
Descriptions of euthanasia as social representations: comparing the views of Finnish physicians and religious professionals

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Abstract In many western societies health professionals play a powerful role in people's experiences of dying. Religious professionals, such as pastors, are also confronted with the issues surrounding death and dying in their work. It is therefore reasonable to assume that the ways in which death-related topics, such as euthanasia, are constructed in a given culture are affected by the views of these professionals. This qualitative study addresses the ways in which Finnish physicians and religious professionals perceive and describe euthanasia and conceptualises these descriptions and views as social representations. Almost all the physicians interviewed saw that euthanasia does not fit the role of a physician and anchored it to different kinds of risks such as the slippery slope. Most of the religious and world-view professionals also rejected euthanasia. In this group, euthanasia was rejected on the basis of a religious moral code that forbids killing. Only one of the religious professionals - the freethinker with an atheist world-view - accepted euthanasia and described it as a personal choice, as did the one physician interviewed who accepted it. The article shows how the social representations of euthanasia are used to protect professional identities and to justify their expert knowledge of death and dying.

Keywords: euthanasia, death and dying, social representations, physicians, religious professionals

Introduction

In modern and contemporary Finnish culture, as in most modern and late modern cultures, expert knowledge ('know-how') of death and dying has been entrusted to physicians and pastors (Bauman 1992, Utriainen 1999: 71). Accordingly, it is possible to assume that the ways in which death-related topics are officially constructed in a given culture are strongly influenced by the views of these professionals. During recent decades the process of dying has become a medicalised event in which nurses and doctors play an important and powerful role in many people's experiences of dying. In late modern western societies, medical experts are usually the ones who deal with the transition between life and death (Bauman 1992,

Timmermans 2005, Utriainen 1999). Widespread institutional care is very much a phenomenon of developed countries and the rates of hospital deaths have been rising steadily for many years in these countries (Seale 2000). In 2009, approximately 70 per cent of deaths in Finland occurred in a hospital or other healthcare institution (Statistics Finland 2009). Death has been removed from homes to hospitals where health professionals take care of dying patients. Religious professionals also meet seriously ill people and discuss death and dying in their work; however, the role played by religions or other world-views is not always visible in the specific context of treatment decisions in advanced diseases (Gielen *et al.* 2009).

In many countries euthanasia has been the subject of hot debate in recent years. Euthanasia is not legal in Finland but the issue of legalisation has occasionally arisen in the general public and in various discussion forums. Arguments today often focus on the question whether a suffering, dying patient should be allowed to die by euthanasia (Hänninen 2003, Silvonemi *et al.* 2010, Walter 1994). Distinctions between active euthanasia (terminating the life of the patient with a lethal drug at the patient's explicit request) and passive euthanasia (withholding or withdrawing life-saving treatment) have been made and are still being made in some countries (Louhiala and Hildén 2006, Van Wesemael 2011:13) including Finland (Silvonemi *et al.* 2010). Descriptions of euthanasia are cultural constructions and have evolved through the years depending on the cultural and societal environment. According to the European Association of Palliative Care, euthanasia means the administration of drugs with the intention of ending the life of a person, at that person's voluntary and informed request (Materstvedt *et al.* 2003).

End-of-life decisions, including opinions on euthanasia, have been studied in Finland by Ryyänänen *et al.* (2002), Hildén *et al.* (2004), Ryyänänen and Myllykangas (2003), Louhiala and Hildén (2006), Silvonemi *et al.* (2010). Ethnographic studies on the care of dying patients in Finnish hospital settings have been undertaken by Peräkylä (1990, 1991) and Utriainen (1999, 2010), but qualitative studies on euthanasia are rare. In this article we show how Finnish physicians and pastors contemplate euthanasia. The conceptions of euthanasia held by religious and medical professionals have not been studied before from the perspective of social representations, and studies connecting this approach to death-related topics have been rare.

This study asks the following questions: how do Finnish physicians and religious professionals describe euthanasia; what are their views on euthanasia; and which descriptions and views of euthanasia are shared among physicians and religious professionals and which descriptions and views differ between the two groups?

A social representational approach

The approach that is presented here builds on previous studies in the area of social representations (Moscovici 1961, 2008). The social representational approach (Farr and Moscovici 1984, Moscovici 2008, 2011, Rätty *et al.* 2006) offers a modernised version of Durkheim's notion of collective representations and provides tools for conceptualising branches of knowledge about socially meaningful issues such as euthanasia in contemporary late modern society (Pirttilä-Backman and Helkama 2001). It takes into account the influence of culture, society and language on individual representations and focuses on the shared images of a relevant social object.

Social representations can be thought of as a spectrum of beliefs, social practices and shared understandings that exist both in the minds of individuals and in the fabric of society (Moscovici 2000). They constitute an environment of thought in relation to the individual or the group. In

his early writings Moscovici (1984) suggested that there is a clear distinction between scientific knowledge (the reified universe) and common sense or lay knowledge (the consensual universe) (Morant 2006). However, many authors (for example Purkhardt 1993) have noted that the distinction between reified and consensual universes is overstated. Moscovici (1998) has replied to this critique by suggesting that the forms of knowledge development that characterise scientific communities can also be conceptualised as social representations (Joffe 2003, Morant 2006).

The social representational approach has also been criticised for lacking clear definitions (Jahoda 1988, Potter and Litton 1985). However, the approach is lucid in its view that social representations provide people with a code for naming and classifying various aspects of their worlds. Each individual has a part to play in the way our world is represented (Moscovici 2000: 36–7). The purpose of representations is, according to Moscovici (1984, 2000, Flick 2000), to make something unfamiliar, or to make unfamiliarity itself familiar. There are two basic processes behind social representations: anchoring and objectification. Anchoring means classifying and naming, whereas in objectification the unfamiliar is transformed into the very essence of reality (Moscovici 2000: 42–9). The origins of the process of anchoring lie ‘in the way it is inscribed in the language, images or situations typical of the social environment’ (Moscovici 2011: 456). This process familiarises us with new social representations and takes us back to what was familiar about old representations (Moscovici 2011: 456–7).

