Nursing Ethics Education in Finland from the Perspective of Code of Ethics

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NURSING ETHICS EDUCATION IN FINLAND FROM THE PERSPECTIVE OF CODES OF ETHICS

by

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ABSTRACT

The purpose of this study was to analyze nursing ethics education from the perspective of nurses' codes of ethics in the basic nursing education programmes in polytechnics in Finland with the following research questions: What is known about nurses' codes in practice and education, what contents of the codes are taught, what teaching and evaluation methods are used, which demographic variables are associated with the teaching, what is nurse educators' adequacy of knowledge to teach the codes and nursing students' knowledge of and ability to apply the codes, and what are participants' opinions of the need and applicability of the codes, and their importance in nursing ethics education. The aim of the study was to identify strengths and possible problem areas in teaching of the codes and nursing ethics in general. The knowledge gained from this study can be used for developing nursing ethics curricula and teaching of ethics in theory and practice.

The data collection was targeted to all polytechnics in Finland providing basic nursing education (i.e. Bachelor of Health Care). The target groups were all nurse educators teaching ethics and all graduating nursing students in the academic year of 2006. A total of 183 educators and 214 students from 24 polytechnics participated. The data was collected using a structured questionnaire with four open-ended questions, designed for this study.

The data was analysed by SPSS (14.0) and the open-ended questions by inductive content analysis. Descriptive statistics were used to summarize the data. Inferential statistics were used to estimate the differences between the participant groups. The reliability of the questionnaire was estimated with Cronbach's coefficient α.

The literature review revealed that empirical research on the codes was scarce, and minimal in the area of education. Teaching of nurses' codes themselves and the embedded ethical concepts was extensive, teaching of the functions of the codes and related laws and agreements was moderate, but teaching of the codes of other health care professions was modest. Issues related to the nurse-patient relationship were emphasised. Wider social dimensions of the codes were less emphasized. Educators' and students' descriptions of teaching emphasized mainly the same teaching contents, but there were statistically significant differences between the groups in that educators assessed their teaching to be more extensive than what students had perceived it had been.

The use of teaching and evaluation methods was rather narrow and conventional. However, educators' and students' descriptions of the used methods differed statistically significantly. Students' knowledge of the codes and their ability to apply them in practice was assessed as mediocre by educators and by students themselves. Most educators assessed their own knowledge of the codes as adequate to teach the codes, as did most of the students. Educators who regarded their knowledge as adequate taught the codes more extensively than those who assessed their knowledge as less adequate. Also students who assessed their educators' knowledge as adequate perceived the teaching of the codes to be more extensive. Otherwise educators' and students' demographic variables had little association with their descriptions of the teaching. According to the participants, nurses need their own codes, and they are also regarded as applicable in practice. The codes are an important element in nursing ethics education, but their teaching needs development.

Further research should focus on the organization of ethics teaching in the curricula, the teaching process, and on the evaluation of the effectiveness of ethics education and on educators' competence. Also the meaning and functions of the codes at all levels of nursing deserve attention. More versatile use of research methods would be beneficial in gaining new knowledge.

KEYWORDS: nursing ethics, codes of ethics, nurse education, teaching, nurse educator, nursing student

Olivia Numminen

Hoitotyön etiikan opetus Suomessa eettisten ohjeiden näkökulmasta tarkasteltuna

Turun yliopisto, Lääketieteellinen tiedekunta, Hoitotieteen laitos
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TIIVISTELMÄ

Tämän tutkimuksen tarkoituksena oli analysoida hoitotyön etiikan opetusta sairaanhoitajien eettisten ohjeiden näkökulmasta sairaanhoitajien peruskoulutuksessa Suomen ammattikorkeakouluissa seuraavilla tutkimuskysymyksillä: Mitä tiedetään sairaanhoitajien eettisistä ohjeista käytännössä ja koulutuksessa, mitä eettisten ohjeiden sisältöjä opetetaan, mitä opetus- ja arviointimenetelmiä käytetään, millä taustamuuttujilla on yhteys opetukseen, mikä on hoitotyön opettajien tietoperusta eettisten ohjeiden opettamiseen, mitkä ovat sairaanhoitajaopiskelijoiden tiedot eettisistä ohjeista ja taidot soveltaa niitä, ja mitkä ovat vastaajien mielipiteet eettisten ohjeiden tarpeellisuudesta ja soveltuvuudesta sekä niiden opettamisen tärkeydestä osana hoitotyön etiikan opetusta. Tutkimuksen tavoitteena oli tunnistaa eettisten ohjeiden ja hoitotyön etiikan opetuksen vahvuuksia sekä mahdollisia ongelma-alueita. Tutkimuksesta saatua tietoa voidaan käyttää hoitotyön etiikan opetussuunnitelmien ja etiikan teoreettisen ja käytännön opetuksen kehittämiseen.

Aineiston keräys kohdistettiin kaikkiin Suomen ammattikorkeakouluihin, joissa on tarjolla sairaanhoitajakoulutusohjelma (sairaanhoitaja AMK). Kohderyhminä olivat etiikkaa opettavat hoitotyön opettajat ja lukuvuonna 2006 valmistuneet sairaanhoitajaopiskelijat. Kaikkiaan 183 opettajaa ja 214 opiskelijaa 24. ammattikorkeakoulusta osallistui tutkimukseen. Aineisto kerättiin tätä tutkimusta varten kehitetyllä strukturoidulla kyselylomakkeella, jossa oli myös neljä avointa kysymystä.

Aineisto analysoitiin SPSS (14.0) ohjelmalla ja avoimet kysymykset induktiivisella sisällönanalyysillä. Aineisto esitettiin kuvailevan tilastotieteen menetelmin ja vastaajaryhmien välisiä eroja mitattiin vertailevan tilastotieteen menetelmin. Kyselylomakkeen luotettavuus arvioitiin Cronbach'in α-kertoimella.

Kirjallisuuskatsaus osoitti, että tutkimusta eettisistä ohjeista on vähän ja se on lähes olematonta ohjeiden opetuksen alueella. Sairaanhoitajan eettisiä ohjeita ja niihin sisältyviä eettisiä käsitteitä opetettiin paljon, ohjeiden tarkoituksia ja ohjeisiin liittyviä lakeja ja sopimuksia opetettiin jokseenkin paljon, mutta muiden terveydenhuoltoalan ammattien eettisten ohjeiden opettaminen oli vähäistä. Opetuksessa korostui hoitaja-potilassuhteeseen liittyvät asiat. Eettisten ohjeiden yhteiskunnalliset ulottuvuudet korostuivat vähemmän. Opettajien ja opiskelijoiden kuvaukset opetuksen määrästä keskittyivät samoihin opetussisältöihin, mutta ryhmien väliset erot olivat tilastollisesti merkitseviä opettajien arvioidessa oman opetuksensa määrällisesti suuremmaksi kuin mitä opiskelijat olivat sen havainneet olleen.

Opetus- ja arviointimenetelmien käyttö oli melko kapea-alaista ja perinteistä. Opettajien ja opiskelijoiden kuvaukset käytetyistä menetelmistä erosivat toisistaan tilastollisesti merkitsevästi. Sekä opettajat että opiskelijat itse arvioivat opiskelijoiden tiedot eettistä ohjeista ja taidot soveltaa niitä käytännössä keskitasoisiksi. Useimmat opettajat arvioivat oman tietoperustansa riittäväksi eettisten ohjeiden opettamiseen kuten useimmat opiskelijatkin. Ne opettajat, jotka arvioivat omat tietonsa riittäviksi, opettivat eettisiä ohjeita enemmän kuin ne, jotka arvioivat omat tietonsa vähemmän riittäviksi. Myös opiskelijat, jotka arvioivat opettajiensa tiedot riittäviksi kokivat saaneensa enemmän opetusta eettisistä ohjeista. Muilla opettajien ja opiskelijoiden taustamuuttujilla oli vähän yhteyttä heidän kuvaukseensa opetuksesta. Opettajien ja opiskelijoiden näkemysten mukaan sairaanhoitajat tarvitsevat omat eettiset ohjeet, ja ne ovat pääasiallisesti sovellettavissa hoitotyön käytäntöön. Ohjeet ovat tärkeä osa hoitotyön etiikan opetusta, mutta niiden opettamista pitää kehittää.

Jatkotutkimus tulisi kohdistaa etiikan opetuksen organisointiin opetussuunnitelmissa, opetusprosessiin, ja opetuksen vaikuttavuuden sekä opettajien pätevyyden arviointiin. Myös eettisten ohjeiden merkitys ja tarkoitukset kaikilla hoitotyön tasoilla ansaitsevat huomiota. Monipuolisempi tutkimusmenetelmien käyttö olisi hyödyksi uuden tiedon hankkimiselle.

AVAINSANAT: hoitotyön etiikka, eettiset ohjeet, sairaanhoitajakoulutus, opetus, hoitotyön opettaja, sairaanhoitajaopiskelija

TABLE OF CONTENTS

LIST OF ORIGINAL PUBLICATIONS

This doctoral thesis is based on the following papers which are referred in the text by their Roman numerals from I to V.

I Numminen O, Van der Arend A, Leino-Kilpi H. (2008) Nurses' codes of ethics in practice and education: a review of the literature. Scandinavian Journal of Caring Sciences 23(2): 380-394

II Numminen O, Van der Arend A, Leino-Kilpi H. (2009) Nurse Educators' and Nursing Students' Perspectives on Teaching Codes of Ethics. Nursing Ethics 16(1): 69-82

III Numminen O, Leino-Kilpi H, Van der Arend A, Katajisto J. (2009) Nurse educators' teaching of codes of ethics. Nurse Education Today 30(2):124-131

IV Numminen O, Leino-Kilpi H, Van der Arend A, Katajisto J. (2009). Nursing students and teaching of codes of ethics: an empirical research study. International Nursing Review 56 (4): 483-490

V Numminen O, Leino-Kilpi H, Van der Arend A, Katajisto J. Comparison of Nurse Educators' and Nursing Students' Descriptions on Teaching Codes of Ethics. (submitted)

LISTS OF FIGURES, TABLES AND APPENDICES

LIST OF FIGURES

LIST OF TABLES

LIST OF APPENDICES

1. INTRODUCTION

Ethics as an essential element of professional nursing care dates back to the time of Florence Nightingale and Victorian Age England in 1860's. Abhorred by the sickrooms where people were crammed and the ways they were treated by vagrant women made Nightingale to realize that care of the sick needs to be totally reorganized. After establishing her nursing school in St. Thomas's Hospital in London in 1860, Nightingale expected her nurses to be women who behaved in a civilized manner, who had theoretical and practical knowledge of nursing, but who also had a moral disposition (Kuhse 1997, Sorvettula 1998, Kuhse & Singer 1999, Bostridge 2008). The concept of professional nursing was established.

Since Nightingale's time ethics has been a prerequisite of professional high quality nursing care (e.g. Opetushallitus 2006). Today ethics is equally important in nursing and consequently nursing education. Such things as new technology, medicalization, individualism, as well as reducing human action to juridical or economic issues have influenced our ethical thinking. Moreover, globalization, migration, shortage of nurses, new diseases, an aging population and access to health care are but a few examples of the sources to new and complicated ethical issues in health care (Hunt 1997a, Ryynänen & Myllykangas 2000, Meulenbergs et al. 2004, ICN 2008), which may, unfortunately, actualize in the most gruesome way (e.g. Healthcare Commission 2009).

Throughout the history of professional nursing the codes of ethics have been regarded as a fundamental part of nurses' professional ethics. The official need for the codes was expressed as early as in 1897 (Fowler 1999). The first code was issued by the American Nurses Association in 1950. However, the need of the codes had already been discussed throughout the world and in 1953 ICN (The International Council of Nurses) issued its first code for nurses worldwide. Thereafter a significant number of national nurses' associations have developed their own codes of ethics of which many are adaptations of the ICN code. (Fry & Johnstone 2002.) The Finnish Nurses Association's first own code was issued in 1973 and the latest version dates back to 1996 (Sorvettula 1993, The Finnish Nurses Association 1996).

In basic nursing education, ethics is currently one of the central competence areas of the professional nurse. The nurse's practice is guided by human rights, social and welfare legislation and nurses' codes of ethics. Ensuring patient safety and high quality services have been central determinants in defining the minimum requirements for education. (Opetushallitus 2006.)

Regardless of their importance in nursing practice and education, research focusing on the codes has been scarce both nationally and internationally, particularly in the area of education. However, the European Commission research project, "The Ethical

Codes in Nursing: European Perspectives on Content and Functioning " and "Code of Ethics and Conduct for European Nursing", issued by European Federation of Nursing Regulators (Sasso et al. 2008) manifest an increased interest in nurses' codes and their need. Nevertheless, more research-based knowledge of ethics and ethics education is still badly needed. (Leino-Kilpi 1999, Leino-Kilpi 2001, Leino-Kilpi 2004, Gastmans & Verpeet 2006.)

Thus, due to the ethical complexity of modern health care, the importance of the codes as a part of nurses' professional ethical competence, and the lack of research concerning the codes and their teaching, are good reasons to focus research on teaching of nurses' codes of ethics in current basic nursing education.

The purpose of this study was to analyze teaching of nurses' codes of ethics as an integral part of nursing ethics education in the basic nursing education programmes in polytechnics in Finland. The study focused on the extent of implemented teaching concerning practices in teaching ethics, i.e. teaching contents, and teaching and evaluation methods. The study also evaluated the educators' and the students' knowledge of the codes and their demographic variables which were related to the extent of teaching of the codes. The purpose was to compare the educators' and students' data. The aim of the study was to identify strengths and possible problem areas in the teaching of the codes and of nursing ethics in general. The knowledge gained from this study can be used for developing nursing ethics curricula.

In this study the key terms were defined as follows. *Education* is a process of training and developing the knowledge, mind, and skills or character of the student by formal schooling. The process of formal schooling is an action that is officially organized, systematic, goal-directed, periodical, and carried out in institutions by professional teachers following a curriculum. The term *teaching* as an element of education is sometimes used synonymously with education where applicable. The term *learning* refers to the outcomes of education. (Hirsjärvi & Huttunen 1997.)

The code of ethics refers to a set of officially proclaimed moral standards and principles of a profession, with which a profession guides the action of its members and indicates its responsibility to society (Hurwitz & Richardson 1997, Melia 1998, Johnstone 1999, Bandman & Bandman 2002, Butts & Rich 2008). This study, "Nursing Ethics Education in Finland from the Perspective of Codes of Ethics", refers to the above defined formal schooling provided by polytechnics in which the focus is on education of the codes of ethics of the nursing profession. *The nurse educator* refers to a qualified health care teacher and *the nursing student* refers to a graduating nursing student. In this study, nurses' codes of ethics are referred to also using the terms *"nurses' codes"* or just *"the codes"*, where appropriate. The study process is shown in Figure 1.

