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THE VALUE OF NURSES' CODES: EUROPEAN NURSES' VIEWS

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Nurses are responsible for the well-being and quality of life of many people, and therefore must meet high standards of technical and ethical competence. The most common form of ethical guidance is a code of ethics/professional practice; however, little research on how codes are viewed or used in practice has been undertaken. This study, carried out in six European countries, explored nurses' opinions of the content and function of codes and their use in nursing practice. A total of 49 focus groups involving 311 nurses were held. Purposive sampling ensured a mix of participants from a range of specialisms. Qualitative analysis enabled emerging themes to be identified on both national and comparative bases. Most participants had a poor understanding of their codes. They were unfamiliar with the content and believed they have little practical value because of extensive barriers to their effective use. In many countries nursing codes appear to be 'paper tigers' with little or no impact; changes are needed in the way they are developed and written, introduced in nurse education, and reinforced/implemented in clinical practice.

Introduction

Questions about the usefulness of codes of ethics in nursing have been discussed in the nursing literature for the past decade.¹⁻⁴ However, as Tadd highlighted in an unpublished report for the United Kingdom Central Council for Nursing, Midwifery and Health Visiting,⁵ relatively little empirical research has been undertaken to determine how codes are viewed or used in day to day practice.⁶⁻⁹ Most of these studies, like those carried out in the USA,¹⁰⁻¹³ indicate that nurses lack knowledge and awareness of their respective codes, fail to use them proactively to shape their moral

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thinking, and rely on either personal experience or the prevailing organizational culture as the basis of their moral responsibility and commitment.^{14,15} Other than Tadd's 1999 study,⁵ which involved a questionnaire survey of 1465 nurses and 58 in-depth telephone interviews with questionnaire respondents who had indicated their willingness to participate, most research on codes has involved quantitative methods.

The considerable responsibility shouldered by nurses for the safety and well-being of sometimes vulnerable people demands high standards of technical and ethical competence. Some authors see codes as a source of ethical guidance for nurses,^{2,16,17} while others emphasize different functions. These include a public relations function to enhance professional status,¹⁸⁻²⁰ promoting professional solidarity and loyalty,^{16,20,21} the provision of guidance and professional support^{18,20,22} and a disciplinary function.^{19,20} What nurses think about the functions that codes fulfil was one of the questions addressed by this study.

This article will provide a brief overview of the empirical work undertaken within the project as a whole, and then focus on some of the findings related to nurse participants.

Aims of the study

The project was a three-year study designed to explore and analyse the practical, ethical, deontological and disciplinary implications of existing codes of nursing ethics in six European countries, and make recommendations for further developments concerning codes of ethics for nurses in Europe.

The objectives of this project were to:

- Hold focus groups/interviews with nurses, key persons (eg those responsible for developing codes, policy makers or nurse legislators) other health professionals, and service users in each country;
- Analyse the data using qualitative methods;
- Determine from the data the practical, ethical, deontological and disciplinary aspects of the function and content of codes of ethics.

Method

In total, 65 focus groups and 22 interviews involving 436 participants were held in six countries (UK, Finland, Italy, Greece, Poland and the Netherlands). Forty-nine focus groups were held with nurses, eight with users/potential users of nursing services, five with other health professionals (this group was not recruited in the Netherlands), and three focus groups involving 19 participants were held with key persons. Twenty-two individual interviews were also conducted.

No code of nursing ethics exists in Belgium, so a slightly different approach was adopted for eliciting the views of Belgian nurses. This part of the study has been reported elsewhere.²³

Focus groups

An important feature of this study was the intention to explore the beliefs and values of the different groups through their own eyes and from their own distinct perspectives. Qualitative methods were therefore believed to be most appropriate and focus groups were selected as the chief method of data collection. The strengths and weaknesses of focus groups as a method have been well described.^{24–26} It is said that focus groups are particularly appropriate when exploring the opinions of a range of participants, in this case about the use and function of nursing codes.²⁷ Focus groups are also appropriate in cross-cultural comparative research because they are useful in elucidating cultural values and exploring how linguistic exchanges operate within a given cultural context.²⁸

To ensure that all researchers were familiar with the methodological approach and to increase the potential for comparison, common training on focus group methodology was provided. In addition, a focus group schedule was developed from analysis of the literature and the content of the nursing codes undertaken in an earlier project. The schedule was piloted with groups of nurses and a biographical data collection sheet was developed.