Moscovici’s original study (1961, 2008) on the reception of psychoanalysis in France explored how three parts of French society in the 1950s reacted to psychoanalytical ideas. Moscovici found that different segments - the urban-liberal, the Catholic and the communist-represented psychoanalysis in different ways. Moscovici’s approach has been applied in various studies and many researchers have adopted a social representation framework to study, for instance, health and illness (Herzlich 1973). Herzlich (1973) often referred to in studies on social representations, explored the social representations of health and illness among professional and rural workers. In her study, Herzlich used open-ended interviews and classified the contents of these interviews into three categories: illness as destructive, illness as a liberator and illness as an occupation. Death-related topics have also been investigated using this approach. Mercer and Feeney (2009) explored social representations of death held by two groups of nurses in a hospice setting. Bradbury (1999) studied social representations of death and illuminated the perspectives of both the grieving relatives and death workers such as funeral directors. In her study Bradbury showed how talk about a person’s death often focused upon its perceived goodness or naturalness and argued that these social representations can be viewed as an expression of the need to make death familiar.

In Finland euthanasia is not legal but the issue of euthanasia concerns the general public and ordinary people, who often say they accept euthanasia for terminally ill patients suffering from extreme pain (Jylhäkangas 2006). In this context it is useful to explore how the idea of euthanasia is perceived among physicians and religious professionals to whom the know-how of death and dying has been delegated. Do they view it as an unfamiliar, dangerous and risky practice (Joffe 1999, 2003) or a welcome one? Where do they anchor (Moscovici 1984, 2011, Flick 1995) the idea of euthanasia? Is retrospective anchoring (that is, tying objects and changes to specific experiences and contexts when looking back) used in this process (Flick 1995, Murray 2002)? What kinds of constellations of meaning (Joffe 2003) evolve around euthanasia? When people make classifications, they are assessing and labelling – and in so doing, they reveal their theory of society and of human nature (Moscovici 1984, 2000). Considering this, the relevant question is the following: what kinds of images of euthanasia are constructed among religious and medical professionals?

Methods

Participants

This article describes the results of 12 qualitative, semi-structured interviews with Finnish religious professionals ($n = 6$) representing different kinds of religions or world-views (see Table 1) and physicians ($n = 6$) coming from different hospitals across Finland and working in various medical contexts (see Table 2). The 12 interviewees were chosen, simply by searching the websites of various parishes and public hospitals; ensuring, however, that they worked in organisations in which death is not an unfamiliar subject. Ethical review was not required for this research. However, participation was totally voluntary and the principles of confidentiality and anonymity were carefully followed. All the religious professionals who were contacted expressed their willingness to participate in the study. Of the eight physicians who were asked to participate in the study, six expressed their interest and willingness to be interviewed. All the participants were fully informed of the purpose of the study and assured that their anonymity would be guaranteed during the analysis and publication of the results. Pseudonyms are used in this article to preserve the anonymity of the interviewees.

At the time of the interviews (around 2005), the religious professionals worked as pastors in the following churches in Finland: the Evangelical-Lutheran Church, the Seventh-Day Adventist Church and the Pentecostal Church. Two of the interviewees came from smaller groups, one working as a priest in the Hare Krishna Movement, the other acting as the chair of the

Table 1 *Characteristics of the religious professionals (N = 6)*

<i>Pseudonym</i>	<i>Institution</i>	<i>Position</i>	<i>Gender (female/male)</i>
Maija	Evangelical-Lutheran Church	Pastor	F
Suvi	Evangelical-Lutheran Church	Pastor	F
Teppo	Pentecostal Church	Pastor	M
Saara	Seventh-day Adventist Church	Pastor	F
Pekka	Hare Krishna Movement	Priest	M
Risto	Union of Freethinkers	Chair	M

Table 2 *Characteristics of the physicians (N = 6)*

<i>Pseudonym</i>	<i>Institution</i>	<i>Position</i>	<i>Gender (female/male)</i>	<i>Approx. date of graduation from medical school</i>
Pirkko	A central hospital	Senior physician, geriatrician	F	1970s
Eeva	Geriatric clinic	Senior physician, geriatrician	F	1980s
Matti	An intensive care unit	Senior physician, anaesthesiologist	M	1980s
Marja	An intensive care unit	Anaesthesiologist	F	Beginning of the 2000s
Niina	A municipal health centre	Senior physician, general practitioner	F	1980s
Asko	Paediatrician, retired	Paediatrician	M	1940s

Union of Freethinkers, an independent atheist group advocating the rights of people who do not believe in a god or gods. All work in their local parish and are involved in different types of death ritual such as funerals. Many of them also visit dying patients in hospital. The free-thinker is also active in death work and arranges funeral ceremonies for the members of the Union of Freethinkers.

At the time of the physician interviews (around 2006–2007), the participants worked in hospitals and intensive care units where death is often present due to the advanced age of the patients, terminal illness or accidents.