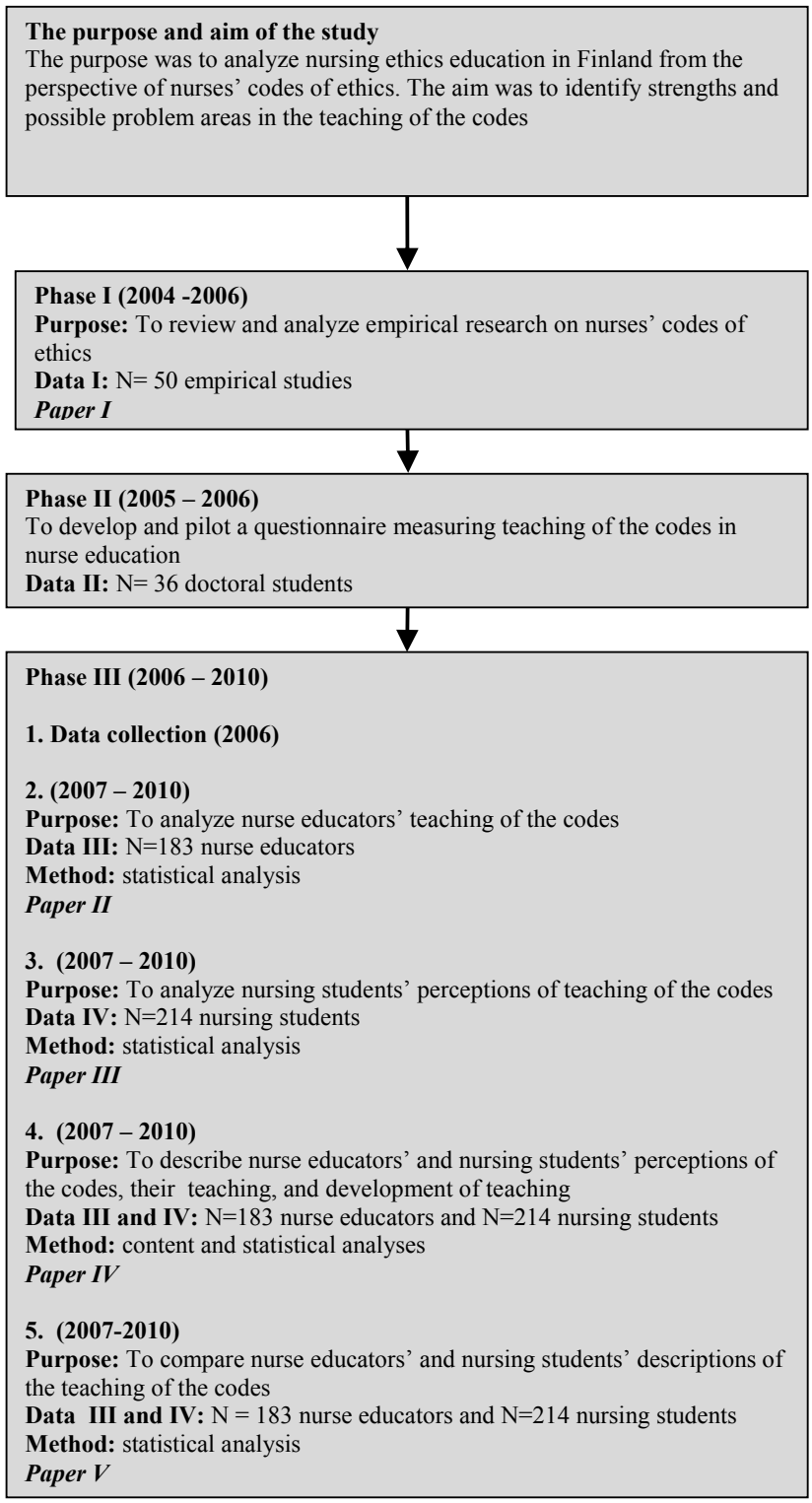


Figure 1. Phases of the study

2. LITERATURE REVIEW

Ethics in nursing covers a large number of topics, including nurses' codes of ethics. Nurses' codes are regarded as an integral element of nurses' professional ethics and consequently of nursing ethics education. The purpose of this literature review is first to define and discuss the concept of the codes of ethics in professional nursing. To understand the context in which teaching of the codes is implemented, it is relevant to describe the structure of Finnish nurse education and to provide an overview of practices in teaching of ethics in the Finnish nursing curricula. Thereafter, earlier empirical research is reviewed, focusing on practices in teaching ethics, the nursing profession's knowledge of and ability to apply the codes, and the profession's perceptions of the codes from the perspective of the teaching of ethics. The chapter closes with a summary of the literature review.

2.1. Codes of ethics

The section provides an overview of the codes of ethics. The focus is on the codes of health care professions, particularly nursing. First, the codes of ethics are defined, and the development of nurses' codes is reviewed. Thereafter, the focus moves to the structure of the contents of the codes and the ethical concepts embedded in nurses' codes. This is followed by a discussion of the functions of nurses' codes. Also laws and agreements in relation to nurses' codes are briefly discussed. The codes of health care professions have evoked criticism of their relevance to contributing to the fulfilment of their goal of ethical conduct, and thus limitations of the codes are addressed as well. Finally The Finnish Nurses Association's Ethical Guidelines of Nursing (1996) are briefly described.

2.1.1. The definition of the codes of ethics

This section starts with defining the codes of ethics and describing their essential features. It continues with brief descriptions of different kinds of codes, the difference between a code of ethics and an oath, and the codes' relation to the law. The last paragraph describes the place of the codes in the field of ethics and philosophy.

Codes of ethics are systems of rules and principles by which a profession is expected to regulate the moral behaviour of its members and demonstrate its responsibility to society (Hurwitz & Richardson 1997, Melia 1998, Johnstone 1999, Bandman & Bandman 2002). Codes of ethics can be described as a "conventionalized set of rules or expectations devised for a select purpose" (Johnstone 1999). Professional codes

of ethics represent an articulated statement of the moral role of the members of the profession, in which professional standards are distinguished from standards imposed by external bodies such as governments, regardless of whether the members agree or disagree with them. The codes also often specify rules of etiquette and responsibilities to other members of the profession, i.e. non-moral rules. (Beauchamp & Childress 2001.) The codes serve as authoritative moral standards governing practice, and they are primarily devised for the welfare of the patient (Shailer 1996, Davis et al. 2006). The codes provide an enforceable standard of decent conduct, a set of rules for accepted and expected behaviour that allows the profession to discipline colleagues who clearly fall below the minimum standard. In this form they are used as a juridical instrument which may partly diminish their moral meaning. The codes indicate in general terms the ethical considerations professionals must take into account in their conduct, e.g. confidentiality or competence. The codes are principles to which professionals as individuals and as a group commit themselves. In nursing, the codes act as the justification to carry out nursing care and as an indication of good and conversely bad behaviour in nursing care. The codes are also a promise to patients as to what kind of service is provided by the professionals. (Benjamin & Curtis 1992, Kalkas & Sarvimäki 1995, Välimäki 2008b.) The codes also tend to foster and reinforce member-identification with the prevailing values of the profession (Beauchamp & Childress 2001).

Codes are professional obligations imposed on the professionals by the professions themselves. The professions thus seek to ensure that persons who enter into relationships with their members will find them competent and trustworthy. The obligations that the professions attempt to enforce are role obligations that are correlative to the rights of other persons (Beauchamp & Childress 2001, Hodgson 2003). The codes are usually formulated and published by the profession's regulatory body, such as the International Council of Nurses or various national nurses' associations (Davis et al. 2006, Grace 2009). The development of their own codes of ethics is an essential feature of present-day professions (Bandman & Bandman 2002), and particularly an important characteristic of professions that address important social needs such as health care (Grace 2009).

Varying terms are used in referring to codes. They may be called, interchangeably, the codes of ethics, codes of conduct, ethical codes, codes of professional conduct, professional codes, code of deontology, ethical guidelines, or just the codes (e.g. Esterhuizen 1996). It has to be noted here that all names used in the context of the codes do not necessarily refer to codes that have an ethical function. For example, a code of conduct does not necessarily refer to ethics. Regardless of their name, most codes aim at ends with moral character and thus could be defined as codes of ethics.

There are also different kinds of codes related to the activity they were developed for, although in common parlance the codes are often related to the codes of a particular profession. For example, the Declaration of Helsinki (1964), and the Nuremberg Code (1947) are codes which were developed as sets of ethical principles for the medical community regarding human experimentation and related research, and are widely regarded as the cornerstone documents of human research ethics. (Downie & Calman 1994, Thompson et al. 2003.)

Although the Hippocratic Oath (2002) is the predecessor of many codes of ethics of health care professions, there is also a difference between an oath and a code. An oath is a formal, solemn, publicly proclaimed commitment to conduct oneself in certain morally specified ways. Codes are simply enumerations, codifications, or collations of a set of moral precepts. One may or may not swear fidelity to a code. When one does swear solemnly to abide by a specific codification of moral precepts, then the code and oath coincide but do not lose their separate identities. (Horner 1996, Sulmasy 1999.)

Codes are not laws. Laws are concerned with the minimum of what patients are entitled to expect, and dealing with the failures to maintain this minimum. The standard of care required by codes of ethics is more than a need to avoid the danger of litigation. Codes of ethics of health care professions also represent the discipline's promise to society. The moral commitment required by the codes of ethics makes them more demanding than the letter of the law. (Lesser 2003, Välimäki 2008a.) Although codes of ethics are not legally binding, they are influential in shaping practice and setting standards by which nurses will be judged. Breaches of the codes are viewed seriously. For example, a nurse is liable to be struck off the professional register should she/he be found guilty of professional misconduct by breaching the codes. (Rowden 1987, Dimond 1990, Pyne 1992, Grace 2009.) In that sense the codes are sometimes referred to as quasi-laws, because they are likely to be taken into account in disciplinary and complaints proceedings. The codes are a template against which nurses can be judged in the event of a complaint alleging misconduct. Failure to comply with them could be used in legal proceeding. (Hendrick 2000.)

Codes represent normative ethics. Normative ethics is a part of philosophical ethics, which studies ethical norms. Normative ethics seeks an answer to the question: Which general norms are worthy of moral acceptance for the guidance and evaluation of human conduct and for what reasons? The theories of normative ethics express, create and defend moral rules and values. Normative ethics tries to define rules that could be used to guide human conduct. It deals with ideas that people ought to regard as right and wrong, unlike descriptive ethics, which focuses on what people in fact believe to be right and wrong. Thus, normative ethics is prescriptive by its nature. Normative ethics

also differs from meta-ethics, which studies the nature of moral arguments, and from applied ethics which applies normative rules in practice. Moral theories of deontology, consequentialism, and virtue ethics are regarded as normative ethical theories. (Van der Arend 1992, Beauchamp & Childress 2001.) The codes represent a deontological approach to normative ethics (Kalkas & Sarvimäki 1995).

2.1.2. The development of nurses' codes of ethics

The development of nurses' codes of ethics is addressed here from the viewpoint of the historical origins of the Finnish nurses' codes of ethics. The origin of the nurses' codes dates back to Florence Nightingale and to the St. Thomas School of Nursing which she had founded in 1860 in London, England. In her school of nursing Nightingale expected her students to commit themselves to ethical precepts and values which she regarded as important in carrying out professional nursing (Sorvettula 1998, Kuhse & Singer 1999). The next step towards the development of nurses' codes of ethics took place in the United States. In 1893 Lystra Gretter, principal of the Farrand Training School for Nurses at the Harper Hospital of Detroit, Michigan, composed the "The Nightingale Pledge" (Appendix 1) and it was first introduced to nurses in their graduation ceremony in the same year. The Nightingale Pledge (1893) was an adaptation of the Hippocratic Oath (2002) taken by the medical profession (Appendix 2). However, there was no evidence that Florence Nightingale had contributed to the pledge or knew of its content. It was assumed that Lystra Gretter's thought was to add weight to the pledge by using Florence Nightingale's name in the pledge. (Fowler 1999, Thompson et al. 2003.)

The official need for the codes of ethics for nurses was expressed as early as in 1897 in the first constitution of the Nurses' Associate Alumnae in the USA, which is the forerunner of the American Nurses' Association. In 1903, the Nurses' Associate Alumnae stated in their constitution that one aim of the organization was to promote the ethical standards of the nursing profession. However, it took nearly a quarter of a century before the first written version of the codes of ethics was formulated. It was published in the American Journal of Nursing in August, 1926 under the title "Suggested Code". Due to its use of arcane language and the impact of the First World War on peoples' lives and attitudes, the code was regarded as dated and was never adopted. Yet, in 1940 another attempt was made by introducing the "Tentative Code" in the American Journal of Nursing as well, but this code was also rejected, because its content was regarded as unsuitable at the time because it was putting too much emphasis on nursing as a full and legitimate profession (Fowler 1999). The first codes of ethics for nurses called *"Code for Nurses"* was produced and adopted by The American Nurses Association in 1950.

However, the discussion of the need for the codes of ethics was not limited to the USA. During the first half of the 20th century the topic was discussed by professional nursing

organizations throughout the world. The International Council of Nurses (ICN) started the development of its codes of ethics meant for all nurses worldwide in 1923 at The ICN Congress held in Montreal, Canada, but this development work was interrupted by the Second World War. (Quinn 1989, Freitas 1990, Fry & Johnstone 2002.)

Nevertheless, for the ICN Congress held in Sao Paolo, Brazil in 1953, the ICN's Ethics of Nursing Committee had produced a draft of the codes. The draft was accepted in the congress as the first codes for nurses worldwide. The ICN codes of ethics were translated into several languages and distributed to member associations. (Quinn 1989). Thereafter a significant number of national nurses' associations have developed their own codes of ethics for nurses. Many of these codes are adaptations of the ICN codes of ethics, but some national associations have developed their own versions of the codes of ethics. (Fry & Johnstone 2002.) Since the first version of 1953, the ICN codes of ethics has been revised several times in 1965, 1973, 1977, 1989, 2001, and 2006 (Appendix 3).

Since their initial introduction, most codes of ethics for nurses have been further developed and revised. The revisions have reflected the changes within nursing, society, and health care, demonstrating that nursing and nursing ethics do not exist in isolation (Viens 1989, Fowler & Tschudin 2006, Barrazetti et al. 2007). The historical origins of the Finnish nurses' codes of ethics are presented in Table 1.

Table 1. The historical origins of the Finnish nurses' codes of ethics

Year	Development process	Developer	Development process	Location and country
1860	(Introduction of idea)	Florence Nightingale	Students expected to commit themselves to ethical precepts and values	St. Thomas Hospital School of Nursing in London, England
1893	"The Nightingale Pledge"	Lystra Gretter	An adaptation of the Hippocratic Oath	Farrand Training School for Nurses at the Harper Hospital in Detroit, Michigan, USA
1897	(Initial idea)	The Nurses' Associated Alumnae of USA, later The American Nurses Association	Initiated the idea of development of codes of ethics for nurses	USA
1903	(Aim to develop a code)	The Nurses' Associated Alumnae of USA, later The American Nurses Association	The organization stated in its constitution the aim to develop the codes of ethics for nurses; however, the development was interrupted by the First World War	USA
1923	(Start of development of a code)	International Council of Nurses (ICN)	Started the development of codes of ethics for nurses worldwide	The ICN Congress in Montreal, Canada
1926	"A Suggested Code"	The American Nurses Association (ANA)	The first codes of ethics for nurses published in the American Journal of Nursing (AJN) Never adopted for use officially by ANA	USA
1940	"A Tentative Code"	The American Nurses Association (ANA)	Published in the American Journal of Nursing (AJN) Never adopted for use officially by ANA	USA
1950	"Code for Nurses"	The American Nurses Association (ANA)	The first national codes of ethics for nurses. A substantive revision from the "Tentative Code"	USA
1953	"Draft for Nurses' Codes of Ethics"	The ICN's Ethics of Nursing Committee	A draft for nurses' codes of ethics accepted as the first codes of ethics worldwide	The ICN Congress in Sao Paolo, Brazil
1965, 1973, 1977, 1989, 2000, 2006	"The Code of Ethics for Nurses"	ICN	Revised versions of the 1953 version of the ICN Code. The name revised in 2000 to "The Code of Ethics for Nurses"	Geneva, Switzerland
1953	"International Ethical Guidelines", later "Nurses' Ethical Guidelines"	The Finnish Nurses Association	A translation from the 1953 ICN Code	Finland
1973	"The Ethical Guidelines of Nursing"	The Finnish Nurses Association	An adaptation of the 1973 version of The ICN Code	Finland
1996	"The Ethical Guidelines of Nursing"	The Finnish Nurses Association	A revision of The Finnish Nurses Association's 1973 version of "The Ethical Guidelines of Nursing"	Finland
2002	"Principles of Health Care Ethics"	The National Advisory Board on Health Care and Ethics (ETENE)	A compilation of common principles for all health care professions	Finland

2.1.3. The structure of the contents of nurses' codes of ethics

In most countries around the world, nurses' codes of ethics are based on earlier or more recent versions of the International Council of Nurses' (ICN) Code of Ethics for Nurses. Thereafter the codes have been adapted to the nursing context of each particular country. Some countries have adopted the ICN Code as such. Thus, the ICN Code of Ethics for Nurses acts as a commonly accepted ethical framework for nurses throughout the world (Fry & Johnstone 2002), but the differences in national characteristics such as culture, religion, care culture, health policy, and legislation have indicated that also the nurses' national codes of ethics are needed. (Esterhuizen 1996, Meulenbergs et al. 2004).

The ICN Code is composed of the preamble and essential aspects of nursing practice that are grouped under four main elements. Some national codes have included a document providing interpretative statements to ease nurses' understanding and applicability of the codes (e.g. the American Nurses' Association 2001). The preamble of the ICN Code states the fundamental responsibilities of the nurse as promoting health, preventing illness, restoring health and alleviating suffering. It also states the essential ethical values and human rights inherent in nursing and to whom the nurse is to provide nursing care. The four main elements of the code deal with the nurse's professional relations: 1. *Nurses and people* concerns the nurses' relation to people needing nursing care, 2. *Nurses and practice* concerns the nurse's relation to ethical standards in nursing practice, 3. *Nurses and the profession* concerns the nurse's relation to implementing standards of nursing practice as a professional group, and 4. *Nurses and co-workers* concern the nurse's professional conduct in relation to other health care workers. (Fry & Johnstone 2002.) The focus of the ICN code and ICN-based codes is on four fundamental responsibilities: to promote health, to prevent illness, to restore health and to alleviate suffering. This emphasis forms the red thread of the codes. The patient is the central focus of the nurse's work. (ICN 2006, Butts & Rich 2008.)