Participants were purposively targeted and selected using preselection criteria aiming for maximum variation. However, within the nurse focus groups attempts were made to promote homogeneity in terms of seniority to avoid potential problems associated with hierarchy. Most participants found the method acceptable, regardless of the different countries and cultural backgrounds involved. Despite the recommended number of participants per group being between eight and ^{10,29} it was evident after conducting a number of groups that between five and eight was the optimum number because larger groups lacked cohesion and could be difficult to control.

A moderator and an assistant facilitated the discussions, which were audio-taped with participants' consent, and biographical data sheets were completed. All participants were given a copy of their respective codes to facilitate discussion and prevent the feeling of being tested. Detailed field notes were made of verbal and non-verbal group interactions. Immediately following each group, a debriefing session between the moderator and the assistant was recorded. This enabled significant points to be added to the field notes and first impressions of the key messages identified.

For each group of participants (nurses, key persons, other professionals and users) all centres reported that theoretical saturation was achieved and additional data yielded no new information.³⁰

Although maximum variation was achieved among the participants, focus groups, like all data collection methods, have weaknesses, not least because self-selection may result in a bias towards those who have a specific interest in the topic. Discussion in focus groups can also promote consensual rather than conflicting opinions, especially without skilled moderation. By using maximum variation sampling and carrying out the focus groups in a range of locations, the likelihood of uncovering divergent dialogues as well as increasing reliability and validity was increased.^{24,25} Given the constraints of focus group methodology, caution must be exercised about making statements concerning transferability of the data.

Table 1 Participants by category, gender and country

Country	Nurses (n = 311)		Users (n = 47)		Other professionals (n = 37)		Key persons (n = 41)		Total
	M	F	M	F	M	F	M	F	
Finland	2	33	3	7	0	6	0	4	55
Greece	8	46	3	6	1	6	2	3	75
Italy	6	43	1	3	4	3	2	4	66
Netherlands	13	26	1	4	–	–	2	5	51
Poland	0	74	6	4	6	4	2	12	108
UK	6	54	1	8	5	2	2	3	81
Total	35	276	15	32	16	21	10	31	436

Participant characteristics

Table 1 provides an overview of the numbers and sex of participants in each category by country. In all categories more women participated, which reflects the nature of the health and social care workforce in most countries, but does not explain the preponderance of women in the user category. Participants' ages ranged from 20 to 83 years, with the overall mean age of 44.01 years.

Nurse participants

The age range of the nurses was 20–61 years, with a mean of 38.64 years (Table 2).

In terms of educational attainment, 35 nurse participants were educated to basic level and 42 to high school level; 162 had obtained a tertiary certificate or diploma and 32 were graduates. The country details are shown in Table 3.

In terms of experience, the nurses had been qualified for varying lengths of time ranging from nine months to 40 years (Table 4). Fifteen student nurses were also invited to participate at one centre subsequent to comments about education and the code.

As well as having varying amounts of experience, the nurse participants were recruited from a range of employment settings, occupations and specialisms. Employment settings included acute hospitals, private care facilities, primary care, hospices, elderly care homes, psychiatric hospitals and institutions for people with learning

Table 2 Age range of nurse participants (years)

Country	20–29	30–39	40–49	50–59	60–69	Missing	Range	Mean
Finland	4	9	15	7	0	0	26–57	42.17
Greece	2	45	6	1	0	0	26–50	35.48
Italy	8	34	6	1	0	0	22–51	34.93
Netherlands	7	4	14	13	0	1	21–56	42.81
Poland	11	31	23	8	1	0	24–61	39.20
UK	15	16	21	5	0	3	20–56	37.30
Total	47	139	85	35	1	4	20–61	38.64

Table 3 Educational attainment of nurses

Country	Basic school	Higher school	Certificate/ diploma	Degree	Missing data
Finland	0	0	34	1	0
Greece	0	0	45	9	0
Italy	0	0	49	0	0
Netherlands	0	0	39	0	0
Poland	31	26	0	17	0
UK	4	16	34	5	1
Total	35	42	201	32	1

disabilities, while occupations and specialisms included paediatric nurses, adult nurses, district and public health nurses, family and school nurses, specialist practitioners, ward managers, staff nurses, nurse lecturers, midwives and nurse managers.