Interviews

All interviewees were contacted via e-mail to ask them to participate in the study and to set up an interview appointment. Most interviews were conducted at the hospital or organisation where the interviewee worked at the time the data were gathered. Interviews followed specific death-related themes but the questions were open-ended. The interviewees were asked for their own descriptions of euthanasia. In order to grasp their concept of euthanasia, they were first asked to describe it: ‘What comes to your mind when you hear the word ‘euthanasia’?’ (‘Do you think that ‘euthanasia’ is a proper word or do you think that some other word would be more suitable? If so, which word would you prefer?’). In addition, the interviewees were asked about their acceptance or rejection of euthanasia: ‘What do you think about euthanasia? Is there any situation in which you could accept euthanasia? (Why? Why not?)’. The interviews also included questions about the interviewee’s religion or personal world-view.

The length of the interviews varied from 1 to 2.5 h. They were recorded digitally and transcribed verbatim, with every word in the same order as spoken. The research material consisted of approximately 500 pages of transcribed text. This article contains excerpts from the interview transcriptions translated from Finnish into English in accordance with the original speech. The interviews were conducted and transcribed by the first author who also translated the excerpts used in the analysis.

Analysis

The units of qualitative content analysis were words and sentences related to euthanasia. Also broader statements related to this theme were analysed. Analysis included three phases: (i) reading through the interview transcriptions and (ii) paying attention to all parts that contained euthanasia-related expressions. In the third phase, (iii) the contents of the euthanasia descriptions were compared and classified according to recurrent and group-specific themes. The qualitative data analysis and research software ATLAS.ti was used to classify the transcripts around the meaningful themes of the study. The aim was to find group-specific expressions and make visible both the elements that are unique to a particular group and those that were also found in other groups.

Findings

In this section the euthanasia descriptions, views and arguments given by the interviewees are analysed in detail. We show examples of recurrent themes among each professional group, such as the sacredness of life and the fear of the slippery slope among the interviewees opposing euthanasia and the question of autonomy among those who accepted euthanasia. Eventually, these arguments are connected to the professionals’ views on death. For pastors, death is ‘in the hands of God’ whereas for physicians, a good death can be achieved with medicine.

Descriptions of euthanasia

Many of the interviewees made a distinction between active and passive euthanasia and described it in various ways (see Table 3), some of them giving their opinion of euthanasia spontaneously before they were asked for it. The euthanasia descriptions of the physicians varied, ranging from ‘killing’ (Matti, anaesthesiologist) to ‘a pleasant death’ (Asko, paediatrician). In the same way, variation could also be found in the euthanasia definitions given by religious professionals, many of whom anchored it in the Christian moral code that forbids killing. One of the pastors, for example, described euthanasia in the following way: ‘Euthanasia can be passive or active and there is a big difference between them ... active euthanasia means killing’ (Maija, pastor in the Evangelical-Lutheran church).

Euthanasia views and arguments

When asked for their opinions on euthanasia, most of the interviewees considered it in its narrower, active form, namely administering drugs to end life. Most of the interviewees, physicians as well as religious professionals, opposed euthanasia. Geriatrician Pirkko, for instance, described euthanasia as something that is ‘very strictly regulated’ and afterwards said that it is ‘a thought that can be entertained only in a very immature society. One of the pastors, Saara, said that she agrees ‘with the Seventh-day Adventist Church that does not accept active euthanasia’. When thinking about euthanasia, the interviewees mainly depended on the conception of death defined by their professional background and leaned on their own profession-specific knowledge (see Table 4).

Natural death and sacredness of life

In the responses of the religious professionals, dying should ‘occur naturally’. Their objection to euthanasia was based on the argument that all human life is always sacred. Thus,

Table 3 *Descriptions of euthanasia among religious professionals and physicians*

<i>Religious professionals</i>	<i>Physicians</i>
Euthanasia means helping someone to die. (Saara, pastor)	When I think about euthanasia Holland is the first thing that comes to my mind ... euthanasia is very strictly regulated in Holland. (Pirkko, geriatrician)
Euthanasia is described as a merciful death but I think that mercy and death are not compatible... I think euthanasia means hastening death. (Teppo, pastor)	Definition of euthanasia depends on the value that culture gives to life. What comes to my mind is slippery slope. (Eeva, geriatrician)
Euthanasia can be passive or active and there is a big difference between them. Active euthanasia means killing. (Maija, pastor)	Euthanasia, death assistance ... euthanasia means active action. (Niina, general practitioner)
On one hand euthanasia is a good word but on the other hand it beautifies and hides. (Suvi, pastor)	Holland comes to my mind when I think about euthanasia. (Marja, anaesthesiologist)
Euthanasia is clearly a concept that emphasises the supremacy of medicine... a person is killed with a poisonous injection. (Pekka, priest)	Euthanasia means killing. (Matti, anaesthesiologist)
The concept of euthanasia is widespread in Finland but I prefer the synonymous concept of death assistance or helping someone to die. (Risto, a freethinker, chair)	I think that there is a good thought behind euthanasia, that death would be comfortable and pleasant. (Asko, paediatrician)

Table 4 : *Examples of euthanasia views and arguments among religious professionals and physicians*

<i>Religious professionals</i>	<i>Physicians</i>
It feels strange and unacceptable to hasten death actively ... It is the ultimate ... Life is in the hands of God. Man should not take too much power in these matters. (Teppo, pastor, the Pentecostal Church)	I think euthanasia is a very dangerous thing, no one is on the side of the weakest ... It will easily go towards a slippery slope. Then it will be given to individuals whose lives are not so much worth living anymore, like patients with severe dementia. (Eeva, geriatrician)
We don't accept that a person is killed with a poisonous injection or any other similar way just because suffering is unbearable ... According to our view, suicide is not accepted. A person's life should not be ended even if he wishes to die. Murder is never accepted. (Pekka, priest, the Hare-Krishna Movement)	I don't accept a situation in which someone asks others to kill him and his life is taken away. I don't accept euthanasia ... I would be anxious if it was accepted in Finland, because anaesthesiologists would be the ones who would have to do it. (Matti, anaesthesiologist)
I accept active euthanasia ... Nobody owns us, and because we can always commit suicide we should, in my opinion, also have the opportunity to die through euthanasia. (Risto, chair, the Union of Freethinkers)	If someone suffers from a serious illness and has pain, and the pain could be also psychological, I don't understand what kind of damage would happen if one had the opportunity to decide about his own death ... I don't understand why so many physicians react so negatively toward euthanasia. (Asko, paediatrician)

intervention by an outside agent was considered murder. Pastor Maija, for instance, said: 'I certainly cannot accept it; in euthanasia a man takes the role of God'. This was a central theme in their thoughts on euthanasia and symbolised the special value they attributed to human life: 'A person's life should not be ended even if he wishes to die. Murder is not accepted in any situation' (Pekka, priest in the Hare Krishna Movement).