However, very few studies have focused directly on the general content of nurses' codes. A study comparing several national nurses' codes indicated that the most commonly agreed themes were the nurse's practice competence, good relations with co-workers, respect for the life and dignity of the patient, as well as confidentiality and commitment to non-discrimination of the patients. (Sawyer 1989.) A more recent study (Dobrowolska et al. 2007) compared four national nurses' codes aiming at identifying the moral duties and obligations included in these codes. The most essential moral duties and obligations were respect for humans, right to knowledge and informed consent, confidentiality, professional competence, cooperation with others and maintenance of professional standards and prestige. The first priority was the patient and his rights. However, the emphasis of each obligation varied between the codes. Meulenbergs et al. (2004) concluded in their literature review that for the codes to be relevant to nurses in modern

health care, they have to be developed to enhance the moral goal of nursing practice, instead of focusing on professionalism or protecting nurses against external influences.

Nurses' codes also address all levels of nursing care (Table 2). Nursing that takes place in nurse-patient relationships is micro-level nursing care. Nursing discussed as a professional action is meso- level nursing care, and nursing discussed from the social perspective is macro-level nursing care. (Heikkinen & Leino-Kilpi 2010.)

Table 2. Nurses' codes and levels of nursing care

Level of nursing care	Content of the code
Micro/Nurse/Patient	Nurses and patients
	The work and professional competence of nurses
	Nurses and their colleagues
Meso/Professional	Nursing and the nursing profession
Macro/Social	The mission of nurses
	Nurses and society

Based on their content, nurses' codes of ethics are normative documents in that they provide moral standards of how nurses should behave, i.e. what is right and wrong conduct or practice in nursing, (Van der Arend 1992, Repo 2009). These claims are presented in the form of moral obligations and consequent duties. The obligations inherent in the codes are related to the nurse's professional role and they are correlative with the rights of other persons, e.g. patients. (Beauchamp & Childress 2001.)

Bandman & Bandman (2002) describe eleven obligations of the nurses' codes. These concern the nurse's professional competence, malpractice, exercise of informed judgement, responsibility and accountability, respect for human dignity, and respect for privacy. Furthermore, the obligations concern the nurse's contribution to the development of nursing knowledge, improvement of standards of nursing, maintenance of high quality nursing care, maintenance of integrity in nursing, and collaboration with members of other health care professions to meet the health needs of the public. These obligations concern the nurse's clinical and professional practice, and nurses' self-care and self-development. Nurses' respect of patients' dignity and autonomy, nurses' accountability and good judgement, and working within standards of practice refer to clinical practice. Maintaining authenticity in all professional relationships and avoidance of impaired practices (e.g., breaching of the confidentiality or privacy of the patient) refer to professional practice, whereas commitment to professional and moral growth, contributing to the advancement of nursing knowledge, collaboration with other health care professionals and the public, and promoting sound practices refer to self-care and self-development. The obligations of the codes include essential professional moral

values such as integrity, honesty, compassion, veracity, fidelity, advocacy, and care, all of which are distinctly moral in nature. Some values of the codes could also be categorized as virtues, e.g. compassion. (Fry & Johnstone 2002.)

2.1.4. The ethical concepts embedded in nurses' codes of ethics

Nurses' codes of ethics include several ethical concepts. The essential ethical concepts enshrined in the codes are beneficence, non-maleficence, autonomy, justice, patients' rights, privacy, truth-telling, veracity, fidelity, confidentiality, responsibility/ accountability, duty, and sanctity of life. (Fry & Johnstone 2002, Beauchamp & Childress 2001, ICN 2006.) These concepts are regarded central in health care in general, and are consequently reflected in nurses' codes (ETENE 2002b).

The concepts are expressed in the codes either explicitly or implicitly. Also, the emphasis of each concept may vary between national codes of ethics. For example, the Finnish Ethical Guidelines for Nursing (The Finnish Nurses Association 1996) do not explicitly bring forward the concept concerning patients' rights. The most likely explanation for this is that patients' rights are already very strongly regulated by law in Finland (The Act on the Status and Rights of the Patient 1992). The essential ethical concepts are presented in Table 3.

Table 3. Ethical concepts embedded in nurses' codes of ethics*

- *Autonomy/Self-determination is a duty to respect a human being's right and ability to freely determine about matters concerning her/himself based on her/his wishes and values.*
- *Non-maleficence is the prevention of harm and the removal of harmful conditions.*
- *Beneficence is the moral obligation to act for the benefit of another.*
- *Justice is a duty to treat people as equal without discriminating them on morally untenable justifications (e.g. age, sex) and a duty to aim at distributing existing resources equally.*
- *Patients' rights are both legal and moral rights. They include the right to good care, to access to care, to knowledge, and to self-determination, the right to complain about malpractice, and the right to confidentiality.*
- *Privacy is the right to physical safety based on respect of human self-determination, and the duty to confidentiality of patient information.*
- *Truth-telling is a duty to honesty based on the respect of a human being and his/her self- determination, and the respect of confidentiality of the care relationship.*
- *Confidentiality is a duty not to disclose information concerning another human being without his/her consent to such parties that this information does not concern.*
- *Duty is action regarded as right, which can be demanded from an individual based either on legal or moral justifications.*
- *Sanctity of life is a duty to sustain human life based on the idea that destruction of human life is morally wrong.*
- *Responsibility/Accountability is a human being's responsibility for his/her own actions, including the responsibility for a deed and the responsibility to a person who was the object of the deed, so called human responsibility and task responsibility.*

*Based on the national codes of Finland 1996, ANA 2001, ICN 2006, NMC 2009

Many of these principles and concepts alone have been the focus of nursing research or theoretical discussion. In some studies and articles the presence of the principle or concept in the codes has been referred. The interest of the research has been on education (e.g. Välimäki et al. 2008), participants' experiences and perceptions (e.g. Proot et al. 2002, Redman & Fry 2003, Deshefy-Longhi et al. 2004, Malcolm 2005, Hilden & Honkasalo 2006*,* Joolaee et al. 2006, Barnoy & Tabak 2007, Välimäki et al. 2008), awareness (e.g. Woogara 2004), knowledge (e.g Zülficar & Ulosoy 2001), or action (e.g. Woogara 2005, Heikkinen et al. 2007) in relation to the concept in question. These studies have been carried out in various nursing and cultural contexts. (e.g. Van Thiel & Delden 2001, Hanssen 2004, Kanerva 2006, Teeri 2007, Nyrhinen et al. 2007, Vaartio 2008). In Dobrowolska et al. (2007), the identified duties and obligations in the codes were respect for humans, right to knowledge and informed consent, confidentiality, professional competence, cooperation with others, and maintaining professional standards and professional prestige. The emphasis of each obligation varies between the codes. The first priority is the patient and his rights.

Theoretical articles have dealt with concept clarification (e.g. Wiens 1993, Wade 1999, Milton 2008), literature review (Moser et al. 2007), relationships between concepts (e.g. Woogara 2001, Hyland 2002), discussing concepts in different nursing contexts (e.g. Easley & Allen 2007, Dickens & Sugarman 2008), and care situations (e.g. Zanchetta & Moura 2006, Cutcliffe & Links 2008), and in their relation to ethical theory or legislation (e.g. Vivian 2006, Begley 2008, Hodkinson 2008). Discussion has focused also on the problems and possibilities, and the implications of the principles and concepts in relation to nursing (e.g. Sim 1995, Austin 2001).

2.1.5. The functions of nurses' codes of ethics

Ethical literature describes the codes of ethics to have several functions, which can be approached from different viewpoints (Table 4). In many nursing texts the functions of the codes are addressed on a very general level. For example, the codes guide nursing practice and help nurses' in their ethical decision-making, or they help nurses to provide care toward the health and the well-being of the patient. (Fry & Johnstone 2002). Sometimes the functions of the codes are described in the context of a particular nursing area to which the codes may offer help, for example oncology or perioperative nursing (Beck et al. 1993, Scanlon & Glover 1995, Berlandi 2002). These are, of course, relevant ways to refer to the functions in relation to the focus of these texts. However, an analysis of the codes and literature indicates that the codes serve several functions, and the analysis has helped to uncover and categorize both the explicit and implicit functions inherent in the codes.

Table 4. Approaches to the functions of the codes

In relation to the nurse's work	*In relation to the aim*	*In relation to the profession*	*In relation to morality*
Professional	Guide	Internal	Quasi-moral
Social	Regulate	External	Moral
Practical	Discipline	Internal and external	Non-moral
Ethical	Protect		
Legal	Inform		Overt
Duty	Proclaim		Covert
Educational	Negotiate		

Meulenbergs et al. (2004) describe the functions of the codes as quasi-moral, moral or non-moral based on the objectives of the codes. The relation of quasi-moral functions to the moral objectives is indirect. Examples of quasi-moral functions are the use of the codes to establish disciplinary systems or using them as a socialization process, such as the taking of an oath. In both cases increasing conformity to the codes regarded as a moral function is sought by enforcing rigid rules and sanctions, and stimulating professional loyalty by taking an oath. Thus, the moral function of conformity is achieved through quasi-moral functions of discipline and socialization. Typical non-moral functions are those that serve some other goals than a profession's moral qualities. An example of a non-moral function is using the codes to aspire the status of a profession as has been the case with nursing. (Shailer 1996, Meulenbergs et al. 2004.)

Shailer (1996) speaks about overt and covert functions of the codes of ethics broadly following the same chain of thought as Meulenbergs et al. (2004). Overt functions are such as to provide moral guidance for professional conduct, to contain principles that reflect agreed standards of a profession, to function as a public statement of ethical principles agreed by members of the professional group, and to inform others what to expect through the professional service. Although the codes have no legal status, they are used as a benchmark of good practice both in daily practice and by bodies responsible for professional conduct. Thus, overt functions of the codes seem to focus on altruistic enhancement of human good. Purposes that enhance some other goal than human good or do it indirectly are covert functions of the codes. As examples of covert functions Shailer (1996) mentions enhancement of professional status, claiming of professional autonomy, and the function of the codes as a disciplinary measure.

Functions of the codes can be defined as external or internal or both by their nature. External functions describe the nursing profession's position towards society. Internal functions define the professional's position within the profession. Some functions have both internal and external qualities. Bandman & Bandman (2002) describe four ways to how the codes of ethics function as the basis of professional status in nursing. First, the codes show society that nurses should understand and accept the trust and responsibility invested in them by the public (external). Secondly, the codes define the

nurse's relationship to the patient as one of patient advocate, to other health professionals as a colleague, to nursing profession as a contributor, and to society as a representative of health care for all (external and internal). Thirdly, the codes provide guidelines for professional conduct for ethical practice and holds nurses accountable for professionally acceptable standards of nursing care (internal). And finally, the codes provide the means of self-regulation to the profession (internal).

Hussey (1996) categorizes nurses' codes (UKCC 1992) into seven significant functions that the codes might fulfil. The codes serve as *guidance* to professionals in their work. The codes *regulate* professionals by prescribing their moral responsibilities, standards of moral behaviour and values. The codes *discipline* the professionals by identifying the transgressions of the code and justifying the sanction. The codes *protect* the public and the patients. The codes *inform* the patients, colleagues, employers and society about the standards of the profession thus promoting confidence and trust. The codes *proclaim* the status of a profession by accompanied moral autonomy and responsibility. And finally, the codes serve as a tool for *negotiation* in disputes by explaining or justifying a stance or course of action and as such the codes act as a tool of protection for the profession concerned. However, the significance of each function is a rather complex matter, since all of these functions can justify the existence of the codes, and the codes can be criticized if they fall short of them, but all of the functions may not be as good as they are intended to be (e.g. disciplinary function), and that problems may also arise when the functions conflict with each other. (Hussey 1996.)

Based on the analysis of the codes and literature, the following seven functions of the codes can be identified. The task of the *professional function* is to state and promote the nurse's professional position in society by providing nurses with certain rights and responsibilities (Viens 1989, Bandman & Bandman 2002). The codes describe the fundamentals of the nurse's professional behaviour, and inform members of the profession's values and ideals. In their professional function the codes also provide a framework and support to nurses in their professional practice, and protection both to patients as well as to professionals in their care relationships. The codes guide nurses in the development of their professional thinking and ethical decision-making. The codes regulate the mutual relationships within the profession and strengthen professional solidarity by sharing the common codes. (Erlen 1993, Limentani 1999, Scanlon 2000.)

The *social function* describes the relationship between the profession and society. The codes express the nurse's basic task in society. The codes are a means of articulating the covenant relationship of trust between the profession and society. They serve to inform the nurse and society what is expected and required from the profession in ethical matters, informing about the nurses' professional responsibility and accountability. The codes are a public statement, which informs society of the things, values and goals that

are held important by nurses. (Dunn 1994, Scanlon & Glover 1995, Donnelly 2000, Bandman & Bandman 2002.)

The *practical function* of the codes provides ethical guidelines, principles and values for the profession as it delivers care in practice. The codes set the standards of ethical nursing practice by describing the general attitudes and expected forms of moral conduct. The codes also provide nurses with a framework for ethical decision-making in practice. (Twomey 1989, Hall 1990, Limentani 1998, Limentani 1999, Scanlon 2000, Bandman & Bandman 2002, Välimäki 2008a.)

The *ethical function* of the codes expresses the moral values and ideals of the profession to which the professional group commits itself. The codes are a statement of a common ethic of a profession, and indicate what is right and wrong in carrying out nursing care. The core values of the codes are caring of patients by promoting the welfare of the patient and avoiding doing harm. The codes assist nurses in examining the ethics of their encounters with patients and guide their actions. (Davis 1985, Woodruff 1985, Viens 1989, Quinn 1990, Benjamin & Curtis 1992, Chapell 1995, Sellman 1996, Hamric 1999, Scanlon & Glover 1995, Scanlon 2000, Berlandi 2002, Nogueras 2002, Arraf et al. 2004, Välimäki 2008a.)

The *legal function* of the codes is to act as criteria in assessing professional misconduct. Although the codes do not have a status of law, breaching the codes may lead to legal sanctions. The codes also protect nurses against legal responsibilities in cases of possible misconduct or malpractice. The codes act as a medium of professional self-regulation. (Shailer 1996, Bandman & Bandman 2002.)

The *duty function* expresses the obligations that nurses must fulfil. The codes are a form of normative and prescriptive ethics. The codes delineate the general ethical obligations that must be taken into account in professional practice, what nurses morally, ethically or legally ought or ought not to do. Nurses' obligations are both moral and non-moral by nature. According to the codes, nurses have obligations in relation to other nurses, patients and their kin, to the general public, to themselves, to their dependants and to their employees. (Davis 1991, Hunt 1992, Van der Arend 1992, Namei et al. 1993, Edwards 1996, Hunt 1997b, Scott 1998, Hamric 1999, Dimond 2002, Nogueras 2002.)

The *educational function* supports nurse educators, clinical instructors and students by expressing the standards of quality nursing care. The codes provide for educators, clinical instructors and students a tool to illustrate their opinions and actions concerning nursing care and nursing practice, and help them to recognize their own as well as their patients' values. The codes guide the development of nursing curricula by describing the criteria of ethically high quality care. (Numminen 2000, Männistö 2001, Bandman & Bandman 2002.)

Research on the functions of nurses' codes has been scarce. According to Meulenbergs et al. (2004), due to dominance of economics, legalization of health care environments and the multidisciplinary nature of the nursing profession, the emphasis in the codes' functions has to change to suit modern health care. The codes should focus more on moral aspects of nursing instead of on professionalism or acting as a disciplinary measure. The codes should also be closely integrated to nurse education. According to nurses' views, the codes could fill several functions such as supporting professional identity and status, clarifying nurses' responsibilities, providing professional standards, giving confidence and security, supporting nurses in their relationships with patients, and guiding professional practice. In content, attention should be paid to the nurse's personality and to the relational nature of nursing as well as to the function as a disciplinary measure. Development of the codes should be nurse-based, practical, clear and continuous, and be disseminated in education, practice, and management, and be known to society and the media. The codes are an important content of nursing education. (Verpeet et al. 2005, Tadd et al. 2006, Verpeet et al. 2006, Heymans et al. 2007.) The codes had a significant impact on nurses' views on professional autonomy and responsibility, and on bringing to attention the moral nature of nursing and the codes' function as a guideline (Barrazetti et al. 2007).