Data analysis

Data collection and analysis continued concurrently according to the method of constant comparison.³¹ All group discussions were transcribed verbatim. The analysis utilized the inductive thematic method, which involves detailed scrutiny of the transcripts to identify themes, which are then coded. In each centre two researchers independently coded the transcribed data and in some centres a computer software package (Atlas-ti 4.1) was used. The codes were compared and agreement was reached by discussion. The data were then examined for similarities and differences within themes and descriptive accounts were written, retaining the context of the discussion where possible. Negative or deviant cases (that is, examples that contradicted emerging themes) were investigated closely.

A broad analytical framework based on the analysis of the country codes was agreed between partners to enable comparative analysis of the data, although the possibility of new themes emerging remained. The individual country analyses of nurses' opinions on the content and function of nursing codes was then translated into English. These reports provided the basis for this comparative cross-country analysis.

In developing the comparative analysis, data from each centre were read frequently and closely by three of the present authors. All quotations were then cut and pasted into a word processing document without country identifiers, to give an overall sense

Table 4 Length of time nurses qualified

Country	Range (years)	Mean (years)	Missing data	Not available (student nurses)
Finland	3–30	16.4	0	0
Greece	4–29	13.5	0	0
Italy	0.5–29	11.19	0	0
Netherlands	0.67–30	14.46	3	0
Poland	1–40	17.56	0	0
UK ^a	0.75–32	13.95	1	15
Total	0.5–40	14.51	4	15

^a15 participants were student nurses.

of participants' views while minimizing the potential for bias. Detailed notes were then made. The narrative from all reports was treated in the same manner as the quotations, and again detailed notes were made. Lists of themes and their associated codes used in individual countries, again without reference to the countries developing them, were drawn up and notes made. These activities, together with extensive discussion with colleagues, enabled major categories to be identified. The data were then colour coded and arranged into what were termed 'super themes' both to test the categorization of themes and to enable the researchers from the individual centres to agree the categories and placement of data. The process also ensured that any outlying data could be identified.

The identified and agreed super themes were:

- Knowledge of and familiarity with nursing codes;
- Functions of codes;
- Content of nursing codes;
- Nursing relationships in the codes;
- The codes' relationship to laws and organizational policies;
- Learning about nursing codes;
- The codes in practice;
- What it means to be a professional;
- Positive aspects of nursing codes;
- Barriers to using codes in nursing;
- Criticisms of codes;
- Changes to and development of nursing codes.

Findings

Within the confines of this article it will not be possible to discuss each of the above points in detail but key findings in relation to knowledge and functions of codes, how codes are used in practice and barriers to their use will be explored.

Knowledge of and familiarity with nursing codes

With the exception of most Italian participants, who demonstrated a sound knowledge and understanding of their code, the majority of nurse participants were largely unaware of the content of their respective codes and had little knowledge of the relationship of their codes to other key nursing documents.

I never used the code in practice. I never saw the professional code within an organization and I have never heard anybody discussing the document. (Netherlands)

We talked about it at school but we didn't discuss the code so I do not really remember it. I think I know what it means to be ethical but I do not remember paragraphs. (Poland)

I would recognize it but I don't know it cover to cover. I mean if I had a quick glance at that then I would say, 'Oh yes I've heard of that and I think I know that.' (UK)

I knew of its existence; however, I have never read it. (Greece)

A variety of reasons for such comments were put forward. Some participants stated that only cursory attention had been given to their code during their education, while others claimed the documents were not readily available. Others argued that nurses are 'practical' people who are not interested in delving into theoretical matters or who, after working hard all day, are not inclined to go home and read a code of ethics.