The question of autonomy

Almost all the physicians and religious professionals emphasised the autonomy of the dying person, reminiscent of the almost transcendental value given to the individual in contemporary western cultures (Bloch and Parry 1982, Walter 1994). However, they did not always relate this autonomy to the issue of euthanasia. All the pastors were opposed to euthanasia; however, the freethinker Risto with an atheist world-view described euthanasia as a good death and saw it as a solution to the problems of the suffering that a dying person experiences towards the end of life. He noted that freedom and autonomy are important principles to freethinkers. In his argument, the right to autonomy was a powerful maxim (Ryan 2007: 295), as the following excerpt illustrates:

Risto Freethinkers are, or at least should be, open-minded and more tolerant towards euthanasia than other people. There is no restrictive doctrine in freethinking. According to our life stance, people should have the right to decide about their own issues, including euthanasia.

Interviewer Um.

Risto Sometimes the doctors ask ... if there is for example a patient who is unconscious and it is not possible to know his wishes ... if the unconscious

patient gets for instance pneumonia the doctors can ask the relatives about their opinions about um um ...

Interviewer Medication?

Risto Yes, medication ... for pneumonia. Sometimes the relatives say that because the patient wouldn't want to be medicated we can agree with that ... I support active euthanasia. Nobody owns us, and because we can always commit suicide we should also have the opportunity to die through euthanasia.

One paediatrician expressed a similar view and claimed that suffering individuals should have the right to make choices, including the time and circumstances of their own death:

If one thinks about it objectively it is clear that if someone suffers from such a serious illness that he has pains all the time, and the pain could be also psychological, I do not understand what kind of damage would happen if one had the opportunity to decide about his own death. (Asko, paediatrician)

Asko's view was exceptional among the physician interviewees. All the others opposed euthanasia.

The role of a physician

I am afraid that active euthanasia will be legalised. (Pirkko, geriatrician)

I do not accept a situation in which someone asks others to kill him and his life is taken away. I do not accept euthanasia. (Matti, anaesthesiologist)

Pirkko's and Matti's views illustrate a typical response among the physician interviewees. Eeva, a geriatrician, described euthanasia in a similar way. She thought about the role of a doctor and was worried about the feelings of guilt related to performing euthanasia:

Interviewer Do you think that euthanasia will be legalised in Finland in the future?

Eeva I do not say that never ... because the world changes so quickly. But there exist always such demands. I am also wondering why it is always demanded that it should be a physician who does it. It is so much against the basic work that a physician should be doing, which is helping people and optimising good life ... and what it would be like to live with the feelings of guilt. I cannot understand how I could live in such a world in which there would be a group of physician executioners doing it.

A central argument used by physicians opposing euthanasia concerned the principles of medicine (Grey 2007). Many physicians worried about their role as a physician if euthanasia was legalised: 'It would be very hard for me if euthanasia was permitted' (Niina); 'Why it should always be a physician who does it?' (Eeva); 'I would not wish to be involved in such activity' (Matti). General practitioner Niina said it would be very hard for her if euthanasia was permitted in Finland:

Niina The Dutch have done it ... I have discussed euthanasia with Dutch chief physicians. I can understand that in some special situations where there is tremendous pain and suffering, euthanasia is used. But in spite of the certain

circumstances in which I can understand it, it would be very hard for me if euthanasia was permitted in Finland. I guess I am just basically a physician ... I have seen many people with quadriplegia who have thought that they definitely want to die ... but after 1 or 2 years they said they were lucky that their death wish had not come true.

The pastors interviewed were critical of the supremacy of medicine. Many of them thought about euthanasia from the point of view of their professional, theological knowledge and considered that in euthanasia, the medical profession had too much power to determine the line between life and death, creating a world in which man takes the role of God.

Worrying about the weakest and the slippery slope

The rejection of euthanasia by religious professionals closely resembles that of the medical profession but uses different rationales. Common themes between the two groups could also be found. The following extracts are examples of the overlapping theme in both the physicians' and the pastors' responses, namely the feeling that there is 'something wrong in society':

Society wants to eliminate individuals who don't produce money. (Maija, pastor in the Evangelical-Lutheran church)

Euthanasia is a thought of a very immature society. (Pirkko, geriatrician)

No one is on the side of the weakest. (Eeva, geriatrician)

Maija, Pirkko and Eeva expressed their worries about the individuals whose lives are not worth much to society. Eeva suggested that if euthanasia were to be legalised there would be a risk that it would be administered 'to individuals whose lives are not so much worth living any more, like patients with severe dementia'. According to this kind of slippery slope argument, permitting euthanasia to be a part of the care for terminally ill patients will beyond doubt lead to abuse, such as involuntary euthanasia (Hermsen and ten Have 2002, Seale 1998: 185). This example shows how the interviewees understood the risks they perceive in euthanasia (compare Joffe 2003).