2.1.6. Laws and agreements and nurses' codes of ethics

There is a close association between the law and ethics in health care. Both can be regarded as forms of social control, which provide rules, principles and standards concerning permitted and prohibited behaviour (Farrar & Dugdale 1990). Law is a way to institutionalize morality. Law is concerned whether a deed complies with legislation, whereas morality is concerned with whether a deed complies with moral values and principles (Kalkas & Sarvimäki 1995, Lesser 2003).

The practical difference between codes and legislation lies in the form of sanctioning, in cases of breaching of the codes or breaching the law. In serious cases of breaching the codes, the regulatory body of the profession (e.g. National Nurses Association) may give the offender an official warning or in more grievous cases cancel the professional licence to practice nursing. The consequence of breaching the law always results in a legal sanction. However, a serious breaching of the codes may also meet the conditions of breaking the law and result in legal procedure. Thus, the appeal to the codes does not necessarily protect from litigation. (Fletcher et al. 1995.) The law provides a means of holding professionals publicly accountable, and as an impartial institution it limits the potential impartiality based on professional self-regulation inherent in the codes. (Thompson & al. 2003). Both the law and ethics have had an impact on the formulation of most codes of ethics (Hendrick 2000). Consequently, many national and international laws and agreements are also closely related to nurses' codes of ethics. First, various

laws and agreements refer to the same ethical concepts or moral commitments as do the codes. For example, most national nurses' codes include statements concerning patients' rights, but in many cases patients' rights or human rights in general are also regulated by national or international legislation. Second, in the same way that nurses' codes include statements concerning professional competence and professional responsibilities, these issues are also regulated by legislation. Moreover, nurses may encounter ethical situations where acting according to the moral commitments of codes may conflict with legislation (Lesser 2003), e.g. in issues concerning end-of-life decisions. Ethical concepts embedded in the Finnish Ethical Guidelines of Nursing (1996) are also manifested in central national and international legislation relevant to health care. Essential legislation is presented in Table 5.

Table 5. Finnish and international legislation relevant to health care

United Nations' Universal Declaration of Human Rights 1948
European Convention of Human Rights 439/1990
United Nations' Convention on the Rights of the Child 1989
The Constitution of Finland 731/1999
Act on the Status and Rights of the Patients 785/1992
Primary Health Care Act 66/1972
Patient Injury Act 585/1986
Mental Health Act 1116/1990
Medical Research Act 488/1999
Act of National Authority for Medicolegal Affairs 1074/1992
Act on the Protection of Privacy in Electronic Communications 516/2004
Act on Health Care Professionals 559/1994

2.1.7. The limitations of professional codes of ethics

An analysis of the codes of ethics has revealed a number of their limitations. The limitations described in the following paragraphs deal with the codes of ethics of health care professions in general and are applicable to nursing codes as well. The summary of the limitations is presented in Table 6.

Table 6. Summary of the limitations of the codes

	Limitations	Justification
1	Weaknesses in philosophical foundations	Argumentation from authority Arbitrary choice of values
2	Normative and prescriptive nature of the codes	Morality is more than following a set of rules. "Given values" neglecting profession's own values.
3	The prominence of disciplinary function	May provoke fear and anxiety rather than empower.
4	The exceedingly demanding nature of the codes	Expect nurses to perform supererogatory acts.
5	The generality, abstractness, and ideal of nature of the codes, or too specific nature of the codes	Open to wide interpretation – risk of moral relativism. Do not provide support in specific situations of daily practice As a "top-down" set of rules undervalue contextual factors in moral situations. Inflexible set of rules hindering further ethical reasoning.
6	Poor applicability to practice	The demands of modern heath care context – new unprecedented ethical issues, pluralistic multi-cultural society.
7	Self-serving nature of the codes	Serve professional interests rather than reflect moral view point - e.g. enhancement of professional status. The codes are a unilaterally proclaimed document while they should be a contract between the health care professionals, society and the patients to have moral weight.
8	Misuse of the codes	Protection of colleagues in cases of malpractice.
9	Impact on moral behaviour	Uncritical acceptance of the codes. The codes do not necessarily improve moral behaviour

For a long time, the codes of ethics in health professions were the only source of argument in assessing good or bad, right or wrong professional conduct, and the codes still continue to set the standards of ethical conduct to the most health professionals and laymen alike. However, from the beginning of the era of medical ethics the codes as the only source of argumentation has been challenged. (Pellegrino 2002.)

First, the codes are criticized for weaknesses in their philosophical foundations. The codes are regarded as self-evident without justification. They are taken to be *prima-facie,* self-justifying obligations. Justification based on the codes is argumentation from authority, which philosophically is regarded as the weakest form of argumentation. Any argument from authority, to be valid and effective, has to establish the qualifications of the authority, whether a person, institution, or tradition. Moreover, the authority must be free of conflicts of interest and use expertise in the right circumstances and in the right field of inquiry. Consequently, to fulfil these prerequisites any code of ethics today is under attack. Not until recently have the codes been subjected to justification through ethical argumentation. (Pellegrino 2002.) Therefore anyone who intends to use the codes has to decide whether a code is simply a social construct without any intrinsic claim to moral authority, whether it has a claim to authority that is only transient and subject to change in response to social preferences, or whether the moral authority of the codes rests in their being stable reflections of moral obligations rooted in the nature of the profession itself, e.g. nursing. (Hussey 1996, Pellegrino 2002.) Moreover, the codes are criticized

for the arbitrary choice of their values and principles. Also the use of terms is confusing, e.g. what is meant by ethics. For this reason the codes do little to develop or support active, independent, critical judgement and discernment associated with good moral judgement and professionalism. On the contrary the codes may engender confusion, passivity, apathy and even immorality. (Pattison 2001, Pattison & Wainwright 2010.)

Second, the normative nature of the codes has provoked critical discussion. Accordingly the problem of most codes is that they present themselves as a set of rules. However, morality is something more than following mere rules, and the codes should not be used by following them literally. (Hussey 1996, Hunt 1997b.) The codes' prescriptive nature may foster a "cookbook" approach to ethics. The codes have also been regarded as something different from the rest of ethics, i.e. the codes are "given" to professionals neglecting the meaning of professionals' own values. Historically, nurses' codes have their roots in medical ethics and therefore in principles of beneficence and non-maleficence. An approach based on principles neglects the personal commitment to human beings, and the meaning of attitudes, emotions and feelings. (Downie & Calman 1994, Thompson 2002.)

Many authors point out that the codes are an example of rules that are not enough, but need supplementary knowledge of ethics to overcome the shortcomings of the codes. The codes lay down general principles but cannot advise on their interpretation, for example explain how to decide between conflicting principles, or when they should be disregarded in favour of another kind of argumentation. Breaking the codes based on deliberation may produce a higher degree of morality. Moral deliberation needs uncertainty, not abiding strictly to the codes. (Esterhuizen 1996, Hussey 1996, Seedhouse 1998).

Third, due to their normative and prescriptive nature the disciplinary function of the codes becomes prominent. Although the codes of ethics are not legally binding, they are nonetheless influential in shaping practice and setting standards by which nurses will be judged. In that sense they arguably have the same status as law. As mentioned earlier, the codes could be thus referred to as "quasi-laws" and used in disciplinary and complaints proceedings. Failure to comply with them could also be used in legal proceedings. (Hendrick 2000.) Through their strong quasi-legal nature, the codes (e.g. UKCC 1992) discipline nurses rather than empower them to deliberate ethics (Pattison 2001). According to Esterhuizen (1996) and Scott (1998) in some countries the codes are interpreted in a literal and normative way which entails fear and sanction and do not reflect professionalism or autonomy. It forces nurses to disguise their errors. Thus, the codes' disciplinary function may intimidate nurses. This anxiety should be alleviated by teaching the codes and familiarizing students with the codes. (Pask 1994.) Van der Arend (1992) points out that given an adequate judicial system, the codes as a purely normative

document are unnecessary for use as a disciplinary measure, and questions their value in clinical practice.

Fourth, the codes are criticized for being too demanding for nurses by setting the professional standards too high. Edwards (1996) states that the codes, referring to the UKCC (1992) code, require nurses to perform supererogatory acts, i.e. to act in a way that supercedes ordinary moral obligations. However, the codes don't offer any support network in fulfilling the supererogatory obligations (Tadd 1994**).** For example, nurses who would like to report malpractice refrain from whistle-blowing in fear of harm to themselves. Codes may not be effective without better support for whistle-blowers without which the self-regulating function of the codes becomes a mockery. (Tadd 1994.)

Another example of supererogatory standards of the codes is nurses' accountability. Accountability of nurses is not dependant of the existence of the codes, as their accountability can be regulated by other statutory bodies. Besides, nurses are not always in positions which give them authority to be accountable. Nurses are accountable and autonomous in some tasks related to their jobs but not in all tasks. The codes do not take into account the various degrees of autonomy and accountability (Tadd 1994, Tadd & Pyne 1995). According to Beauchamp & Childress (2001) some professional codes claim more completeness and authority than they are entitled to claim or oversimplify moral requirements. As a consequence the professionals may mistakenly suppose that they satisfy all moral requirements if they obediently follow the rules of the code, just as many people believe that they discharge their moral obligations when they meet all relevant legal requirements. The pertinent question is whether the codes are comprehensive, coherent, and plausible in their moral norms without justification of their choice over other norms and principles, i.e. in their incompleteness and lack of justification.

Fifth, the codes are criticized for being too general, abstract and idealistic by nature (Hussey 1990, Hunt 1992, Hussey 1996, Pattison 2001, Thompson 2002, Heikkinen et al. 2006). Consequently the codes are open to wide interpretation or they do not apply in specific situations for their general nature. This may lead to use of one's own moral judgement. According to Pattison (2001) "Naïve, instinctive, untutored, commonsense moral judgement, which may be no more than a set of unexamined prejudices and assumptions, cannot be the answer to helping professionals to behave in an ethically aware and responsive way". The codes also ignore the professionals' experience which the professionals bring along and have developed within their social life, as if professional life was altogether different from ordinary life. Blind following of the codes may even lead to unethical behaviour. (Hussey 1990, Seedhouse 1998, Pattison 2001.) The discrepancy between the abstract codes and the reality of nursing practice may also create a burden for nurses. The generality and vagueness of the codes can also mislead

and misinform the public (Hunt 1992). The codes are created from a top-down basis and may distance the practitioners by neglecting the real situation constraints (Thompson 2002). However, Benjamin & Curtis (1992) state that to be simple, comprehensive and consistent enough, and acceptable to all nurses and cover all areas of nursing, the codes have to be abstract and general, but as a consequence causes varying interpretations in application in practice.

The codes are also criticized for their being too specific which makes them an inflexible list of do's and don'ts and hinder further ethical reasoning (Hussey 1996). Moreover, specific rules always lack guidance if new cases occur (Seedhouse 1998).

Sixth, partly as a consequence of their generality and abstractness the codes are criticized for their poor applicability to practice (Pattison 2001, Thompson et al. 2003). The codes do not give practical guidance in matters of general morality or on the special issues thrown up by professional duties (Downie & Calman 1994). The codes set out ideals and the general rights, duties, values and policies which should govern the professional practice and describe a common ethical context for heath care, but they are of limited use in solving new and complex ethical problems. The codes provide a clear and comprehensive document for further discussion. The codes and principles and their limitations make us understand that moral discussion could be broadened to include personal sensitivity and other issues that can be relevant in making ethical decisions. (Limentani 1998, Limentani 1999, Thompson et al. 2003.) Moreover, the values of the codes may not apply in a pluralistic multicultural society. There is a need of balancing the demands of the clients with the standards of a profession. The answer to this should not be to create increasingly vague and flexible codes. On the other hand the misuse of the codes by justifying professional monopolies is a danger. (Downie & Calman 1994, Hussey 1996.) Shailer (1996) states that the knowledge base of the emerging professions, such as nursing, is not highly developed and therefore their codes are criticized for the vagueness of their values which causes difficulties in their application to practice (Shailer 1996). Although the codes do no harm, they may prevent further discussion to improve ethical nursing care (Tadd 1994). Codes are too outdated to carry moral authority in the modern health care context (Sugarman 1994).

Seventh, several authors point out the self-serving nature of the codes. Codes may have been developed for the interest of professional groups for their own protection rather than to reflect the impartial and comprehensive moral viewpoint (Beauchamp & Childress 2001). Berlant (1975) speaks about the codes as the creed to monopolize the healing arts. The codes are not made sufficiently available to the general public, i.e. the patients who enjoy the nursing care, but rather to nurses themselves (Benjamin & Curtis 1992, Tadd 1994). Hence, the values of the codes may differ from the values of the patients (Downie & Calman 1994). In another words the codes do not speak to the client, but the carer

has the power over a vulnerable client (Thompson 2002). The codes are unilaterally proclaimed whereas they should be a contract negotiated between individual patients, society, and health professionals to have moral weight. The codes serve professional collective self-preservation, control, conformity and obedience, rather than ethical awareness and behaviour (Pattison 2001, Pellegrino 2002).

According to Bandman & Bandman (2002) the vested interests of the codes depend on the functions that the codes have been developed to serve. Nurses' codes put patients' interests and rights first before nurses' own interests. The natural explanation to this is that both the patients and the nurses are undervalued and underserved groups.

Shailer (1996) speaks of the covert purposes of the codes. Referring to emerging professions, such as nursing, she mentions enhancement of professional status, professionalizing aspiring professions, promotion of the professionals' own interests and promotion of professional disciplinary functions. In their search for status these professions muster support from the public by publishing information about standards and service. According to Shailer (1996) the codes in enhancing professional status appeal to four myths: The myth of independence with associated autonomy, the myth of the altruistic motives of professionals, the myth of peer review, and the myth of professional wisdom. Consequently the codes may 1) include claims that cannot be upheld, i.e. nurses' autonomy and accountability vs. doctors' autonomy and accountability, 2) include discrepancies between personal moral and professional accountability and accountability to the organization and other professions, i.e. whistle-blowing, and 3) the codes can be used punitively in threatening disciplinary action. Many codes are exclusively too profession-specific. Nurses' codes are obliging to nurses but not necessarily to other professionals involved. Health care is best delivered in teams. (Benjamin & Curtis 1992, Downie & Calman 1994.)

Eighth, the codes also give way to their misuse although their moral authority is accepted. For example, the codes are used as a professional prerogative such as restricting the exercise of a legitimate technical expertise by members of some other profession or that the codes provide for a group of professionals (e.g. doctors or nurses) the moral leadership of health team. The codes are interpreted legalistically. Claiming knowledge of the codes makes teaching of other ethics unnecessary. The codes are used to enhance elitism, sexism or the guild mentality. The codes are used to emphasize professionals' manners and style "etiquette", e.g. protecting the reputation of the profession in safeguarding an impaired colleague, and the codes are used to ridicule the profession. Abuse and violation of the codes does not vitiate the codes themselves. (Pellegrino 2002.)

And finally, the last criticism focuses on the codes' impact on morality and moral behaviour. The codes' beneficence to patients and therefore the codes' existence

have been accepted uncritically. Their existence does not necessarily improve nurses' ethical behaviour. The codes do not automatically increase moral awareness and better care, nor do they guarantee absolute ethical conduct by health care professionals. (Johnstone 1987, Tadd 1994, Tadd & Pyne 1995.) The codes have not made nurses or doctors virtuous (Pellegrino 2002). Even the claim that the codes are not needed at all has been suggested, because the codes are not the only document that reflect nurses' values, norms and responsibilities. Other documents can also set out professional nursing ethics, and replace the codes and the functions of the codes (Verpeet et al. 2003).

Due to the limitations of the codes, additional education in ethics is needed to overcome the shortcomings of the codes. For example, the codes do not help nurses in recognizing ethical problems. (Hussey 1990.) The statements of the codes may prove controversial and therefore their use requires a considerable amount of supporting argument (Hussey 1996). According to Benjamin & Curtis (1992) the problem with the codes is that the codes cannot alone answer the moral question: "What, *all things considered*, ought to be done in a given situation?" Additional ethical knowledge is needed, such as knowledge of identification of moral issues, ethical reasoning, ethical principles and the decision-making process.

2.1.8. The Finnish Nurses Association's codes of ethics

The Finnish nurses' codes of ethics officially the Ethical Guidelines of Nursing (Appendix 4) issued by The Finnish Nurses Association (1996) start with an introductory sentence stating the aim of the guidelines, mission of the nurse, and the quarters that the codes are to inform. Thereafter the essential aspects of ethical nursing practice are grouped under six major headings: 1) The mission of nurses; 2) Nurses and patients; 3) The work and professional competence of nurses; 4) Nurses and their colleagues; 5) Nurses and society; and 6) Nurses and the nursing profession.