Nurses are not 'paper-people'. The code is a booklet; we are familiar with the code because we are interested in it. But if you give the codes to the nurses in the working departments, they will say, 'Thank you very much' and that is it. (Netherlands)

When you work eight hours during the day, you are exhausted and you have absolutely no intention to read theoretical things about your profession during your leisure time. That means that only the 'die-hards' will read about theoretical things. These people, there are a few, are members of nurses' associations or nursing advisory boards. (Netherlands)

Another reason put forward was that the content and principles embodied in codes constituted a 'commonsense' knowledge, used unconsciously by most nurses:

When I look at this code, I use it every day . . . it is somehow in the background . . . without being aware of it . . . (Finland)

Functions of the codes

Despite most participants claiming that they were not aware of their code, or did not use it in practice, many made assertions about the various functions that codes fulfil.

Codes as a guideline

Most participants expressed the view that codes offer guidelines for practice, establish boundaries and rules, and provide professional standards.

The code is a guideline for the nursing profession. (Netherlands)

This is a kind of guide, signpost. (Poland)

I believe that a code sets the boundaries in which the professional acts. (Greece)

It is a series of guidelines providing indications on how to perform an activity. (Italy)

An important aspect of such guidelines was standardizing professional practice.

In my opinion the function of any code is to standardize conduct and I think that the code of deontology for nurses is aimed precisely at that. (Italy)

However, not everyone agreed with this and some participants questioned the value of codes as a guide.

For me the function and the value of the code are not clear. During your education you get information about several philosophical principles. When you go to work, you have the rules of the institution and visions of the department. The professional code is the next document. You can mention it as a guideline, but what is the reason to formulate a guideline when you have already four or five guidelines? What is the surplus value of the professional code? (Netherlands)

Codes as a representation of the profession and the professional

Another significant function identified by many participants concerned endorsing a professional identity, which involves promoting an ethical framework, declaring the profession's role in society, providing an image of the 'ideal' professional, setting professional boundaries, regulating the relationships between colleagues and subordinates, and affirming shared professional and ethical values.

I see the code as having only the function to identify the profession and the professional. Seeing yourself in it, identifying with its articles. (Italy)

All nurses have a duty in society, some societal task, but these codes of ethics show how to implement the mission, how nurses act; they give support to nurses by being guides. (Finland)

I believe that the code determines professionals' identity. (Greece)

I think every profession has a picture of an ideal professional and the code is an attempt to name this feature that every ideal nurse or doctor should have. (Poland)

Some participants were reluctant to admit that they practiced according to prescribed norms and values. Instead they expressed the opinion that their own values and norms guide their practice.

The code is a framework that you use in your work situation. Based on this framework you try to deliver good quality care in accordance with your own norms and background. (Netherlands)

For some participants the idea that one's professional and personal norms and values could be different was an anathema. Values were not like a professional mantle donned when entering work and left hanging on a peg at the end of a shift.

We can't have two different personalities. I've got the same personality on and off duty. (Italy)

For others, the split between professional and personal was quite distinct.

I disagree with 'all aspects of my life'. To be a model of honour and integrity in my workplace, towards my colleagues, patients and to everything that has to do with nursing ... there are aspects of our lives that have nothing to do with nursing or diseases. My family life does not concern either patients or the hospital. (Greece)

Quite frankly that is your job; it is none of their business whether you have been pole-dancing in the afternoon ... You are a professional person so it doesn't matter what you do; as long as it is legal and you are not breaking the law, it doesn't matter what you do outside of work. (UK)

Codes as promoters of professional status

The professionalizing function of codes was also mentioned by many participants.

It is the same with all health care professions, you are respected if the profession has its own code of ethics. (Finland)

We want to be professionals, and a professional group needs a professional code. (Netherlands)

The code could perhaps help to make nurses better known. Social recognition is what's really missing. (Italy)

Codes as public protectors

The majority of participants emphasized the role of codes in public protection.

The code ensures the nurse's commitment to the patient . . . the way the code is written means it functions as a protective umbrella for the patient. (Greece)

It should be a guarantee for the patients we take care of. (Italy)

It is a protection for the public in that we can be called to account if we go against those codes. (UK)

However, some participants also believed that patients had too much power and that this impeded their practice.

