only feel the good. But I can will the good" because willing fuels the 'I' when we focus on always asking the question, "How is it good in the individual situation?" I believe that is what the spirit of the times demands of us. That is what is Michaelic in the present moment. That is what will ultimately lead us therapeutically out of this pandemic – I am totally confident about this – that if we don't lose the human being in all these questions, but always put what is human in the center, and you can't generalise that, you can only do that concretely. In this respect, we are of course in a hospital as a team, where everything we do is of course a team effort – I, too, can only speak here because we are a therapeutic team – we are of course in a very special situation, because we are allowed to wrestle with this zeitgeist out of free will, and not just encounter it in the abstract via media or via narratives or all the things that also scare us. But I would encourage you to keep focusing on the human being, because I think that is the therapeutic path that we can definitely take, even if other therapeutic means are not yet available. That is something we have learned anew in Arlesheim, that we can trust in the person – in the doctor in the person – and that we must always invite them to cooperate. That is probably the strongest inoculation against any external infection, that you take care of this core of being and keep it healthy, nourish it and, I think, that is why you also come together here to share such nourishment with each other.

Thank you very much for letting me share that.