The aim of the guidelines is to provide support for nurses' daily ethical decision-making and to inform society of the general principles of nursing and the mission of nurses in society.

The mission of nurses defines the nurse's essential tasks in society as obligations to promote and maintain health, to prevent illness and to alleviate suffering. These tasks concern all the population, all age groups and all care situations. The nurse also supports individuals' personal resources and aims to improve their quality of life.

In the nurse-patient relationship the emphasis is on the nurse's personal responsibility for her actions to the patient, on protection of human life and improvement of the well-being of the patient. The nurse respects the patient as a valuable human being, his/her

autonomy and self-determination, and commits to confidentiality regarding patient information. The nurse treats the patient as a fellow human being, basing the relationship on mutual trust and openness. The nurse exercises impartiality in her work treating her patients as equal human beings.

Regarding *the work and competence of nurses* the guidelines highlight the nurse's personal responsibility concerning her work and continuous development of professional competence. This obligation to provide and maintain competent care is a joint responsibility of nurses.

The nurse's relationship with colleagues emphasises mutual support and professional respect, maintenance of professional competence and development, and the common obligation to maintain ethical standards in patient care.

Nurses' relation with society addresses nursing at community, national and international levels. At the community and national levels the nurse is obligated to participate in discussion and decision-making concerning the health, quality of life and well-being of people, to collaborate with patients' families or their significant others, encouraging their participation in care. The aim is in empowering people in issues concerning health. The nurse also cooperates with relevant health and patient organizations. At the international level the nurse is obligated to participate in the work of international health organizations sharing knowledge and skills. At the global level the nurse bears responsibility for the development of living conditions concerning health, and her duty is to promote equality, tolerance and joint responsibility.

The guidelines obligate the *nursing profession* to accomplish its tasks in a dignified manner. The profession supports the ethical development of its members and commits to maintaining the humane nature of nursing care. The profession looks after the well-being of its members and through professional organization secures just social and economic working conditions for its members. The nurse is responsible for the expertise of the profession, active development of the professional scientific knowledge base, and enhancement of education in order to improve the well-being of the population.

2.2. Nurse education and teaching of ethics in Finland

This section starts with a description of the structure of current Finnish nurse education. Thereafter practices in teaching of ethics are addressed.

2.2.1. The structure of Finnish nurse education

Nurse education in Finland is provided by polytechnics and universities. Development of polytechnic education was started in 1991 (The Act 391/1991, The Decree 392/1991). First, nine polytechnics were made permanent in 1996, and in 2000 the permanent status was granted to all 29 polytechnics, replacing previous college-level basic nursing education. University education in nursing started in 1989. A total of 25 polytechnics and five universities offer nursing education in their nursing education units and departments of nursing throughout the country. Polytechnics offer basic and advanced nursing study programmes, granting Bachelor of Health Care and Master of Health Care degrees, whereas nurses graduating from universities are entitled as Bachelors of Nursing Science and Masters of Nursing Science. As the focus of this study, in the following paragraphs the polytechnic nursing education will be addressed in more detail.

The function of polytechnics is based on several laws, acts, and decrees. The most central documents are the Polytechnics Act (351/2003) and the Polytechnics Decree (352/2003) issued by the Finnish Parliament. These govern the administration and organization of education and define the nursing degrees.

As a member state of the European Union, nurse education in Finland is also based on the European Union and the Council of European Communities legislation, first issued in 1977. Council Decision 77/454/EEC (EU Council Decision 1977) set up an Advisory Committee on Training in Nursing with the task of helping to ensure a comparably high standard of training in the various categories of nursing personnel throughout the EU. Directive 77/452/EEC (EU Council Directive 1977) concerns the mutual recognition of diplomas and other evidence of the formal qualifications of nurses responsible for general care. Directive 77/453/EEC (EU 1977c) concerns the coordination of provisions laid down by law in respect of the activities of nurses. It defines the knowledge and skills required of nurses for the diploma, including sufficient knowledge of the nature and ethics of the profession and the general principles of health and nursing, and it includes a headline content description of a three year training programme for nurses responsible for general care. Directive 89/595/EEC (EU 1989) amended the application rules of the two previous directives. Directive 2001/19/EC (EU 2001) included nurses in the general system for the recognition of professional qualifications. All these were replaced by Directive 2005/36/EC (EU 2005) on the recognition of professional qualifications. These directives define the same qualification requirements for all nurses in EU countries and provide an opportunity for nurses to work throughout the member countries of the European Union. According to §11 of the Polytechnics Decree (352/2003) nurses and midwives must fulfil the requirements set by European Union legislation. (Opetushallitus 2006.)

The education and exercise of health care practice are strongly regulated due to the special nature of the health care field, its significance in society, and its risks to patient safety. The Act on Health Care Professionals (559/1994) and the Decree on Health Care Professionals (564/1994) regulate the professional nursing practice. The purpose of these regulations is to enhance patient safety and the quality of care by ensuring that professionals meet the educational and competence qualification requirements. The National Supervisory Authority for Welfare and Health (Valvira 2010) grants, upon application, the right to practice as a licensed professional and authorises the use of the occupational title of the health care professional. According to the Decree 423/2005 (Valtioneuvoston asetus 2005) licensing is granted to 17 occupational titles of health care professions, one of them being a nurse. The practice of these professions is restricted to licensed professionals only. Professionals entitled to use an occupational title will be entered into the central register of health care professionals maintained by the National Supervisory Authority for Welfare and Health, which also issues decisions on the above matters, also in cases where training has been undertaken outside of Finland.

The following description of basic nursing education in polytechnics in Finland is based on the educational qualification requirements for nurses issued by the Ministry of Education in 2006 (Opetusministeriö 2006). According to this document, a qualified nurse is a specialist of nursing care. The specialist role of the nurse consists of competences in the following areas: 1) Ethics, 2) Health promotion, 3) Nursing decision-making, 4) Supervision and instruction, 5) Collaboration, 6) Research and development work, and management, 7) Multicultural nursing, 8) Social activity, 9) Clinical nursing, and 10) Pharmacotherapy (medication).

The basic polytechnic degree in nursing (Bachelor of Health Care) takes approximately 3.5 years and consists of 210 ECTS (European Credit Transfer and Accumulation System) study points. One ECTS study point is equivalent of 27 hours of student work. Education consists of basic and professional studies, clinical practice studies, a maturity test and a thesis, and elective studies. Thus, the Ministry of Education makes decisions concerning the degrees and degree programmes of the polytechnics. However, the polytechnics themselves can draw up the content of their curricula provided that they fulfil the qualification requirements issued by the ministry. As a result the curricula may vary considerably (Table 7).

Table 7. Basic nurse education and its minimum ECTS study point requirements*

Mandatory studies	***Minimum ECTS study point requirement***
Basic and professional nursing studies	117
Basic theoretical studies in nursing science	6
Professional studies in clinical nursing science (including studies in pharmacotherapy, 9 ECTS, and infection defence, 6 ECTS)	75
Knowledge acquisition skills, research and development studies	6
Communication and language studies	9
Social and behavioural science studies	6
Studies in natural and medical sciences (including studies in anatomy and physiology, 4ECTS)	15
Clinical practice	90
Thesis	15
Elective studies	3

* Opetushallitus 2006

2.2.2. Practices in the teaching of ethics in the Finnish nursing curricula

The following subsections provide an overview of the development of the Finnish nursing ethics curricula followed by an analysis of Finnish nursing ethics curricula of the academic year of 2003 in order to outline how the teaching of ethics and the codes appeared in these curricula, according to which the participant students of this study completed their ethics studies.

2.2.2.1. Development of the Finnish nursing ethics curricula

The roots of the Finnish professional nursing education lie in the tradition and heritage of Florence Nightingale (Fowler 1989, Sorvettula 1998). According to Nightingale, nurses should have both theoretical and practical instruction in nursing (deGraaf et al. 1994). When the theoretical teaching increased during the first decades of the 20th century, ethics was also introduced into the nursing curricula. However, its importance as a subject has fluctuated depending on the prevailing philosophical schools of thought of the time, such as asceticism, romanticism, pragmatism and humanism. The importance of ethics was also tied with different definitions of the foundation of nursing, such as duty, altruism, or the nurse-patient relationship, which partly originated from aforementioned philosophical schools of thought. (e.g. Smith & Davis 1985, Huggins & Scaltzi 1988, Sorvettula 1993, Mölsä 1994, Kalkas-Sarvimäki 1995, Holt & Long 1999.)

In the educational reform of vocational schools and colleges in 1987 the development of curricula was based on a comprehensive approach, in which the organization of education was aimed at qualifying the student broadly to master different fields of nursing (Ammattikasvatushallitus 1987, Ammattikasvatushallitus 1989). In these curricula ethics education covered the following areas: ethics as a field of study, ethical principles,

the concepts of the human being, social and professional values, nursing principles, ethical decision-making, professional ethics, and patients' rights. Ethics education was implemented throughout the nursing studies. (Mölsä 1994.)

In 1996, the Finnish Board of Education issued new national guidelines for curricula for social and health care education at the college level. In the new curricula, the nurse's work was guided by ethical principles of respect for life, respect for human beings, autonomy, justice and equality. The goals of nursing ethics included the ability to make ethically reasoned choices and decisions, and to deliberate and solve ethical issues based on the ethical principles. The goals also included the ability to recognize and respect different values, and to understand that values were the basis of the nurse's work. Thus the student should internalize the values and principles guiding nursing, should know the codes of ethics and laws of health care, and be able to apply them in practice. The content of ethics education reflected these goals. Ethics education was implemented both as separate ethics education modules and in the integrated format. (Opetushallitus 1996.)

In the most recent document concerning ethics education in nursing, issued by the Ministry of Education in 2006 (Opetusministeriö 2006), ethical knowledge was defined as one key area of the nurse's professional competence and action as a specialist of nursing care. According to the document, the nurse's ethical action is guided by human rights, social and health care legislation and nurses' codes of ethics. The nurse implements ethically high quality care respecting human rights, follows legislation concerning patients' rights and is responsible for the realization of these rights in nursing her/his patients. The nurse acts according to the legislation concerning the nursing profession, and is responsible for her/his professional development and knows her/his responsibility as the developer of nursing care. The education covers the following contents: philosophy of nursing and ethics, human rights and human dignity, the legislation of social and health care as well as other legislation guiding professional action, and the rights and duties of the nurse. (Opetusministeriö 2006.) Within this framework, each nurse education unit in polytechnics is allowed to devise their own, more detailed curricula.

2.2.2.2. An analysis of teaching of ethics in the Finnish nursing curricula 2003

The data for this study was collected from students who graduated in the autumn term of 2006. These students had begun their bachelor degree nursing studies in 2003 and thus completed their studies according to the curriculum of this year. Thus, nursing education curricula of the year 2003 were analysed covering all (n = 39) participating nursing education units. The curricula used as references are presented in Appendix 9. The purpose was to describe how ethics education was presented in their curricula. Because teaching of the codes takes place along with other nursing ethics education, the education of ethics was analysed as a whole. The syllabus of each curriculum was thoroughly

scrutinized for its objectives, contents, and teaching and evaluation methods related to ethics. Polytechnics are allowed to formulate their own curricula provided that it takes into account EU directives and other regulations concerning the minimal requirements of basic nursing education. Therefore the curricula differed from each other to some extent. For example, some curricula had fairly detailed descriptions of the objectives and teaching content, and used teaching and evaluation methods, whereas in some curricula these things were expressed rather generally. All curricula had not included the used teaching and evaluation methods or teaching materials. Therefore this analysis, though carefully made, should be seen only as a rough description of the tendencies visible in the curricula, which may lend to various interpretations in the reality of teaching. The first part discusses learning objectives and teaching contents and the latter part focuses on teaching and evaluation methods.

Learning objectives and teaching contents

Ethics was specified in the general objectives of all nursing education programmes. Ethical competence was defined as an essential element and basis of the nurse's professional competence. Particularly nurses' commitment to moral and professional values was emphasized. Ethical principles and concepts, national and international rules and regulations as well as professional ethics were cited as guides in nurses' professional action. Nurses' codes of ethics were mentioned directly only in one curriculum implying that most likely the codes were regarded as a part of professional ethics. The following ethical principles were specified: justice, autonomy and self-determination, equality, respect for life, respect for the human being, and respect for human rights. The aim of the education was to educate nurses who know about ethics, who can think about ethical matters, and who are able to make ethical decisions and act upon them in practice. The personal and professional moral responsibility of nurses in carrying out nursing care was highlighted.

Based on the analysis, the objectives and content of ethics in the nursing curricula fell within five main themes. However, it was not possible to define the order of the importance of each theme. The first theme focused on the philosophy and ethics of nursing. Teaching included such topics as central trends of Western philosophy, essential ethical theories, ethical principles and concepts, the philosophical foundations of nursing, and what is nursing ethics. Teaching also discussed different definitions of the human being as well as ethics as a means of justifying one's actions. The second theme dealt with ethical values. The focus was on the value basis of the health care system, on professional nursing values, on a student's or nurse's personal values, and on health as a value. Teaching was concerned with the philosophical foundation of the value system and its development, and the meaning of values in guiding nursing practice. The multicultural nature of the values was recognized as well. The third theme dealt with legislation, norms and regulations. Essential laws of the health care system were regarded as important. Particular focus

was placed on legislation and regulations concerning patients' rights, including the role of the patients' ombudsman, children's rights, and human rights in general. Teaching also dealt with the juridical status of health care professionals, nurses' responsibility and accountability, and legislation concerning issues related to confidentiality of patient information. The focus of the fourth theme was on professional ethics. It dealt with issues such as what is meant by professional ethics, nursing as an ethical practice, nurses' professional ethical growth and ethical competence, and ethically high-quality nursing care. Nurses' codes of ethics were also referred in context with professional ethics. The fifth theme dealt with ethical decision-making. It discussed ethical issues in nursing care, ethical deliberation and moral reasoning, and the nature and process of ethical decision-making (Table 8).

The following terms were used in the curricula to express what was expected of the student. Within varying teaching contents the student was expected to observe, to form a view, to clarify, to understand, to weigh, to analyze, to justify, and to internalize the contents of the teaching. Further on, the student was expected to know, to manage, and to be able to act on the learnt content. Or the student was expected to apply, to deepen, or to develop her/his knowledge and skills.

Table 8. Contents in ethics curricula in 2003*

Contents	
Philosophy and ethics	Trends in Western philosophy Essential ethical theories Ethical principles and concepts The philosophical foundations of nursing Definitions of human being Ethics as a means to justify action
Ethical values	Value basis of health care system Professional values Personal values Health as a value Philosophical foundation of the value system and its development Values as a guide of nursing practice Multicultural nature of values
Legislation and norms/regulations	Essential laws of health care system Legislation and regulation concerning human rights Juridical status of health care professionals The nurse's responsibility and accountability Legislation concerning confidentiality
Professional ethics	Definition of professional ethics Nursing as an ethical practice The nurse's moral growth and competence Ethically high quality care Codes of ethics
Ethical-decision-making	Ethical issues in nursing care Ethical deliberation and moral reasoning The nature and process of ethical decision-making

*References of the polytechnics' curricula 2003 are presented in Appendix 9.

Teaching and evaluation methods

According to the curricula, ethics education was implemented both as separate ethics education modules and as integrated into other theoretical nursing studies and clinical practice at all levels and lines of nursing study programmes. Thus, ethics education permeated nursing study programmes from entrance to exit. Separate ethics education modules took place mostly in the beginning of the studies, during the first or second study semester. The separate study modules consisted mostly of one or two study points (equalling 1,5-3 ECTS). In the separate study modules ethics was often taught jointly with philosophy, the foundations of nursing theory, or nursing science.

Teaching methods used in the context of separate ethics study courses were lecture, discussion, different written assignments, working via the internet, and a portfolio. Learning assignments were realized as an independent work, in pairs or as a team effort. Discussions and presentations of written assignments took place in seminars.

The assessment methods mentioned in the curricula were an essay written either in an examination session or as a home assignment. An assessment scale from 1 to 5 or pass/fail were commonly used. Student presentations in the seminars were also used in student assessment. The students' active participation in discussions was expected as well (Table 9).