Controlling a good death

Kaufman (2000) writes about the ways in which death is controlled by technology, by medical ideology and by the complex power relations between doctors and relatives (see also Muller 1992, Seale 1998, Slomka 1992). This is evident especially in resuscitation incidents. Even though the timing of death appears to be in the hands of medical personnel it is not always easy to control (Bradbury 1999: 150–1). Marja, an anaesthesiologist working in an intensive care unit, pondered about death happening in the context of intensive care and described the situation of a patient who was going to die soon. In the intensive care unit, death is managed with several medical interventions, of which the most important is relief of suffering. Marja said that in a patient suffering from shortness of breath it is less important to calculate the dose than to relieve the suffering.

Interviewer What do you think about euthanasia?

Marja I do not accept giving a patient a lethal injection just because the patient wants it or the relatives want it. But in the intensive care unit, if there is a

patient for whom it is very hard to breathe, we are not so strict about the doses. I do not know if death comes sooner then. In principle, it can hasten a patient's death but I cannot think that it is euthanasia.

Interviewer Um. Is there any situation in which you could accept euthanasia?

Marja I guess not. It is always possible to alleviate pain. Pain is not a proper reason for asking for euthanasia.

This extract shows both that medical science is both used to alleviate pain and to control the timing of death, which logically results in the unofficial euthanasia of dying patients (Bradbury 1999: 150). For Marja, the most important thing is to alleviate suffering. The 'appropriate dose of pain killers' and 'keeping the patient asleep for the last hours or the last days of her/his life' reflect the medical means by which the phase of dying is being controlled. However, the doctor (who possesses particular expertise in the field of intensive care) has to give up eventually: 'and then they die anyway' (Marja). Within this cultural frame, waiting for death and knowing that death comes (naturally) (Ariès 1974, Glaser and Strauss 1970, Kaufman 2000) due to an old age or illness seem to be replaced by medical decision-making and a self-conscious ethical debate that is intertwined with the moral conflict often related to the dying process (Kaufman 2000: 75, 2010, Peräkylä 1991).

Discussion

In this study the social representational approach was applied to understand the nature of conceptions of euthanasia in two different professional groups. It provided a culture-specific and context-dependent approach, and it has shown how religious professionals and physicians from different backgrounds described their understanding of euthanasia. The content analysis used in this study was data-driven and concentrated on recurrent themes. However, the analysis went hand-in-hand with the theoretical framework, focusing on the classifications and definitions the interviewees gave to the concept of euthanasia. According to the social representational approach (Moscovici 2000, 2008), people are able to imagine different kinds of things by classifying and naming them in order to communicate and represent the unusual in their usual world, according to categories and images familiar to them (Moscovici 2000: 42, 2011). This process was aptly illustrated in the euthanasia descriptions and views of religious professionals and physicians who tended to construct professionally appropriate (Timmermans 2005) images of euthanasia.

Many of the interviewees talked about active (terminating the life of the patient with a lethal drug) and passive euthanasia (withholding or withdrawing life-saving treatment) and made a distinction between them. This is in line with the contemporary societal and cultural situation of Finland, where these concepts appear both in the Finnish media and the literature concerning end-of-life care (Kokkonen *et al.* 2004; Kuuppelomäki 2000, Ryyänen *et al.* 2002). When contemplating euthanasia, the interviewees talked about it very openly. However, this does not mean that everything about death and especially the transformations that happen to the dying human body were clear and easy to discuss. Bradbury's (1999) notion that death in contemporary British culture is taboo (so that words such as 'decompose' are hardly ever used) can also be seen in this study.

Five of the six physicians interviewed rejected euthanasia. They anchored it to different kinds of risks, such as the slippery slope. In so doing, they protected their professional identity. In addition, some of them used retrospective anchoring (Flick 1995, Murray 2002) and talked about their personal experiences, as in the case of the physician who recalled her

patients with quadriplegia. All the physicians based their arguments on medical ethics, including the physician who accepted euthanasia. Euthanasia was less alien to physicians than to religious specialists although two of the physician interviewees defined it as murder or killing. As a concept, euthanasia was familiar to physicians on the basis of their medical education but it was unfamiliar in their professional practice. Euthanasia is illegal in Finland hence it was considered as an alien practice among the physicians. Their definitions of it varied as can be seen from the relatively broad descriptions that most of them gave ranging from a pleasant death to murder. Nevertheless, when articulating their opinions, the definitions they had originally used narrowed further and changed to an idea of a threat, implying that in practice euthanasia does not fit into the role of a physician. All the physicians who rejected euthanasia shared this view. The only physician accepting euthanasia, however, argued constantly that suffering individuals should have the right to decide on their own death.

Almost all the religious professionals rejected euthanasia. Only one of them accepted euthanasia and emphasised a patient's right to autonomy. The idea of euthanasia was more alien to the pastors (Moscovici 2000, 1984) than to the physicians. They anchored (Moscovici 2008, 2011) euthanasia to Christian theology. Thus, once euthanasia was positioned as murder it became easier to reject it. In a survey of the attitudes of world religions to the right to die, Larue (1985) found that although there is no actual discussion of euthanasia in the International Society for Krishna Consciousness, it is clear that the members of this group would reject anything that might alter the natural course of dying. This study confirmed this notion: the interviewee from the Krishna movement emphasised that a good death is described in the Vedas, whereas euthanasia relates to 'the supremacy of medicine'. Thus, Rachels (1986) rightly notes that it would be a mistake to think that the prohibition of euthanasia is exclusively a Christian doctrine; many other religious traditions also reject it (Larue 1985).