Patients are more and more aware of their rights and this is good, but sometimes it clashes with performing our duties and our code. They think they are the only people who are sick at the moment. (Poland)

Codes as a disciplinary measure

Some participants believed that codes should fulfil a disciplinary function.

It should function in a way that any violation of the code would lead to removal of the nursing licence. (Greece)

In my opinion, there is a relationship between disciplinary rules and the professional code. I do not think that disciplinary rules are based on the professional code but I can imagine that the members of a disciplinary committee use the code to judge situations. (Netherlands)

Other participants were against codes being used in disciplinary matters, believing they were too general. They also resented the fact their codes required them to report colleagues in certain situations.

The professional code is too general to be used for disciplinary rules. You can interpret the code in different ways. (Netherlands)

That nurses see to it that other nurses do not act unethically – this sounds like too much watching . . . (Finland)

I mean that is really frightening, I mean we are all already watching our backs as it is because we are all worried about litigation and different things. When you have got to watch the fact that all your colleagues may be watching you because they feel you may not be perfect then . . . (UK)

Using a code in practice

For a majority of the nurse participants the code seemed an irrelevance to their daily work. Most failed to think about the code or make reference to it. Many participants

claimed the code was an unworkable ideal and that the lack of resources made it impossible to adhere to its requirements.

It sounds nice but there is this other part to this code, and it is politics. I know how I should behave towards this patient but in this concrete moment there is no possibility to do it because there is a lack of something. For instance, I know I should talk for half an hour with this patient but I am the only nurse and I have 30 patients. I think the financial conditions that our politicians create for us do not promote obeying the code. It should be guaranteed not only in the code but also in practice. (Poland)

Most participants complained about the changing health care context that emphasized cost-saving and rationalization.

I've been to a course where they said they wanted to make the hospital into a company. I don't agree with that. It's OK from an administrative point of view, accounts must square, but I've got a code that tells me that I have to take care of people. Why should I think in terms of a company? I think that if this thing is accepted, we'll oppose it. (Italy)

Codes as a 'prop'

Participants did find that a code was a useful endorsement in difficult situations.

When family and friends visit a patient and would like to know what his health condition is, then I cannot inform them. But when I say 'Sorry I cannot give you this kind of information' they consider me their enemy and think I am rude. But when I say that I am really sorry but the code does not let me give that information, they say 'OK we understand'. I think referring to some document reinforces what we say. It is contained in some document and so it is important. (Poland)

The codes' role in solving dilemmas

Although some participants believed a code was useful for reflection, there was no clear agreement about whether it should or could provide answers to ethical dilemmas.

I found myself facing dilemmas, but honestly I never thought about getting the code to see what it said about that. (Italy)

It is very good at guiding our professional practice but it doesn't really make you think of the ethical issues. (UK)

When I am confronted with ethical dilemmas during my practical work I refer to my own norms and values, not to the principles of the code. But I think these are the same. (Netherlands)

The codes' role in clarifying actions

Some participants thought that a code could help to clarify nursing actions, even if it did not provide concrete answers.

It clarifies ... but does not give straight answers. (Finland)

Others thought that codes were unable to achieve this.

I believe if we go to the code we are not going to find any solution. (Greece).

Many participants, however, believed that codes should not prescribe definitive actions because this denied nurses their autonomy and, for others, it was experience in day-to-day practice, rather than the code, that taught them how to act appropriately.

I think that a code of deontology should provide in a sentence an indication of the margin of professional autonomy. It's then up to me to be accountable for the decisions I take as part of the autonomy that I was given, and behind that autonomy is my preparation and my ability to collect information, and plan the actions to be taken. (Italy)

I consider that when a code refers to ethical and deontological issues, it shouldn't have the form of 'ought to' or 'must'. It seems to say ... we decide and we prescribe that the nurse must ... It cannot dictate to you your morality. (Greece)

How codes are not used

Dutch participants found it difficult to give concrete examples of how the code was used in everyday practice, except for educational purposes. Most claimed it was not used in the clinical areas, which was also endorsed by the UK nurses.