Table 9. Teaching and evaluation methods in ethics curricula in 2003*

Teaching format	Teaching methods	Implementation format	Evaluation methods	Evaluation outcome
Integration to other theoretical nursing studies and practical training	Lecture	Independent work	Assay (homework or exam session)	Grade 1 to 5
Separate study modules	Discussion	Pair work	Student presentation	Pass/Fail
	Written assignment	Group work	Participation activity	"Participated"
	Portfolio			
	Internet	Seminar		

* References of the polytechnics' curricula 2003 are presented in Appendix 9.

According to the analysis of the curricula the emphasis in teaching was on normative ethics. Legislation and professional ethics were essential parts of the teaching contents. Teaching of values was also highlighted. Objectives and contents related to ethics were brought up in context of many nursing studies, indicating an integrated approach to ethics education. However, the integration was not explicitly or systematically outlined in the curricula. For example, within one curriculum ethics was mentioned in relation to nursing of the elderly and surgical patients but not in relation to nursing paediatric nursing or psychiatric patients.

2.3. Empirical and theoretical scientific literature on teaching of ethics from the perspective of the codes of ethics

This subsection starts with a review of empirical and theoretical scientific literature on practices in the teaching of ethics, i.e. teaching contents and learning objectives, and teaching and evaluation methods. Next, nurses' knowledge of and ability to apply the codes are addressed. Thereafter development of teaching is in focus.

This review of empirical research on nurses' codes in practice and education was based on searches from the Medline database using the keywords: codes of ethics, ethical codes, professional codes, professional conduct, and codes of conduct, which were combined with nursing, ethics, education, teaching, learning and practice in different combinations of the terms to cover the subject area as thoroughly as possible. The search process revealed that, although the literature on nurses' codes of ethics is abundant in non-scientific nursing journals and fairly numerous in scientific nursing journals as well, empirical research focusing directly on nurses' codes of ethics and particularly their teaching has been scarce. For this reason the literature searches were extended to include also such empirical research, which was regarded as relevant to understand, and perhaps to explain factors concerning teaching of nurses' codes of ethics. These studies focused on nurses' and nursing students' professional values and ethical behaviour espoused by nurses' codes of ethics. The initial data search covered the years from 1980 to August 2007. The analysis focused on the main domains of interest of the studies, their main findings and the methodological approaches used in these studies.

An analysis of the publication years of the studies revealed that research related to the codes has slightly increased since the 1980's, but at the same time it has also been fluctuating. First the focus was on nurses' behaviour and values related to the codes as well as nurses' knowledge and use of the codes. It has to be noted that studies on values and behaviour were not directly focusing on the codes, but were using instruments which measured how nurses' values and behaviour correspond with the values of the codes. Around the mid -1990's the interest in nurses' knowledge and use of the codes increased further. At the turn of the millennium studies on the codes in education started to emerge, and around the year 2004 studies on the meaning and functions of the codes were published. The last two domains of interest were most likely boosted by the European Commission Project "The Ethical Codes in Nursing QLG6-2001-00945", which was carried out in 2000-2004 (European Commission 2009). However, thus far the most studied domain of interest directly focusing on the codes has been nurses' knowledge and use of the codes. Nevertheless, the overall number of studies on the codes has remained modest.

The studies fell within five domains of interest which were: 1) nurse education, 2) nurses' knowledge and use of the codes, 3) nurses' views on the content and functions of the

codes, 4) nurses' moral behaviour and 5) values related to the codes. This initial set of data (covering the years 1980-2007) is reported as the Original Publication (Paper I). The search was updated by new empirical research covering the period up to March, 2010. The final catch of all relevant empirical research was 60 papers (Appendix 5).

Theoretical scientific literature was retrieved using the Medline database using the same keywords as in searches of empirical research. Thus the purpose was not to conduct a strict literature review of the theoretical literature on ethics teaching in nursing, but to provide an overview of the context in which teaching of the codes takes place.

2.3.1. Practices in the teaching of ethics from the perspective of the codes of ethics

This subsection on practices of teaching of ethics, i.e. teaching contents, learning objectives and teaching and evaluation methods, is based on theoretical and empirical literature. The focus is on discussing ethics education from the perspective of teaching of nurses' codes of ethics. This approach was chosen because literature and nursing curricula indicate that nurses' codes are taught as a part of the nursing ethics syllabus. Consequently, it was assumed that general learning objectives as well as teaching and evaluation methods used in teaching the codes correspond with those used in teaching ethics in general. The purpose of this overview is to provide background knowledge of nursing ethics education in general for elucidating the theoretical context within which the teaching of nurses' codes of ethics takes place. However, because ethics education in nursing covers a broad area of topics, only literature that was relevant from the viewpoint of teaching the codes was included in the overview. Examination of the literature has revealed that empirical research on teaching ethics in nursing and particularly on teaching of the codes of ethics is scarce (also Leino-Kilpi 1999, Leino-Kilpi 2001, Leino-Kilpi 2004, Gastmans & Verpeet 2006). Therefore also theoretical articles in scientific journals were included as well as Finnish academic theses related to ethics education.

In this overview practices in the teaching of ethics (i.e. the learning objectives and teaching contents) are discussed under the same heading, because in many instances a particular topic can be interpreted either as a learning objective or a teaching content, for example, skills in moral reasoning or critical reflection. The first part of the overview discusses learning objectives and teaching contents and the latter part focuses on teaching and evaluation methods. Reference to the empirical research related to the topic follows the discussion of theoretical literature. In these subsections theoretical literature is addressed first followed by empirical studies relevant from the viewpoint of teaching nurses' codes of ethics.

Learning objectives and teaching contents

The learning objectives and teaching contents of nursing ethics education fell within six main teaching areas. The first teaching area was moral philosophy. Nursing students

should have a strong basis in moral philosophy, i.e. ethical theories, principles and concepts. (Quinn 1990, van Hooft 1990, Cameron & Schaffer 1992, Cartwright et al. 1992, Kanne 1994, Bowman 1995, Gallager 1995, Sellman 1996, Ketefian 1999, Webb & Warwick 1999, Botes 2000, Gastmans 2002, Romyn 2003, Arries 2005, Woogara 2005, Woods 2005). The objective of teaching moral philosophy was to educate nurses who are accountable, personally and professionally autonomous decision-makers capable of participating in interdisciplinary moral discussions (Cartwright et al. 1992). Knowledge of moral philosophy prevents nurses from reacting to ethical dilemmas emotionally. Teaching of moral philosophy should include a variety of ethical theories. (e.g. Quinn 1990.) Virtue ethics emphasizes the importance of the nurse's moral disposition, focusing on virtues of character in Aristotelian spirit, such as compassion, openness, sharing and courage (Pask 1997, Sellman 1997, Bradshaw 1999, Armstrong 2006, Begley 2006, Sellman 2007), and pays attention to the moral behaviour of students (Cameron et al. 2001, Park et al. 2003, Kim et al. 2004). Ethics of care enhances caring relationships and attitudes characterized by receptivity, relatedness and responsiveness, which should permeate all nursing education including also the student-educator relationship (Harbison 1992, Hanford 1993, Crowley 1994, Woods 1999). Teaching should also include rationalistic ethical theories, i.e. deontological, teleological and principle-based theories which could be taught together with virtue ethics and the ethics of care (van Hooft 1990, Edwards 1994, Bowman 1995, Gallager 1995, Lipp 1998, Botes 2000, Gastmans 2002, Romyn 2003, Arries 2005, Woogara 2005, Vanlaere & Gastmans 2007).

Research indicates that nursing students used more care orientation than orientation based on universal ethical theories in their moral reasoning (Peter & Gallop 1994), whereas Lipp (1998) found that nursing students used both orientations simultaneously in varying degrees depending on the situation, and therefore both orientations should be taught to students.

The second teaching area was moral reasoning and ethical decision-making (Hussey 1990, Quinn 1990, Allmark 1992, Foster et al. 1993, Kanne 1994, Ketefian 1999, Jaeger 2001, Nortvedt 2001, Snider 2001, Doane 2002, Kim et al. 2004, Woogara 2005, Armstrong 2006). Nursing students should know ethical decision-making processes and models, be able to recognize and contemplate ethical problems, and be motivated to act in moral situations towards moral agency as the main objective of teaching (Hussey 1990, Allmark 1992, Doane 2002, Kim et al 2004, Armstrong 2006).

Research indicates that nursing students found the use of ethical principles and ICN Codes of Ethics useful in developing their ethical decision-making skills (Dinç & Görgülü 2002). The welfare of the patient guided students' moral reasoning, and in decision-making they applied codes of ethics. The most commonly referred ethical concept was veracity and the principles of human dignity and non-maleficence. (Han & Ahn 2000.)

The majority of the students experienced the use of a decision-making model as helpful (Cameron et al. 2001, Park et al. 2003).

The third teaching area was professional values (Quinn 1990, Weis & Schank 1991, Bowman 1995, Sellman 1996, Glen 1999, Snider 2001). Teaching should cover the fundamental professional values of nursing reflected in nurses' codes and clarification of personal values (Cowart & Allen 1982, Vito 1983, Quinn 1990, Snider 2001) Teaching of values in the modern health care environment should be based on inter-professional dialogue (Glen 1999).

Research indicates that nurses' codes form a part of their value system. Education initiates the value formation for practice which continues as professional socialization process in practice. (Schank & Weis 2001, Heikkinen & Leino-Kilpi 2004). Leners et al. (2006) observed that nursing education had a positive impact on nursing students' value formation, whereas Eddy et al. (1994) found that studying ethics, theology, and philosophy did not significantly affect values. Nursing students' professional values were in accordance with the values of nurses' codes. Respect for human beings and caring were regarded as good nursing (Kelly 1991, Kelly 1992). However, according to Kalb & O'Connor-Von (2007) students had diverse perspectives of respect for human beings, and therefore its teaching should be particularly addressed. Nursing students' most identified values were related to the nurse-patient relationship rather than to social issues of the profession (Schank & Weis 1989, Leners et al. 2006). But internalization of social values inherent in the codes of ethics was also important for the empowerment of nurses (Weis & Schank 1991). Comparison between American and British nurse educators' and nursing students' code-related professional values revealed more similarities than differences between the groups. The differences were explained by cultural differences (Weis & Schank 1997, Schank & Weis 2000). Students' professional values were related to sex and ethnicity, although not significantly. Nevertheless, the need for a strong professional value base should be recognized and also students' demographics taken into account in planning educational approaches. (Martin et al. 2003.)

The fourth teaching area was professional ethics. Understanding the moral nature of nursing practice (Quinn 1990, Allmark 1992, Sellman 1996, Gastmans et al. 1998) and the codes of ethics were important elements of the nurse's professional ethical knowledge base (Quinn 1990, Sellman 1996, Ketefian 1999, Snider 2001, Vanlaere & Gastmans 2007) However, to form a relevant teaching content the codes should be formulated from the practice viewpoint (Gastmans & Verpeet 2006). Analysis of the codes of several health care professions might be a good way to develop an ethics course which would suit all health care professions (Stone et al. 2004). In assessing nursing students' assignments, the codes of ethics should not be used as a punitive measure if students' answers did not comply with the codes (Esterhuizen 1996, Snelling & Lipscomb 2004, Lipscomb &

Snelling 2006). Hussey (1996) points out that the codes have several shortcomings. To overcome them, additional teaching in ethics is needed.

Research indicates that that nurses' codes were one of the nurse educators' most taught subjects in the nursing ethics curricula (Numminen 2000, Görgülü & Dinç 2007). Nurse educators, nurse executives and nurses viewed the teaching of the codes as important. However, theoretical teaching was not enough, but needed clinical situations to practice the use of the codes, and continuing education and the nurse's development as a person to open the way to understanding of ethical issues. The positive attitude of superiors and clinical instructors was essential in enhancing discussion of difficult situations. Improvement in their attitudes was needed. Professional education was the most important time to familiarize students with the codes. Teaching of the codes supported ethical decision-making and provided professional identity, knowledge of professional values and quality care. (Heikkinen & Leino-Kilpi 2004.) Education in ethics and commitment to professional ethics had an important contribution to nurses' clinical competence according to nurse educators and nursing executives (Memarian et al. 2007). In some studies, nursing students regarded teaching of the codes to be adequate (Dinç & Görgülü 2002) or even too extensive (Ajanko 2003), and some studies found teaching to be inadequate (Tadd et al. 2006). Students felt that the codes were useful in developing and supporting their ethical decision-making skills (Dinç & Görgülü 2002). They regarded most statements of the codes as important, particularly the statement to provide safe and competent care (Lui et al. 2008). Two studies focusing on concepts of human dignity and patients' rights embedded in the codes revealed that students had diverse perceptions of human dignity (Kalb & O'Connor-Von 2007) and that students considered the implementation of patients' rights important, but teaching of the rights had been incoherent and deficient (Simula 1998). In their decision-making, safeguarding the patient, respecting the patient's rights and maintaining standards of care were the nursing students' most referred-to statements of the codes (Han & Ahn 2000). Tabak & Reches (1996) found that students had more knowledge about ethics and the codes than nurses, perhaps due to the improved and more systematic teaching.

The fifth teaching area was critical reflection, and its importance in encountering ethical situations was much emphasised (Hussey 1990, Van Hooft 1990, Allmark 1992, Foster et al. 1993, Kanne 1994, Sellman 1996, Durgahee 1997b, Hunt 1997a, Seedhouse 1998, Ketefian 1999, Webb & Warwick 1999, Diekelman & Diekelman 2000, Nogueras 2002, Lemonidou et al. 2004, Vanlaere & Gastmans 2007, Kyle 2008). According to Allmark (1992) ethics education would enhance nursing students' critical thinking skills, help them to identify their decision-making processes, and empower them in acknowledging that their opinions matter. Hussey (1990) points out that health care ethics is different from everyday ethics. Intuition is not enough in solving problems. It calls for an ability to recognize problems, the ability to reflect and to act on them and to be motivated to do so.

Reflection is needed if nurses want to participate in moral discussions in health care as autonomous moral agents. Education in ethics must provide tools for critical reflection of ethical situations. The critical companionship approach enhancing the teaching nursing skills, caring attitude, i.e. virtues and enhancement of the ethical function of the nurses' codes of ethics provide tools for nurses' reflective thinking. (Vanlaere & Gastmans 2007.) Reflective thinking should utilize rationalist ethical theories but also pay attention to affective elements inherent in ethical situations (van Hooft 1990, Diekelman & Diekelman 2000). The role of educators' should be to enhance students' in-depth rather than superficial thinking, to provoke discussions of ethical issues, to enhance students' use of logical reasoning, argumentation and reflection in analysing ethical issues (Foster et al. 1993, Kanne 1994), and to provide the students with opportunities to reflect their own moral experiences in their development towards moral professional maturity and personhood (Lemonidou et al. 2004). Judgement should not be reduced to a following of mere rules (e.g. the codes). Discretion and critical reflection is needed. (Hunt 1997a, Seedhouse 1998.) Nursing students need a common ethical baseline, such as codes of ethics and knowledge of main ethical theories and principles, to be able to reflect and justify their arguments (Sellman 1996, Ketefian 1999, Webb & Warwick 1999).

The sixth teaching area was moral sensitivity. Moral sensitivity refers to such things as perception of moral situations, the ability to feel empathy and the appreciation of the moral views of others (e.g. Scott 1995, Doane 2002). Morality and moral sensitivity are components of the nurse's professional role. Therefore teaching of the ethical ideals of nursing care, which enhances morality and emotional sensitivity, is important. It makes nursing students aware of the expected moral behaviour and standards and of care. (Scott 1995, Scott 1996, Scott 2000.) Thus, ethics education should not only focus on rationalist ethical theories but focus also on Aristotelian virtue ethics in which sensitivity and feelings are components of practical reason. Education should develop students' sense of empowerment, which is a combination of feelings of confidence, insight and sensitivity. It is enhanced by training habits, attitudes and by encouraging reflection on performed actions. (Van Hooft 1990.) Appreciation of sensitiveness in interpersonal communication, i.e. moral imagination, requires the development of the virtues of compassion, openness, sharing and courage (Pask 1997, Armstrong 2006). Professional ethics means nothing without understanding of the importance of civic morals which should be incorporated into professional life (Rozsos 1996, Hunt 1997b). To develop moral awareness and empathy, ethics education should offer the students opportunities to reflect on their own experiences, offer continuous peer support throughout clinical practice, and enhance clinical instructors' and nurse educators' function as role models. (Scott 1996, Lemonidou et al. 2004). Moral sensitivity enhances clinical competence (Nortvedt 2001, Memarian et al. 2007) and it is necessary for moral theorizing and responsible decision-making (Jaeger 2001). Education should enhance students' sensitivity to the contextual factors

and relationships inherent in ethical situations (Doane 2002) and their cultural sensitivity (Yarbrough & Klotz 2007).