Some representations overlapped and could be found in both groups, such as the importance of pain alleviation, the autonomy of the individual, and the slippery slope argument according to which euthanasia would put the most vulnerable patients at risk. In this way, the social representations of euthanasia served to control the fear which euthanasia would cause. The professionals were fearful of the slippery slope occurring if euthanasia was legalised and therefore limited their ideas about euthanasia to risk-related ones. Once euthanasia was positioned as a risk, it became easier to reject it (compare Chapman 2000, Joffe 1997).

In an increasingly individualised western culture, experience and training may have a stronger influence on the attitudes and practices of medical professionals than personal religious or ideological convictions. However, Gielen *et al.* (2009) suggest that professional experience, training in palliative care and personal religious or ideological convictions can conflict when professional caregivers have to decide which attitude to adopt or what should be done in a particular situation. Seale (2010a) found that doctors who described themselves as non-religious were more likely than others to report having taken decisions they expected or partly intended to end life (see also Cohen *et al.* 2008, Seale 2009, 2010b). In the study by Smets *et al.* (2011), religious beliefs were a strong determinant of the attitudes of physicians to euthanasia. In addition, trained physicians did not agree that euthanasia law impedes the development of palliative care. Interestingly, most of the physician interviewees in this study reported that they do not accept euthanasia and that they believed in God and were members of the Evangelical-Lutheran church. Nevertheless, they do not base their arguments on religion, but mostly on biomedical ethics and on their personal experiences as a physician (compare Cohen *et al.* 2008).

Physicians' and religious professionals' work involves the practical application of expert or scientific knowledge systems in direct interaction with ordinary people. Considering this, it might be expected that these professional groups can play an intermediary role in translating

the knowledge generated by scientists and other professionals into shapes that are compatible with common sense (Morant 2006). All the interviewees in this study said that they contemplate questions of death and dying in their work. However, on the basis of the results of this study, it is possible to suggest that the world of experts and the world of ordinary people who are dependent on expert medical knowledge (Walter 1994, 198) do not necessarily meet when thinking about the issue of euthanasia. In light of the relatively high acceptance of euthanasia among the general public (Cohen *et al.* 2006, Rynänen *et al.* 2002) and the low acceptance of euthanasia among physicians (Louhiala and Hildén 2006, Rynänen *et al.* 2002, Silvonemi *et al.* 2010) further explorations are needed to discover how and why social constructions of physicians about euthanasia differ from those of lay people. It would also be interesting to discover whether lay people are trying to change the current situation in which only physicians and pastors hold professional knowledge of death and dying.

In a study by Mercer and Feeney (2009), representations of death functioned as coping strategies protecting hospice nurses in their work environment. In a similar way, the group-specific euthanasia representations in this study revealed the values of the interviewees who made euthanasia familiar in accordance with their broader knowledge of death. However, this is not always easy. Physicians treating incurable patients are often confronted with complex end-of-life decisions (Rietjens *et al.* 2012) that can evoke strong emotions and distress (Silvonemi *et al.* 2010). The findings of our qualitative study are compatible with the survey of Silvonemi *et al.* (2010) in which the views, fears and training needs of Finnish physicians representing different fields of medicine were evaluated. Only 19 per cent of the respondents ($n = 661$) thought that euthanasia should be legalised, and 68 per cent reported their fear that euthanasia was open to inappropriate use. Most of the physicians interviewed in this study also expressed this fear. In addition, they were concerned about their role as a physician; since they would be the ones who would have to perform euthanasia if it was legalised.

The present study offers a qualitative description of the ways in which physicians and religious professionals discuss end-of-life issues in contemporary Finland. It was inspired by the notion that cultural strategies, metaphors and taboos that characterise humanity's response to death can best be accessed through qualitative methodologies (Bradbury 1999). Interviews were semi-structured and followed specific themes but were open-ended; the questions in the research interviews were not based on fixed choices. One of the strengths of this study is that it gave the interviewees the opportunity to describe and talk about euthanasia in their own words. However, the main limitation relates to the relatively small numbers involved, which means it is not possible to draw far-reaching conclusions from the results. However, the present study shows the value of paying attention to the context and cultural dependency of conceptions of euthanasia.

Conclusion

This article addresses the ways in which Finnish physicians and religious professionals perceive and describe euthanasia and conceptualises these descriptions and views as social representations rising from their profession-specific knowledge and values. The interviews and qualitative content analysis show a need to construct professionally meaningful descriptions of euthanasia. Euthanasia conceptions related mostly directly to the interviewees' work and professional ethics. Two viewed it as a merciful act, whereas others defined it as killing or an otherwise distressing event that does not fit either the religious conception of death or the role of the physician. Thus, euthanasia was integrated into existing categories and world-views (Flick 1995, Moscovici 1984, 2000) related to the profession-specific know-how of death and

dying. In this way, professional knowledge maintained the socially defined reality and legitimised marginal situations, in this case dying, in terms of the shared social reality (Berger 1990, 43–4) in which euthanasia was either rejected or accepted. The perception of euthanasia was based on group-specific and socially shared frames with a marked, although not always sharp, difference between the interviewees. Religious professionals and physicians held profession-related views of euthanasia but similar conceptions between the two groups could also be found, such as the fear of a slippery slope. Eventually, social representations of euthanasia were used to protect professional and social identities (Chapman 2000, Páez *et al.* 1991) and to justify the existing professional knowledge of death and dying.

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Acknowledgements

The authors would like to acknowledge the study participants for their time and willingness to be interviewed for this study. We would also like to thank the anonymous referees and the journal's editors for their insightful comments on this article. In addition, the authors would like to thank the Kone Foundation for supporting this study.