I use the code for students working in our department. They have to work out nursing cases, and then I advise them to refer to the professional code. (Netherlands)

I never used the code in practice. I never saw the professional code within an organization and I have never heard anybody discussing the document. (Netherlands)

I have learnt nothing about it on the ward. (UK)

I have never learnt it from other nurses. (UK)

Unconscious use of codes

Many participants claimed that codes were used unconsciously in practice because the values and advice contained in them were already 'within' nurses, and therefore they did not need to think about the content.

I would say that they [nursing values] come from the backbone. (Finland)

It's things that are taken for granted, that you've got inside of you, that come naturally. (Italy)

Codes as advocates

Participants also claimed that codes were useful in improving the environment of care.

I have used it in some situations in patient care ... when I have tried to get resources. (Finland)

They wanted me to take charge of a 35-bed ward and I had been qualified only about five or six months, and I thought I probably could have coped but I felt I was being put upon, and I thought, no why should I, so I used my code there. (UK)

Further discussion with participants confirmed that such uses of codes enabled them to acquire equipment, procure more staff and reinforce practical procedures such as correctly completed medication sheets. Many participants believed that in today's climate it was necessary to safeguard themselves, using their code as a form of self-protection, although some believed codes lacked impact in this respect.

You can use it as a form of protection as well if you find yourself in a certain situation, for example, when the ward is understaffed and there are not enough qualified staff nurses on the ward to protect the patients. Then you can quote your code of conduct and say that you are not working in a safe environment. You can draw on it, use it to your advantage. (UK)

When you have the feeling that you need a document to protect yourself it is more valuable in my opinion to refer to the law than to the professional code. I think that the doctor will not be impressed when you are referring to your professional code. (Netherlands)

Despite a number of uses being specified, many barriers to the use of codes were also identified.

Barriers to using codes

The barriers mentioned can be characterized as both internal and external.

Internal barriers

Internal barriers included a lack of awareness and interest by nurses and a lack of self-respect as professionals, together with a lack of motivation. Participants claimed that many nurses lacked certain 'professional' skills, and failed to discuss and implement their codes in practice. Education about codes was often inadequate and many participants were limited in their understanding of what being a professional involves.

Neither in practice nor during my nursing education have I heard of professional codes; we have never discussed it. And I have 30 years of practical experience as a nurse. (Netherlands)

My opinion is that nurses are not brave enough; they do not trust in their professional skills . . . there is no courage. (Finland)

In my opinion it just doesn't stick with you, it's all very theoretical in school and then the nurse gradually loses sight of it. I don't know why that happens, but it happens very often when we should all be relying on it. Very often it goes out of your mind and it's gone, but I don't know if it's the nursing profession that steers away from it. (Italy)

I think we don't use it enough because we don't all know what it involves. Nobody knows or is perhaps aware of all the information in there. (UK)

I believe that we are not well informed as a profession; we are afraid, we hesitate because of this unawareness of the code and the law. Basically I have the impression that we don't respect ourselves. We count on other professionals, such as physicians and psychologists. (Greece)

External barriers

As well as internal barriers, many external barriers were also highlighted.

Constraints in the system. These included inadequate financial and physical resources, too little time and too few staff. Without these basic requisites, participants claimed that standards of care were less than those demanded by their codes.

Here we have a drip, a bedpan and serving dinner, and we do not even have time to wash our hands. We have to do it, but how, when we have no time? Yes we know what is in the code but we have no time to act according to the code. (Poland)

There is always a conflict with what your employers expect you to do and resource restraints, time limitations and staff limitations, and skill mix of staff, which might come from the lack of resources whether it is money or manpower, and that is a big issue. (UK)

Considering the current situation in Greek hospitals with the great nurse shortage, I don't think that even the most conscientious nurses have time to do everything as it has to be done. (Greece)

Many times you feel uncomfortable because you know you've given little information to the patient or a relative on how to tackle a health problem. You don't have the time to do it properly ... (Italy)

Professional relationships. Professional relationships were also cited as barriers to using the code. Particular mention was made of nurse–doctor relationships.