Teaching and evaluation methods

Discussion on teaching methods in nursing ethics education has been fairly abundant in scientific nursing journals. Many of the discussions are descriptions of different approaches or individual teaching methods which have been applied in teaching ethics and consequently suggestions of good ways to teach ethics. However, empirical research focusing on teaching methods and their effectiveness is scarce, as is research on ethics education in nursing in general (Leino-Kilpi 2001, Gastmans & Verpeet 2006). Discussion on outcome evaluation is minimally addressed in these discussions. First, different approaches to teach ethics are described, followed by a discussion on individual teaching methods.

An integrated teaching format was suggested by some authors. Ethics should be integrated throughout professional nursing education (Snider 2001, Milton 2004, Yarbrough & Klotz 2007) and effective integration should be well organized and systematic (Gaul 1989). In the integrated teaching format the competence of ethics educators is important. Educators should also consider participation in team teaching. The integration could be complemented with separate ethics study units. (Hussey 1990.) Research focusing on Finnish nursing ethics education indicated that integrated teaching as well as separate study units were applied in ethics education (Puska 1998, Numminen 2000, Männistö 2001).

Inter-disciplinary and inter-professional approaches to teach ethics were also discussed. Nursing and medical students should be encouraged to participate in shared learning. This would educate them to resolve ethical issues together and help them to understand and respect each others' viewpoints. Also a common language would be learnt in discussing ethics together (Begley 1995b, Gallager 1995, Panchaud 1995, Cloonan et al. 1999, Elder et al. 2003). Shared learning would provide education that was theoretically more consistent with the goals of health care, would reduce moral distress and burnout, and would improve patient care creating cooperation, confidence and willingness to listen and learn from each other (Hanson 2005). Teaching based on an inter-professional dialogue is a good method in teaching values in modern multifaceted health care (Glen 1999).

A context-based approach to ethics teaching was much emphasized (Cameron & Schaffer 1992, Foster et al. 1993, Kanne 1994, Kendrick 1994, Brock et al. 1995, Nolan & Smith 1995, Scott 1996, Durgahee 1997a, Lützen 1997, Webb & Warwick 1999, Woods 1999, Birkelund 2000, Snider 2001, Doane 2002, Gastmans 2002, Nogueras 2002, Nolan & Markert 2002, Doane et al. 2004, Milton 2004, Toiviainen 2005, Woods 2005, Armstrong 2006, Yarbrough & Klotz 2007). Ethics education should be learning from reality

(Birkelund 2000), and be an ongoing dialogue in the practice context. (Snider 2001, Toiviainen 2005). The theory-practice gap should be removed (Kendrick 1994). Nursing students need a theory base in ethics but it should be practically oriented, and clinically focused from a nursing point of view (Brock et al. 1995, Webb & Warwick 1999, Woods 2005). Education should enhance students' understanding of the contextual factors and relationships inherent in each ethical situation and the influence of environmental forces such as organization, and to develop their knowledge and ability to act in complex situations (Lützen 1997, Armstrong 2006, Doane 2002). The educator's role is to bind theory to practice and to enhance discussion in a supportive climate (Foster et al. 1993). Research indicates that students needed ethics education because they had little previous exposure to ethical issues of health care. Students themselves regarded teaching as important but felt that it should not be too theoretical. (Nolan & Smith 1995, Nolan & Markert 2002).

Also an approach which valued students' personal experiences and subjective involvement in ethical situations were regarded as a good and effective bases for teaching ethics (Hussey 1990, Kanne 1994, Nolan & Smith 1995, Holt & Long 1999, Diekelman & Diekelman 2000, Cameron et al. 2001, Park et al. 2003, Romyn 2003, Doane et al. 2004, Kim et al. 2004). Students needed a basic introduction to moral philosophy and its methods but complemented with a strategy that allowed them to use and interpret personal experiences (Holt & Long 1999). Reflective thinking and interpretation of experiences created meaning and significance through discussions and questioning (Diekelman & Diekelman 2000).

Literature describes various individual teaching methods in ethics. However, there is no single teaching method which has proved to have superior qualities compared with other methods and thus would surpass other methods. Therefore an eclectic approach which uses several different methods is recommended. (Sellman 1996.) According to Callery (1990), teaching methods should recognize cognitive, social and affective aspects of ethics. Despite their various names, teaching methods can be typed into groups through their common features and how they are implemented.

Lecturing has been one of the most common and traditional teaching methods in ethics. However, its usefulness in teaching ethics has been questioned due to its disadvantages. Lecturing maintains the traditional gap between theory and practice in failing to discuss ethics as it manifests in clinical reality (Kendrick 1994, Leavitt 1996). It thus fails to challenge students' personal involvement both in understanding and solving ethical problems, and it tends to be authoritative and distancing, implying that there exist objective right and wrong answers to ethical questions (Dibbern & Wold 1995). Research indicated that lecturing still is a much used teaching method in ethics (Puska 1998, Numminen 2000, Männistö 2001)

Discussion is another common teaching method in ethics and nursing literature describes a variety of different types of discussions (Quinn 1990, Cameron & Schaffer 1992, Foster et al. 1993, Kendrick 1994, Bowman 1995, Sofaer 1995, Krawchyk 1997, Glen 1999, Webb & Warwick 1999, Diekelman & Diekelman 2000, Landry & Landry 2002, Toiviainen 2005, Woogara 2005, Garity 2008, Männistö 2001, Dinç & Görgulu 2002, Juujärvi & Pesso 2008). Sharing a story about an encountered ethical dilemma may provoke a discussion (Bowman 1995). Narrative pedagogy using stories emphasizes reflective thinking and interpretation of experiences. It is not solving problems with theories but creating meaning and significance through discussions (Diekelman & Diekelman 2000). A thought experiment as a form of discussion provides students with "broad cases" without details allowing students to imagine their own arguments (Hubert 1999). Kendrick (1994) suggests brainstorming and short quizzes as provokers of a discussion. According to Glen (1999), in modern multifaceted health care, teaching should be based on inter-professional discussion. Toiviainen (2005) points out that the nature of ethics education should be an ongoing dialogue in the practice context. Discussion can take the form of a debate which provides students with practice in analysis and justification (Quinn 1990, Foster et al. 1993, Webb & Warwick 1999, Garity 2008). Some authors speak for structured controversy as an effective form of debate in promoting critical thinking, solving difficult ethical dilemmas, enhancing students' perspective taking, logical arguing and reaching consensus. However, it needs good preparation and involvement from both educators and students (Pederson et al. 1990, Pederson 1992, Sofaer 1995, Mysak 1997) Educators' role in discussions is to provide students with a theory base for solving problems, present thought-provoking questions, listen and enhance discussion in a creative and supportive climate (Foster et al. 1993). In group discussions the educator's role is to act as a facilitator (Durgahee 1997a). Research indicates that small group discussions based on the students' own experiences enhanced the students' ability to recognize ethical problems (Juujärvi & Pesso 2008). Group discussion along with participation and practice opportunities was a good method in improving the students' ethical decision-making skills (Krawchyk 1997, Dinc & Görgulu 2002).

Case studies as a teaching method can use books or student experiences as sources (Foster et al. 1993, Kanne 1994, Kenrick 1994, Brock et al 1995, Holland 1999, Holt & Long 1999). Case studies have been critiqued because of their lack of attention paid to contextual factors in ethical situations. Nevertheless, rather than rejecting it as a teaching method it would be more fruitful to consider ways to teach using cases (Holland 1999).

Written assignments in different forms are also a suggested teaching method. Diary, learning portfolio or an essay were good ways to analyse and reflect ethical issues in nursing. (Cameron & Schaffer 1992, Foster & al 1993, Bowman 1995, Webb & Warwick 1999, Nogueras 2002). Research based on Finnish data indicated that nurse educators

reported different types of discussions and seminars as their most used teaching methods (93%). About 65 % had used independent student work and about 40 % of educators used lecturing much or fairly much. (Numminen 2000.) In another Finnish study, students reported that group discussions (about 80%) and lecturing (about 80%), and independent work (about 60%) had been educators' favoured teaching methods (Männistö 2001).

Yet another method brought up by literature was role plays and drama (Foster et al. 1993, Begley 1995, Sofaer 1995, Landry & Landry 2002). Literature, videos, films and metaphors are good teaching material for role play and drama (Begley 1995). The use of drama and literature brings about strong emotional responses in unreal situations and can be used as a vicarious emotional experience in teaching ethics (Begley 1995). Reliving clinical experiences through story-telling as a teaching method enhances the concept of oneself, communication skills, and new knowledge (Durgahee 1997a) The "Moot Court" or "Mock Trial" is a method in which ethical problems with legal connotations are discussed in a court room setting. It is a good way to teach the difference between law and ethics, since many cases in health care have legal connotations (Langford 1990, Pike 1993).

Also the Internet and interactive television are teaching tools in ethics (Wurzbach 1993, Kanne 1994, Pinch & Groves 2000, Leppa & Terry 2004). Internet-assisted teaching offers opportunities for collaboration and critical thinking, although access barriers and motivation may remain challenges (Leppa & Terry 2004). Internet-based discussions allow students to debate ethical issues at their convenience and are particularly good in interdisciplinary education (Pinch & Groves 2000). Computer programs can be used to learn argumentation (Kanne 1994).

Evaluation of student outcomes in ethics is sparcely discussed or studied in nursing literature. According to Thompson & Thompson (1989) the theoretical part of education can be evaluated like any other theory content using essays or objective tests. However, it is difficult to assess how theoretical knowledge transfers to practice. One way to evaluate would be to observe changes in the students' moral behaviour, although this method would be very demanding in terms of resources such as time and staff (Oberle 1995). The use of different instruments to measure nurses' moral reasoning, ethical decision-making and moral behaviour has been fairly extensive in nursing research. However, this kind of measurement provides information more on a long-time basis than in describing students' progress related to a short-time teaching period or ethics course. Research indicates that nursing education in general and education in ethics had a positive impact on the development on students' moral reasoning and moral behaviour. (Ketefian 1981, Ketefian 1985, Felton & Parsons 1987, Frisch 1987, Cassidy & Oddi 1988, Gaul 1987, Cassells & Redman 1989, Cassidy & Oddi 1991, Pederson 1992, Diercx de Casterlé et al. 1996, Duckett et al. 1997, McAlpine et al. 1997, Yung 1997a, Yung 1997b, Turner & Bechtel 1998, Dinç & Görgülü 2002, Auvinen et al. 2004.)

2.3.2. Nurses' knowledge of and skills to apply the codes

Nurses' knowledge and use of the codes has been the most studied area in dealing with nurses' codes. The most studied participant group has been practicing nurses (Edwards & Haddad 1988, Davis 1991, Miller et al. 1991, Gold et al. 1995, Whyte & Gajos 1995, Miles & Burke 1996, Tabak & Resches 1996, Wagner & Ronen 1996, Whyte & Gajos 1996, Dinç & Ulusoy 1998, Wagner & Tabak 1998, Wilmot et al. 2002, Biton & Tabak 2003, Weiner & Tabak 2003, Schwartz 2004, Strandell-Laine et al. 2005, Hariharan et al. 2006, Heikkinen et al. 2006, Heymans et al. 2007). Nursing students (Tabak & Resches 1996, Han & Ahn 2000, Granot & Tabak 2002) and nurse executives have been studied to some extent, but research on nurse educators is scarce (Granot & Tabak 2002).

Research indicates that nurses' knowledge and use of the codes is deficient at all levels of nursing (Edwards & Haddad 1988, Davis 1991, Miller et al. 1991, Adams & Miller 1996, Miles & Burke 1996, Wagner & Ronen 1996, Wagner & Tabak 1998, Hariharan et al. 2006, Tadd et al. 2006). Best-known were issues related to the nurse-patient relationship (Whyte & Gajos 1995, Whyte & Gajos 1996). Personal experiences and environmental factors where dominant factors in shaping nurses' responses to ethical issues rather than the codes (Edwards & Haddad 1988, Davis 1991, Gold et al. 1995, Tabak & Reches 1996, Wilmot et al. 2002, Schwartz 2004, Hariharan et al. 2006, Tadd et al. 2006). Nurses' attitudes towards ethical problems did not meet the expectations required of nurses by The ICN Code for Nurses (Dinç & Ulusoy 1998). Nurses used the codes both conscientiously and unconscientiously. Hindrances to use were the codes themselves, multi- professional teamwork, patients' family members, organizational factors, the nursing profession, society and its health care policy, lack of knowledge and self-confidence and lack of professional recognition as well as inadequate education. (Strandell-Laine et al. 2005, Heikkinen et al. 2006, Tadd et al. 2006, Heymans et al. 2007.) The possibility to apply the codes in nursing practice had a positive impact on nurses' work satisfaction (Biton & Tabak 2003). The health care setting had no effect on nurses' knowledge level of the codes (Weiner & Tabak 2003). In Tabak & Resches'(1996) study, nursing students had a better knowledge of the codes than nurses, most likely due to better teaching of ethics compared to previous unsystematic teaching. According to Han & Ahn (2000) nursing students applied the preamble and some statements of the codes in their ethical decision-making. Safeguarding the patient, respecting of patients' rights and maintaining a high standard of care were the most applied statements of the codes. Clinical and ethical knowledge was significantly related to the development of students' moral behaviour assessed by nursing faculty members and nursing students themselves (Granot & Tabak 2002).

2.3.3. Nurses' perceptions of the codes and the development of their teaching

Direct research of the nursing profession's views on the codes is also scarce**.** In research focusing on the functions of the codes, nurses have brought up issues related to the need,

applicability and teaching of the codes. Despite their shortcomings, nurses regarded the existence of nurses' codes as important. The codes were seen to be needed because they have many useful functions such as guiding the practice, providing professional standards, endorsing professional identity and promoting professional status. The codes' function was also to protect the public and act as a disciplinary measure. (Tadd et al. 2006.) Belgian nurses, who do not have their own national codes, thought that the codes could be useful but should be practical, and known to nurses and others (Verpeet et al. 2006). Nurses claimed to apply the codes both consciously and unconsciously because the codes were in accordance with other essential nursing values (Tadd et al. 2006, Heikkinen et al. 2006, Strandell-Laine et al. 2005). As shortcomings to applicability, nurses mentioned the abstract and ideal nature of the codes. The codes did not provide clear enough answers to ethical issues to have relevance to their daily nursing practice (Tadd et al. 2006). The possibility to apply the codes in nursing practice had a positive impact on nurses' work satisfaction (Biton & Tabak 2003).

Nevertheless, the codes were regarded as an important content in nursing ethics education (Numminen 2000, Heikkinen & Leino-Kilpi 2004, Meulenbergs et al. 2004, Verpeet et al. 2006, Heymans et al. 2007). Theoretical teaching was not enough, but clinical situations in which to practice the use of the codes were needed, and continuing education and the nurse's development as a person to open the way to understanding of ethical issues. The positive attitudes of superiors and clinical instructors was essential in enhancing discussion of difficult situations. Improvement in their attitudes was needed. Professional education was seen as the most important time to familiarize students with the codes. Teaching of the codes supported ethical decision-making and provided professional identity, knowledge of professional values and quality care. (Heikkinen & Leino-Kilpi 2004.)

Research dealing with the development of the teaching of the codes is minimal. Meulenbergs et al. (2004) suggest that more emphasis should be placed on the ethical function of the codes rather than professionalism in developing the codes and their teaching to suit the demands of the modern health care environment. Also too little time was allocated to teaching ethics.

2.4. Summary of the literature review

To provide a background for this study the first part of the literature review discussed nurses' codes of ethics as an essential part of nurses' professional ethical knowledge base. The codes were defined and their development described, thereafter the codes were explicated in terms of their inherent ethical concepts and principles, functions, and related legislation and agreements. Limitations of the codes were addressed as well.

The latter part of the review focused on the description of current nurse education, and on providing an overview of teaching of ethics from the perspective of nurses' codes of ethics. It dealt with practices of teaching ethics, i.e. teaching contents and learning objectives, and teaching and evaluation, nurses' knowledge of and ability to apply the codes and nurses' views on the development of teaching of the codes based on scientific theoretical literature and empirical research on ethics education and the codes.