References

- Ariès, P. (1974) *Western Attitudes Toward Death: from the Middle Ages to the Present*. Baltimore: The Johns Hopkins University Press.
- Bauman, Z. (1992) *Mortality, Immortality and other Life Strategies*. Cambridge: Polity Press.
- Berger, P. (1990) *The Sacred Canopy. Elements of a Sociological Theory of Religion*. New York: Anchor Books.
- Bloch, M. and Parry, J. (1982) Introduction: death and the regeneration of life. In Bloch, M. and Parry, J. (eds) *Death and the Regeneration of Life*. Cambridge: Cambridge University Press.
- Bradbury, M. (1999) *Representations of Death. A Social Psychological Perspective*. London: Routledge.
- Chapman, E. (2000) Conceptualisation of the body for people living with HIV: issues of touch and contamination, *Sociology of Health & Illness*, 22, 6, 840–57.
- Cohen, J., Marcoux, I., Bilsen, J. and Deboosere, P. *et al.* (2006) European public acceptance of euthanasia: socio-demographic and cultural factors associated with the acceptance of euthanasia in 33 countries, *Social Science & Medicine*, 63, 3, 743–56.
- Cohen, J., van Delden, J., Mortier, F. and Löfmark, R. *et al.* (2008) The influence of physicians' life-stance on attitudes towards end-of-life decisions and actual end-of-life decision-making in six countries, *Journal of Medical Ethics*, 34, 4, 247–53.
- Farr, R.M. and Moscovici, S. (eds) (1984) *Social Representations*. Cambridge: Cambridge University Press.
- Flick, U. (1995) Social representations. In Smith, J., Harré, R. and van Langenhove, L. (eds) *Rethinking Psychology*. London: Sage.
- Flick, U. (2000) Approaching the un-familiar: qualitative methods in studying social representations and health. In Chaib, M. and Orfali, B. (eds) *Social Representations and Communicative Processes*. Jönköping: Jönköping University Press.
- Gielen, J., van den Branden, S. and Broeckaert, B. (2009) Religion and nurses' attitudes to euthanasia and physician assisted suicide, *Nursing Ethics*, 1, 3, 303–18.
- Glaser, B.G. and Strauss, A.L. (1970). *Awareness of Dying*. Chicago: Aldine.

- Grey, W. (2007) Right to die or duty to live? The problem of euthanasia. In Dickenson, D., Johnson, M. and Katz, J. S. (eds) *Death, Dying and Bereavement*. Los Angeles: Sage.
- Hermesen, M.A. and ten Have, H.A. (2002) Euthanasia in palliative care journals, *Journal of Pain and Symptom Management*, 23, 6, 517–25.
- Herzlich, C. (1973) *Health and Illness: a Social Psychological Analysis*. London: Academic Press.
- Hildén, H.-M., Louhiala, P. and Palo, J. (2004) End of life decisions: attitudes of Finnish physicians, *Journal of Medical Ethics*, 30,4, 362–65.
- Hänninen, J. (2003) From Finland, *Palliative Medicine*, 17, 2, 166.
- Jahoda, G. (1988) Critical notes on social representations, *European Journal of Social Psychology*, 18, 3, 195–211.
- Joffe, H. (1997) The relationship between representational and materialist perspectives: AIDS and 'the other'. In Yardley, L. (ed.) *Material Discourses of Health and Illness*. London and New York: Routledge.
- Joffe, H. (1999) *Risk and 'the Other'*. Cambridge: Cambridge University Press.
- Joffe, H. (2003) Risk: from perception to social representation, *British Journal of Social Psychology*, 42, 1, 55–73.
- Jylhäkangas, L. (2006) *Eutanasia, uskonto ja kulttuuri*. In Hänninen, J. (ed.) *Elämän loppu vai kuoleman alku? Hoitopäätökset kuoleman lähestyessä*. (The end of life or the beginning of death? decision-making in the face of death). Helsinki: Duodecim (the Finnish Medical Society).
- Kaufman, S.R. (2000) In the shadow of 'death with dignity': medicine and cultural quandaries of the vegetative state, *American Anthropologist*, 102, 1, 69–83.
- Kaufman, S.R. (2010) Time, clinic technologies, and the making of reflexive longevity: the cultural work of time left in an ageing society, *Sociology of Health & Illness*, 32, 2, 225–37.
- Kokkonen, P., Holi, T. and Vasantola, S. (2004) *Hoitotahto. Potilaan oikeudet ja lääkärin velvollisuudet*. (Living will. The rights of a patient and the duties of a physician). Helsinki: Talentum.
- Kuuppelomäki, M. (2000) Attitudes of cancer patients, their family members and health professionals toward active euthanasia, *European Journal of Cancer Care*, 9, 1, 16–21.
- Larue, G.A. (1985) *Euthanasia and Religion. A Survey of the Attitudes of World Religions to the Right-to-Die*. Los Angeles: Hemlock Society.
- Louhiala, P. and Hildén, H.-M. (2006) Attitudes of Finnish doctors towards euthanasia in 1993 and 2003, *Journal of Medical Ethics*, 32, 11, 627–28.
- Materstedt, L.J., Clark, D., Ellershaw, J., Førde, R., et al. (2003) Euthanasia and physician-assisted suicide: a view from an EAPC ethics task force, *Palliative Medicine*, 17, 2, 97–101.
- Mercer, J. and Feeney, J. (2009) Representing death in psychology: hospice nurses' lived experiences, *Mortality*, 14, 3, 245–64.
- Morant, N. (2006) Social representations and professional knowledge: the representation of mental illness among mental health practitioners, *British Journal of Social Psychology*, 45, 4, 817–38.
- Moscovici, S. (1961) *La Psychoanalyse, son Image et son Public*. Paris: Presses Universitaires de France.
- Moscovici, S. (1984) The phenomenon of social representations. In Farr, R.M. and Moscovici, S. (eds) *Social Representations*. Cambridge: Cambridge University Press.
- Moscovici (1998) The history and actuality of social representations. In Flick, U. (ed.) *The Psychology of the Social*. Cambridge: Cambridge University Press.
- Moscovici, S. (2000) The phenomenon of social representations. In Duveen, G. (ed.) *Social Representations. Explorations in Social Psychology*. Cambridge: Polity Press. Originally published in Farr, R.M. and Moscovici, S. (1984) (eds) *Social Representations*. Cambridge: Cambridge University Press.
- Moscovici, S. (2008) *Psychoanalysis: its image and its public*. Cambridge: Polity Press.
- Moscovici, S. (2011) An essay on social representations and ethnic minorities, *Social Science Information*, 50, 3–4, 442–61.
- Muller, J. (1992) Shades of blue: the negotiation of limited codes by medical residents, *Social Science & Medicine*, 34, 8, 885–98.
- Murray, M. (2002) Connecting narrative and social representation theory in health research, *Social Science Information*, 41, 4, 653–73.