The manner of giving information is very important. Doctors use medical language, which is hard to understand and we [nurses] speak clearly, like a conversation with another person, not a lecture. Nurses are closer to patients and they use the same language as patients, and that is why it is better when nurses give that information. Nurses are better prepared. (Poland)

We had a conflict over the treatment of a child, how the nurses saw it, and the judgements of doctors. We saw it in a different way. Then the doctors lied in the patient record ... I know it ... we were frightened ... we did not dare tell. (Finland)

It is the system; it is doctor-centred. (Greece)

Conflicts between nurses and the absence of teamwork were identified as barriers.

I think that even among nurses there are some conflicts because there is a group of nurses who stress that they are better educated than others. (Poland)

Everyone sees only their own tasks, although we are caring for the same patient, we do not see the work of the other nurse ... there is no co-operation ... (Finland)

There is a lack of collaboration among us. (Greece)

Conflicts between nurses and their managers and fear were also cited as barriers.

I think that we don't want to upset management; we are afraid of what might happen if we did. With my example of that Tuesday night, I mean I didn't want to do it, and I have never done it before. Previously I would have trundled on regardless but then I thought, well it is the patients at the end of the day. But I do think that we don't want to cause trouble. (UK)

Lack of professional recognition. Other participants thought that the fact they are not recognized as professionals is a barrier to using the code, as is the lack of an independent regulatory body in some countries.

The lack of a regulatory body that will take the code and make it its 'flag' in the political arena in improving the nursing profession. (Greece)

Problems with codes. Dutch participants particularly identified the poor visibility or profile of codes and the numerous versions as barriers.

The fact that we have several professional codes makes it difficult to implement ... which code? One uniform code, that is clear, and in that case you know what you have to implement. (Netherlands)

For the implementation of the professional code you need a change of culture. The code is a guideline, I have seen it by chance, but after my nursing education I have never seen it again. The best way is to integrate the code in the structure of the institution to stimulate the active use of the code. In my opinion, the code is at the moment not used in an active way. At the moment the code does not function as a reference booklet. (Netherlands)

In most centres participants thought that their codes were unrealistic. Organizational and health policies make codes difficult to adhere to, as does the fact that many codes contain a number of conflicting elements.

It's wishful thinking; we look at it and say, 'Yes, that would be nice! That's super nurse with her cloak and IP letters [for Infermiere Professionale] on the front'. (Italy)

It is quite contradictory; at times we find it difficult to maintain accountability and follow some policies. (UK)

Discussion

In all countries except Italy, participants claimed they were unaware of their codes and did not use them in practice. Their educational preparation was criticized, as was the lack of availability of codes in clinical areas. Participants acknowledged that nurses were not interested in reading their codes, especially in their own time. The contradiction of such a stance for someone claiming to be a professional did not appear to register.

Another reason why participants claimed nurses were not particularly interested in these documents was that they contained commonsense knowledge. This raises an interesting possibility, which relates to the codes' function and which was identified by Edgar²² as: 'A statement that is banal to the nurse is important, precisely because it may be a revelation to the sceptical and unsympathetic outsider.' Unless it is made clear to whom a statement is addressed, there is a danger that nurses may see codes as trite.

Although many participants claimed they were unaware of their codes and did not use them in practice, this did not prevent them discussing the functions that codes fulfilled. The first contradiction evident from this was that, having said they did not know or use codes, participants then claimed that codes acted as a guide. No one seemed to ask what sort of a guideline it was that was ignored all the time. When asked how codes were used in practice, many participants spoke about their role in solving ethical dilemmas and clarifying nursing actions. That participants may have been trying to give socially acceptable answers must therefore be seriously considered. The similarity of responses in so many European countries may also say something about the preparation of nurses and what societies and professional leaders and bodies expect from nurses in terms of conformity.

