

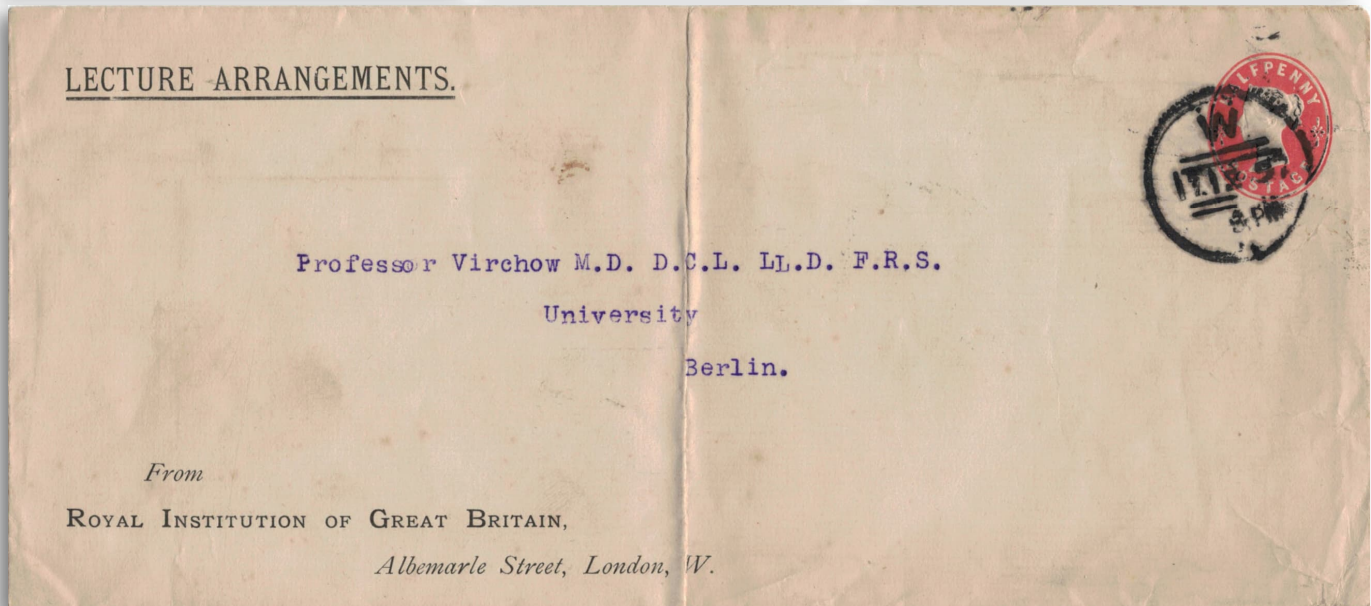
Medicine without an answer to dying

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Structural limits of curative medicine in the 20th century

Medical progress and institutional self-definition

The modern medicine of the early and mid-20th century was largely shaped by a scientific and technological self-conception⁴⁵. Advances in surgery, anesthesia, infection control, and pharmacology led to an unprecedented effectiveness of medical interventions. Disease increasingly came to be understood



Robert Koch, Louis Pasteur, Ignaz Semmelweis, and Rudolf Virchow shaped the scientific orientation of modern medicine in the 19th century. Through cellular pathology, germ theory, bacteriology, and antisepsis, they established a causal-biological understanding of disease aimed at diagnosis, intervention, and cure—an approach that continued to define the institutional structure of medicine well into the 20th century. Virchow occupies a special position: as the founder of cellular pathology, he strengthened the scientific objectification of disease, while at the same time, through his concept of social medicine, he articulated a perspective that understood health conditions as partly determined by social factors. Nevertheless, even within this tradition, dying was not conceptualized as an independent domain of medical responsibility—a structural limitation of cure-oriented medicine that only later led to the development of palliative care approaches. (Philatelic references: North Macedonia 2010: Koch with microscope; France 2022: Pasteur with bacteria; Spain 2025: Semmelweis with soap and handwashing; Virchow: postal stationery envelope (½ penny, Queen Victoria), oval embossed stamp, used 1897 in London West; addressed to Prof. Rudolf Virchow with all his titles, Berlin; sender: Royal Institution of Great Britain, Albemarle Street, London W. As a non-specialist, I cannot determine the exact catalogue number of the postal stationery based on the imprinted stamp.)

as a biological problem that could be diagnosed, treated, and—ideally—cured. This understanding influenced not only everyday clinical practice, but also the organization of hospitals, medical education curricula, and research.