- Páez, D., Echebarria, A., Valencia, J. and Romo, I. *et al.* (1991) AIDS social representations, contents and processes, *Journal of Community and Applied Social Psychology*, 1, 2, 89–104.
- Peräkylä, A. (1990) *Kuoleman monet kasvot*. Tampere: Vastapaino.
- Peräkylä, A. (1991) Hope work in the care of seriously ill patients, *Qualitative Health Research*, 1, 4, 407–33.
- Pirttilä-Backman, A.-M. and Helkama, K. (2001) *Serge Moscovici. Sosiaaliset representaatiot*. In Hänninen, V., Partanen, J. and Ylijoki, O.H. (eds) *Sosiaalipsykologian suunnannäyttäjät*. Tampere: Vastapaino.
- Potter, J. and Litton, I. (1985) Some problems underlying the theory of social representations, *British Journal of Social Psychology*, 24, 2, 81–90.
- Purkhardt, S.C. (1993) *Transforming Social Representations: a Social Psychology of Common Sense and Science*. London: Routledge.
- Rachels, J. (1986) *The end of Life. Euthanasia and Mortality*. Oxford: Oxford University Press.
- Rietjens, J.A.C., Deschepper, R., Pasmán, R. and Deliens, L. (2012) Medical end-of-life decisions: does its use differ in vulnerable patient groups? A systematic review and meta-analysis, *Social Science & Medicine*, 74, 8, 1282–87.
- Ryan, C.J. (2007) Betting your life: an argument against certain advance directives. In Dickenson, D., Johnson, M. and Katz, J. S. (eds) *Death, Dying and Bereavement*. Los Angeles: Sage.
- Ryynänen, O.-P. and Myllykangas, M. (2003) Lääkäreiden, hoitajien ja väestön asenteet eutanasiaan Suomessa, *Lääkärilehti*, 58, 43, 4331–37.
- Ryynänen, O.-P., Myllykangas, M., Viren, M. and Heino, H. (2002) Attitudes towards euthanasia among physicians, nurses and the general public in Finland, *Public Health*, 116, 6, 322–31.
- Räty, H., Ikonen, S. and Honkalampi, K. (2006) Common-sense descriptions of depression as social representations, *International Journal of Social Psychiatry*, 52, 3, 243–55.
- Seale, C. (1998) *Constructing Death. The Sociology of Dying and Bereavement*. Cambridge: Cambridge University Press.
- Seale, C. (2000) Changing patterns of death and dying, *Social Science & Medicine*, 51, 6, 917–30.
- Seale, C. (2009) Hastening death in end-of-life care: a survey of doctors, *Social Science & Medicine*, 69, 11, 1659–66.
- Seale, C. (2010a) The role of doctors' religious faith and ethnicity in taking ethically controversial decisions during end-of-life care, *Journal of Medical Ethics*, 36, 677–82. doi:10.1136/jme.2010.036194.
- Seale, C. (2010b) Continuous deep sedation in UK medical practice: descriptive study, *Journal of Pain and Symptom Management*, 39, 1, 44–53.
- Silvoniemi, M., Vasankari, T., Vahlberg, T. and Clemens, K.E. *et al.* (2010) Physicians' attitudes towards euthanasia in Finland: would training in palliative care make a difference?, *Palliative Medicine*, 24, 7, 744–6.
- Slomka, J. (1992) The negotiation of death: clinical decision making at the end of life, *Social Science & Medicine*, 35, 3, 251–59.
- Smets, T., Cohen, J., Bilsen, J. and Van Wesemael, Y. *et al.* (2011) Attitudes and experiences of Belgian physicians regarding euthanasia practice and the euthanasia law, *Journal of Pain and Symptom Management*, 41, 3, 580–93.
- Statistics Finland (2009) *Numbers, causes and places of death in Finland*. Helsinki: Statistics Finland.
- Timmermans, S. (2005) Death brokering: constructing culturally appropriate deaths, *Sociology of Health & Illness*, 27, 7, 993–1013.
- Utriainen, T. (1999) *Läsnä, riisuttu, puhdas. Uskontoantropologinen tutkimus naisista kuolevan vierellä*. Helsinki: SKS.
- Utriainen, T. (2010) Agents of De-differentiation: Women Care-givers for the Dying in Finland, *Journal of Contemporary Religion*, 25, 3, 437–51.
- Van Wesemael, Y. (2011) *The Euthanasia Practice in Belgium. Evaluation of the Mandatory Consultation Procedure between Physicians*. Brussel: Vrije Universiteit Brussels: Brussels University Press.
- Walter, T. (1994) *The Revival of Death*. London: Routledge.