Participants unanimously claimed that codes provide an image of professional identity for nursing and individual nurses, yet, in most centres, participants were steadfast in their demand that codes had no claims on their personal lives. Another issue raised in relation to this idea of a professional identity was whether there could be separate professional and personal values. The obvious answer is that there can be, depending upon the value in question. For example, individual nurses may agree (or disagree) with euthanasia or abortion, which may or may not be sanctioned by a

country's laws and therefore by professional organizations. However, there are certain values, such as honesty, which would be expected on a personal level from someone entering a profession. The idea that being a professional involves more than just working from 09.00 until 17.00 seemed not to have registered with most participants and, although professional recognition and increased status were important to the majority of the nurses, they resented any of the additional responsibilities or demands that such public recognition may require.

Almost unanimously, participants claimed that codes were there to protect the public; however, many thought that patients had too much power and patients' rights were thought to interfere with the provision of nursing services. Such attitudes could have implications for patient-centred care and public empowerment in health care.

In relation to the disciplinary function of codes, participants were divided. Many claimed that codes were open to interpretation and therefore unsuitable for such use. Participants were also unanimous about the difficulties involved in reporting malpractice or adverse care environments and the stress in which this resulted.¹⁵ From the discussions concerning environments of care and reporting inadequacies, the reality of attempting to provide an acceptable level of care in the face of restricted resources concerned many participants, and their disquiet increased when having to report these matters to those in control.¹⁵

Further disagreement concerned the role that codes play in solving ethical dilemmas or clarifying nursing actions. Some thought these were legitimate functions, while others believed they interfered with nurses' autonomy. One of the most interesting claims was in relation to the unconscious use of codes. This may be closely related to the idea mentioned above that the content of many codes is common sense. However, it is of concern when 'professionals' claim that it is not necessary to 'think about' values because everyone should surely reflect and think about the values on which their practice is based.

In relation to barriers, it appears that nurse education leaves much to be desired, as do nurses' attitudes towards professional status and recognition. However, those responsible for the development of nursing codes need to take account of health care systems and the barriers these impose. The subservient nature of nurses in relation to the medical profession and nurse managers must also be addressed. As Tadd¹ highlighted, ignoring such difficulties imposed on practitioners could imply unethical conduct.

Caution also needs to be exercised in how codes are written so that ambiguities are minimized and the manner in which they are developed and introduced needs to be given serious thought by professional bodies.

In conclusion

Limitations of the study

The collection of data in countries with different native languages means that both linguistic and conceptual equivalence need to be applied in the design of research tools and the translation of interview data. This was no different in this study. Many examples can be found in the literature highlighting the difficulties and complexities of agreeing linguistic equivalence. This does not simply relate to conceptually difficult

terms but also to those that may appear initially straightforward. In our own research, for example, the term 'deontological' needed to be clarified across research teams because this term has a very specific meaning in both Italy and Greece.³² This highlights the importance of ensuring that, even when countries use the same language, concepts and terms are understood in their particular cultural contexts.

One of the critical difficulties relating to qualitative data is corruption through translation. Whatever strategy is chosen, the problem remains that analysis, write-up and dissemination are often reduced to a single language, resulting in the potential loss of culturally-loaded meaning and context. This project (Ethical Codes in Nursing) attempted to address these problems in a variety of ways, for example, by training in how to use focus group schedules generated in English and in translating and back translating by each research team in their own language, as well as in the steps taken in the production of the comparative analysis.

The participants' answers also raised additional concerns. If their answers were not based on a sound knowledge of their codes and experience of their use in practice, then some of the findings need to be treated with great caution when determining recommendations.

Conclusion

Despite these limitations, the study also has some strengths. A large number of participants were involved and, in spite of their diversity and different nationalities, there was a notable consistency within the findings, suggesting that the data represent a general 'truth'. This research also appears to confirm the findings from other studies that nurses lack knowledge of their codes, fail to use them to consider the moral dimensions of their practice, and tend to rely on personal values and experiences. In addition, a narrow and limited view of what it means to be a professional results in the organizational climate and environment of care, often taking precedence over the needs of patients and clients.

In many countries nursing codes appear to be 'paper tigers' with questionable impact on their intended audience. If codes are to be meaningful it is recommended that changes are needed in the way they are developed, written, introduced in nurse education, and reinforced and implemented in clinical practice.

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