Treatment success was measured primarily by objective parameters: survival rates, laboratory values, and surgical outcomes. For disease trajectories without a curative perspective, this system offered only limited

⁴ Charles E. Rosenberg, "The Tyranny of Diagnosis", *The Milbank Quarterly* 80 (2002)

⁵ Roy Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity*, London 1997

answers. Dying was not regarded as an independent medical process, but rather as an expression of the failure of therapeutic possibilities.



Hospitals developed into highly specialized institutions for acute care. Philatelic representations visualize this transformation by staging surgical procedures, large-scale medical technology, specialized hospital architecture, and biomedical research as expressions of therapeutic capability. Healing appears as a technically manageable process; medical progress is portrayed as a success story. Philately has both reflected and reinforced this view of medicine: India 2014, bundle label for the issue “Govind Ballabh Pant Hospital, Delhi” – a state tribute to modern high-performance medicine. Surgical success: Greece 1978, operating scene; Austria 1992, “Theodor Billroth” – a heroization of modern surgery. Specialized top-level medicine: Portugal 2023, “IPO Lisboa” – an oncological center with laboratory medicine as a symbol of curative competence. Clinical effectiveness: Egypt 1993, medical team in action – successful intervention on the patient. Technological progress: Albania 1966, radiological/radiotherapeutic large-scale equipment – machinery as a guarantor of therapeutic efficiency. Scientific evidence: Japan 1981, International Congress of Pharmacologists – visualization of pharmacological efficacy and controllable therapeutic processes.

This orientation was not the failure of individual actors, but rather the result of institutional logics. Medicine defined its sphere of responsibility where intervention was possible. Where this was no longer the case, systematic attention often came to an end.^{6,7}

Dying as an organizational blind spot (also in philately)



Die nicaraguanische Marke „Hospital Solidaridad“ (2011), die britische Millennium-Ausgabe „Caring for the Sick“ (1999) sowie der österreichische Sonderstempel zum 7. Europäischen Kongress für Intensivpflege (Innsbruck 1989) betonen apparative Medizin, klinische Intervention und institutionelle Leistungsfähigkeit. Das Sterben selbst bleibt dabei unsichtbar.

In the classical organization of hospitals, dying had no clearly defined place. Severely ill patients often remained on acute care wards whose routines were not designed for long-term symptom control or existential support. Alternatively, they were discharged early to nursing facilities or sent home, where medical responsibility was often fragmented.

This situation led to a structural invisibility of dying within medicine. There were hardly any standardized treatment goals for patients with incurable diseases, no dedicated care models, and only limited research on symptoms beyond the prospect of cure. Pain, shortness of breath, or anxiety were addressed, but mostly in a reactive manner and without an overarching framework. A systematic engagement with the end of life as a medical responsibility was largely absent.

⁶ Britischen Ganzsache: <https://www.um.edu.mt/library/oar/bitstream/123456789/63334/1/JMPS47%283%29A1.pdf> (14.2.2026)
⁷ Michel Foucault, *Die Geburt der Klinik*, Frankfurt a. M. 1973

Medical education reflected this gap as well. Curricula focused on pathophysiology, diagnostics, and curative treatment. Dealing with chronic suffering, progressive disease, and death played only a marginal role. Medical practice was oriented toward action; the deliberate limitation or redefinition of therapy was not part of the professional self-conception.

Chronic diseases and changing disease trajectories.



Parallel to the successes of acute medicine, the spectrum of disease began to change. Infectious diseases lost importance in many industrialized countries, while chronic and degenerative conditions became more prevalent. Cancer, cardiovascular diseases, and neurological disorders increasingly showed prolonged courses that could no longer be clearly divided into “treatable” and “untreatable.”⁸.

This development confronted the existing medical system with new challenges. Therapies were able to prolong the course of disease without necessarily enabling a cure. The boundary between meaningful treatment and burdensome overtreatment

Philatelically, prevention and disease control are clearly represented—however, the difficult transitional phases between prolonged treatment and the absence of a prospect of cure are not. The stamps address chronic diseases of the late 20th and early 21st centuries: Uruguay 2019 for World Diabetes Day, Chile 2025 for breast cancer awareness, and San Marino 1978 for hypertension. The lower cover shows a meter stamp (Francotyp C) from the Jasmatzi cigarette factory, Dresden A, dated 9 September 1937, illustrating chronic lung diseases (including those caused by smoking).

became increasingly blurred. Yet there were no established concepts to guide these transitional phases in a medically appropriate way. The question of how to care for patients whose illness was no longer curable but still treatable remained largely unanswered.

Prerequisites for a new medical discipline



Maximum card issued by the postal administration of Åland, 2024 issue (€2.30), with special postmark “Mariehamn 7 Feb 2024 – Metamorfos.” The stamp depicts the developmental stages of a butterfly—egg, caterpillar, pupa, and adult—while the card shows the green hairstreak (*Callophrys rubi*) on a yellow blossom. As a motif of metamorphosis, the image symbolically refers to transformation and redefinition—figuratively, to the changing goals of medical practice beyond purely curative approaches.

Seen in this light, the emergence of palliative medicine was less the result of a single idea than a response to a structural deficit. A medical system oriented almost exclusively toward cure was bound to reach its limits once cure was no longer attainable^{9,10}. The

⁸ World Health Organization, *Global Status Report on Noncommunicable Diseases*, Genf 2014
⁹ Clark, David: “From Margins to Centre: A Review of the History of Palliative Care”, in: *The Lancet Oncology* 8 (2007)
¹⁰ Seale, Clive: *Constructing Death. The Sociology of Dying and Bereavement*; Cambridge 1998

growing number of chronically and incurably ill patients made these limits visible and necessitated a redefinition of medical responsibility.

What was decisive was not the abandonment of medical intervention, but its redefinition. The question was no longer whether medicine at the end of life was meaningful, but which goals it could and should pursue in that context. This gave rise to the need for a discipline that systematically assesses symptoms, applies therapies in a reasoned manner, and accompanies the course of illness even beyond curative options.^{11,12,13}

Between Visibility and Absence: Palliative Medicine in Philately

Postage stamps are state-authorized images that condense political self-images and societal priorities.^{14,15} In medical philately, motifs of progress, prevention, and cure therefore predominate: hospitals, research, vaccination programs, and healthcare professions portray illness as a treatable problem and health as an attainable goal. What is striking, however, is the absence of dying. Palliative medicine rarely appears explicitly, as it stands for limitation, a shift in goals, and accompaniment—processes that are difficult to translate into a clearly positive, self-contained visual message.

Only after death does the end of life become philately visible—most notably in the form of mourning mail. As early as the 19th century, black-bordered mourning envelopes, special postmarks, and subdued frankings are documented, making the loss of a person visible. This practice was less state-organized than culturally shaped: the black border signaled socially codified mourning and structured postal communication in the exceptional state of death. The mourning letter shown here originates from Zürich in 1882 and was addressed to the municipal clerk in Enge; it contained a death notice.

A letter from Munich dated 22 December 1934, bearing a machine cancel, carries an 8-pfennig stamp from the Hindenburg definitive series of the German Reich (issue of 1933), here with a black mourning border following the death of Paul von Hindenburg in 1934.

Commemorations of deceased public figures have long existed and continue today (e.g., Liechtenstein mourning stamp for Franz I of Liechtenstein, 1938; United Kingdom mourning issues for Queen Elizabeth II, 2022).

More recent mourning stamps—such as those from Austria (2024), Netherlands, or Germany (2012)—also address death exclusively in the mode of commemoration, tribute, and symbolic remembrance.



¹¹ World Health Organization, *National Cancer Control Programmes*, Genf 2002

¹² Cicely Saunders, *Selected Writings 1958–2004*, Oxford 2006.

¹³ Balfour Mount, "The Problem of Caring for the Dying in a General Hospital", *Canadian Medical Association Journal* 115 (1976)

¹⁴ Pauliina Raento / Stanley Brunn, "Visualizing Finland: Postage Stamps as Political Messengers", *Geopolitics* 10 (2005)

¹⁵ James C. Scott, *Seeing Like a State*, New Haven 1998

Death is indeed present in philately—for example in mourning letters¹⁶ and commemorative issues since the 19th century—but these refer to remembrance after death; the process of dying itself remains excluded. The limited visibility of palliative care is therefore less an expression of taboo than a consequence of the structural visual logic of state representation.

It is precisely in this that thematic philately finds a particular appeal: palliative medicine cannot be captured through a single motif, but only through context, comparison, and the deliberate inclusion of what is not shown.¹⁷ The field gains its depth from the interpretation of indirect references—and from a reflective engagement with the limits of what can be represented.

¹⁶ Die Verwendung von schwarz gerändertem Briefpapier und Umschlägen als Ausdruck von Trauer reicht mindestens bis in die viktorianische Zeit zurück und war im 19. Jahrhundert weit verbreitet.

¹⁷ Fédération Internationale de Philatélie: Special Regulations for the Evaluation of Thematic Exhibits.

¹⁸ Kellehear, Allan (2007): *A Social History of Dying*. Cambridge: Cambridge University Press

¹⁹ Saunders, Cicely (1978): *The Management of Terminal Illness*. London: Edward Arnold.

²⁰ Clark, David (2018), Cicely Saunders: *A Life and Legacy*. Oxford: Oxford University Press