From the viewpoint of teaching nurses' codes of ethics as a part of nursing ethics education, the reviewed literature can be summarized as follows: Empirical research focusing on teaching of ethics is scarce and minimal in the area of teaching nurses' codes of ethics, whereas theoretical scientific literature on nursing ethics education is fairly abundant. Apart from recent studies, empirical research of the codes has been methodologically heterogeneous and inconsistent, implying that caution is warranted in the interpretation of the results from the viewpoint of providing a reliable picture of the state of teaching ethics in nursing in general or teaching the codes of ethics (Paper I)

According to the literature, the aim of teaching ethics is to educate nurses who understand the moral nature of nursing care, who have a sensitivity to moral issues in nursing, who possess virtuous characteristics that are needed for the goal of nursing (i.e. human well-being) and who are autonomous moral decision-makers who can critically reflect on encountered moral issues.

Consequently, ethics education should provide nurses with sufficient knowledge of various ethical theories and values, knowledge of moral reasoning and ethical decision-making processes and models, professional ethics including the codes of ethics, and essential ethical issues of health care and nursing. Teaching should be based on students' experience, be bound to the practical nursing context and prefer the use of an interdisciplinary approach. An integrated teaching format is preferred, supplemented with separate ethics study units. Approach to the use of teaching methods should be eclectic.

Earlier empirical research indicates that teaching of nurses' codes of ethics is regarded as important but contradictory views are express about the adequacy of their teaching. However, nurses' knowledge and use of the codes is deficient throughout the professional hierarchy. Research has acknowledged many kinds of barriers that have impact on nurses' knowledge and use of the codes. Nurses' reliance on their personal experiences and values rather than the codes was prevalent when encountering ethical issues. But nurses' values and moral reasoning seemed to reflect the values embedded in the codes, indicating that nurses' use of the codes is partly unconscious. Nurses' approach to the codes centred on statements dealing with the nurse-patient relationship rather than the social aspects of nursing. Further development of the codes should reflect the reality of

nurses' daily practice and the current health care environment. Studies using instruments based on values embedded in the codes indicated that education has a positive impact on students' moral reasoning and ethical behaviour.

Nurses and nursing students were the largest participant groups in the studies. Little is known about nurse educators and their teaching, nurse executives and their role in facilitating the implementation of the codes as well as cooperation between nurse education institutions and health care organizations concerning nursing students' ethics education. Knowledge of nursing students' views about the codes and their teaching is very limited as well. Thus earlier research provides little direct knowledge of the implementation of teaching of the codes.

3. PURPOSE OF THE STUDY AND RESEARCH QUESTIONS

The purpose of this study was to analyse nursing ethics education from the perspective of nurses' codes of ethics in the basic nursing education programmes in polytechnics in Finland from the perspectives of nurse educators and nursing students. The aim of the study was to identify strengths and possible problem areas in teaching of the codes and ethics in general. The knowledge gained from this study can be used for developing nursing ethics curricula and teaching of ethics in theory and practice.

1. What is known about nurses' codes of ethics in practice and education? (Paper I)

2. Practices in teaching of ethics
   2.1. What is taught about the contents of the codes and to what extent? (Papers II, III and V)
   2.2. What teaching and evaluation methods are used and to what extent? (Papers II, III and V)
   2.3. Which socio-demographic variables are associated with the teaching? (Papers II, III and V)

3. Educators' and students' knowledge of the codes
   3. 1. What is educators' adequacy of knowledge of the codes to teach the codes? (Papers II, III, and V)
   3.2. What is students' knowledge of the codes and what is their ability to apply the knowledge? (Papers II, III, and V)

4. Development of the teaching of the codes
   4.1. What is the need and applicability of the codes, and their importance in nursing ethics education? (Paper IV)
   4.2. How should teaching of the codes be developed? (Paper IV)

4. METHOD

4.1. Phases of the study and methodological approach

Descriptive, comparative and cross-sectional design was used in this study to evaluate nurse educators' and graduating nursing students' descriptions of the teaching of nurses' codes of ethics. The study was conducted in three phases between the years 2004-2010.

The concern of *Phase I* was to critically review empirical research and theoretical literature on nurses' codes of ethics and ethics in general. The purpose of the review was to delineate the extent, quality, and foci of the research on nurses' codes, and primarily to gather evidence of what is known of the teaching of nurses' codes **(**Data I, N= 50, Paper I). Inductive content analysis was used to analyse empirical data in this critical review. (Polit & Beck 2008).

In *Phase II* a questionnaire was developed to measure the teaching of the codes, and it was piloted (Data II, N = 36). These procedures are described in section 4.2.

The purpose of *Phase III* was to evaluate the teaching of the codes in order to get a comprehensive description of the state of the teaching. This phase consisted of data collection from nurse educators and graduating nursing students using the self-designed questionnaire, and of analyses of the collected data. First, nurse educators' and nursing students' responses to open-ended questions were extracted from the questionnaires and transcribed. This data was analysed by a qualitative inductive content analysis and descriptive statistics (Data III, n = 183 and Data IV, n = 214, Paper IV). Second, nurse educators' descriptions of their own teaching (Data III, n = 183, Paper II) and nursing students' perceptions of what they had been taught about the codes (Data IV, n = 214, Paper III) were measured. This data was analysed using descriptive and inferential statistics. Finally, the results of the educators' and students' measurements (Data III, n =183 and Data IV, n = 214, Paper V) were compared. This data was analysed using descriptive and inferential statistics (Figure 1).

4.2. Development of the questionnaire

A self designed questionnaire was used as an instrument to collect data for this study. Literature review (Paper I) and other relevant literature searches revealed that existing questionnaires suitable for this study did not exist. Therefore a questionnaire was designed specifically for this study (Appendices 1a and 1b). The questionnaire was based on the Ethical Guidelines of Nursing issued by the Finnish Nurses Association (1996), which

are an adaptation of the 1973 version of the International Council of Nurses' Code of Ethics for Nurses (Sorvettula 1993), on nursing literature, and on laws and other official documents related to the codes. Because there were two target groups in this study, i.e. nurse educators and nursing students, separate questionnaires were adapted to suit each group. The differences between the two parallel questionnaires dealt with some demographic variables and with the formulation of questions. Educators were asked to estimate their own current teaching of the codes whereas students were asked to estimate their perception of the teaching of the codes during their own nursing studies.

The questionnaire included nine sections. The first section dealt with participant demographics. Demographic variables (Questions 1-13; n = 13 items) included participants' age and sex, basic educational background (students) or basic professional education (educators), other education apart from the current nursing education (students), and the highest educational attainment (educators). The students were also asked to name the specialty area of their nursing studies, and the educators their experience as a nurse educator, and which nursing specialty areas they taught the most. The rest of the demographic variables dealt with the teaching formats used in the teaching of the codes, participants' acquisition of their knowledge of the codes, their research and development work related to the codes, and whether a visiting lecturer was used to teach the codes in the participants' nursing education units.

The second section focused on the participants' perspectives on teaching of the codes (items 14-17; n = 4 items) Participants answered on a 5-point Likert scale (1 = Fully disagree, 2 = Almost disagree, 3 = Neither agree nor disagree, 4 = Almost agree, 5 = Fully agree). The participants were also given an opportunity to support their Likert scale answers by a brief written justification. The items focused on the need of nurses' own codes, their applicability to the modern health care context, and their importance as a part of nursing students' ethics education. Educators were also asked to assess the adequacy of their own knowledge to teach the codes and the students were asked to assess their educators' adequacy of knowledge to teach the codes.

The third section focused on the statements of the codes (questions 18 – 47; n = 30 items). This section was developed by explicating the Finnish Ethical Guidelines of Nursing (1996) into items and thus dealt with the content of the codes exclusively. These items were presented in six themes as in the codes themselves: I. The mission of nurses (5 items), II. Nurses and patients (5 items), III. The work and professional competence of nurses (5 items), IV. Nurses and their colleagues (5 items), V. Nurses and society (5 items), and VI. Nurses and the nursing profession (5 items).

The fourth section focused on ethical concepts inherent in the codes (questions 48-56; n = 9 items). The concepts were explicated from the codes. Each concept was named

and briefly defined. The concepts were patients' rights, privacy, truth-telling, justice, autonomy, confidentiality, duty, sanctity of life, and accountability/responsibility.

The fifth section focused on the functions of the codes (questions 57- 88; n = 32 items). These items were based on the analysis of the Finnish Ethical Guidelines of Nursing (1996) and a review of relevant nursing literature. The items were presented as seven themes: I. Professional function, II. Social function, III. Practical function, IV. Ethical function, V. Legal function, VI. Duty function, and VII. Educational function.

The sixth section dealt with the codes of other health care professions (questions 89-96; n = 8 items). The choice of these codes was based on nurses' close relationship with these professions in practice or their other relevance to nurses.

The seventh section dealt with laws and agreements that are relevant in relation to the codes (questions 97-112, n = 15items). The choice was based on ethical concepts and principals inherent in these laws and agreements as well as in the codes, and were therefore regarded as important for nurses to be familiar with.

In sections 3 through 7 the educators were asked to circle the choice which best described the extent of their teaching concerning the subject matter of each item. The students were asked to circle the choice which best described their perception of the extent of teaching concerning the subject matter of each item. The participants answered on a 5-point Likert scale (1 = Not at all, 2 = Fairly little, 3 = To some extent, 4 = Fairly much, 5 = Very much). In sections 6 through 9 the alternative "other, what…" gave the participants an opportunity to provide an answer of their own choice.

Sections 8 and 9 dealt with teaching methods (question 113, n = 10 alternatives) and evaluation methods (questions 114-116; n = 22 alternatives). Participants were asked to choose from 1 to 3 most used methods from given alternatives. In section nine the educators were also asked to assess their students' knowledge and ability to apply the codes in practice, and nursing students were asked to assess their own knowledge and ability to apply the codes in practice (questions 117-118; n = 2 items). The participants answered on a 5-point Likert scale (1 = Very poor, 2 = Fairly poor, 3 = Average, 4 = Fairly good, 5 = Very good). And finally, the educators and students were provided with an opportunity to describe briefly in writing how they would develop the teaching of the codes or whether they would like to say something else about the teaching of the codes (questions 119-120; n = 2 items).

Sum variables were formed according to theoretical categories. These were obtained by adding up the coded answers and dividing the calculated sum by the number of variables. So the sum variables have the same scale as the individual items. Consequently, the range of the sum variables was the same as the original question had.

The questionnaire was provided with a cover letter which gave the respondents information of the purpose of the study, its target groups, and matters related to research ethics such as anonymity and confidentiality of the respondents. The two questionnaires are presented in Appendices 6 and 7, and the English translation of the educators' questionnaire in Appendix 8.

4.3. Study context and data collection

This study was carried out in polytechnics which provide basic nursing education in Finland. There were 31 polytechnics in Finland in 2006 out of which 25 offered basic nursing education in a total of 41 separate nursing education units located throughout the country.

Data collection for the literature review (*Phase I*) was carried out in 2006-2007 and described in detail in Paper I, and therefore it is not repeated here. Data collection for piloting (*Phase II*) took place in January-February, 2006. The questionnaire was sent to 60 doctoral students in nursing science, who assessed the intelligibility and clarity of the instrument. A total of 36 (60 %) of the students responded. Of these respondents 24 (66.7%) were nurse educators, of whom 17 (70,2 %) had taught, and 7 educators (29.2 %) had not taught the codes of ethics. The remaining 12 respondents (33.3 %) were neither educators nor did they teach the codes. The responses were critically reviewed for their content. Based on the results of the review questions were added (n = 6), or removed (n = 2), and response alternatives either added (n =1), removed (n =2) or reformulated (n = 4). Also the layout of the questionnaire was revised to a more "easy-to-use" format.

The data collection procedure for *Phase III* was initiated in May, 2006. All the nursing education units (n = 41) of polytechnics were approached. A letter was sent to the director of each unit. It included the study permit application form, the questionnaire, and the research plan of the study. The permission to carry out the study was provided either by the principal of the polytechnic or the director of the unit depending on the approval procedure of each polytechnic. All permissions were issued by mid-September, 2006.

Out of all the units, 39 (95%) participated and these involved 24 (96%) polytechnics. One unit declined to participate due to educators' and students' overwhelmingly busy schedules and the other unit would have required a Swedish language version of the questionnaire. Providing a double translated version of the questionnaire for one unit was considered to be unfeasible and expensive.

The participating units were asked to name a contact person. The task of the contact person was to provide the number of eligible participants (nurse educators and nursing students) for the study, to request the required number of questionnaires, and distribute

the questionnaires to the participants. An e-mail letter was sent to the contact persons and it included all necessary information and instructions for carrying out their task. Participants were asked to return the questionnaire directly to the researcher in a pre-stamped envelope.

The target groups in nursing education units were nurse educators and nursing students. An eligible nurse educator had to be a qualified educator to teach nursing and that she/he was teaching or had taught ethics either as separate study units or as integrated studies to students who were studying to become nurses. An eligible student had to study in the basic nursing education programme to become a nurse and graduate by the end of year 2006.

Data was collected simultaneously from both participant groups in November-December, 2006, and completed in January, 2007. One reminder letter was sent after 4 weeks of the first batch of questionnaires. A total of 634 questionnaires were requested for nurse educators. Educators returned 209 questionnaires of which 26 were rejected as uncompleted. Twenty-four of the rejected questionnaires were returned by educators, who indicated that teaching ethics was not their responsibility. Two questionnaires were only partially completed. Thus, 183 of the educators' questionnaires were included in this study. The response rate was 29%. A total of 764 questionnaires were requested for nursing students. Students returned 217 questionnaires of which 3 were rejected as only partially completed. Thus, 214 of students' questionnaires were included in this study. The response rate was 28%.

4.4. Data analysis

Statistical methods and content analysis were applied in the analysis of the data. Analysis started by checking the data to detect any inadequate or irrelevant completions of the questionnaires, before entering it into a statistical software program. In connection with the data checking, the data (written responses to open-ended questions) for the qualitative analysis were extracted and transcribed from the questionnaires.

4.4.1. Measurement scales of the questionnaire

Four different scales were used to describe the distribution of single items of the data: 1) a five- point Likert scale assessing the extent of teaching of the codes: 1= Not at all through 5 = Very much, (items 18-112 and 117-118), 2) a five-point Likert scale assessing the students' knowledge and ability to apply the codes: 1 = Very bad through 5 = Very good (items 117-118), 3) a five-point Likert scale assessing the educators' adequacy of knowledge to teach the codes: 1 = Fully disagree through 5 = Fully agree (item 17), a similar five-point Likert scale assessing educators' and students' opinions of nurses'

codes of ethics (questions 14-16), and a scale in which the respondent was to choose from 1 to 3 alternatives from given alternatives of teaching and evaluation methods (questions 113-116). In this study the Likert scale data was treated as a measurement on an interval scale. Sum variables were formed to measure teaching of the codes and related subject matters (questions 18-112).

4.4.2. Methods of the analyses

Inductive content analysis was used in the analyses of the literature review and the open-ended questions (questions 14-17, 119 and 120). Content analysis is the process of organizing and integrating narrative, qualitative information according to emerging themes and concepts. The content of the narrative data is analysed to identify prominent themes and patterns among the themes. The analysis involves breaking down data into smaller units, coding and naming the units according to the content they represent, and grouping the coded material based on shared concepts. (Polit & Beck 2008.) The technique provides a systematic means of measuring the frequency, order, or intensity of the occurrence of words, phrases, or sentences (Burns & Grove 2009). Content analysis can be used to gather important data to supplement data which could not be retrieved only by structured questions with fixed-end responses. (LoBiondo-Wood-Haber 1998). The content analysis procedure used in this study is described in detail in Paper II.

Statistical data analysis was performed by the Statistical Program for Social Sciences for Windows (SPSS 14.0) software. Descriptive statistics' frequency distribution, percentage, mean, range and standard deviation were used to summarize the data of all variables (items 1 – 120).

Inferential statistics' independent samples *t*-test and analysis of variance (ANOVA) were used to estimate the differences of means between educator groups and student groups. The independent samples *t*-test estimated educators' and students' differences in the extent of teaching of the codes and related subject matters (questions 14-113) in relation to their sex, basic professional education/basic education, highest educational attainment/other education than nursing, length of teaching of ethics as separate study modules, conducting research related to nurses' codes, and participation in development work related to nurses' codes (questions 2, 3, 4, 7, 10, 11, 12), and ANOVA in relation to educators' assessment of the adequacy of their knowledge and students' assessment of their educators' knowledge to teach the nurses' codes (question 17).

Relationships between variables were estimated by Pearson's correlation coefficient (*r*). The relationship was estimated in the educator group between the extent of teaching nurses' codes and related subject matters (questions 14-113) and educators' age, experience as a teacher in years, teaching codes as separate study modules and as integrated teaching (questions 1, 5, 8, 9). The relationships were estimated in the student group between

their perceptions of the extent of teaching nurses' codes and related subject matter items (questions 14-113) and students' age, and teaching the codes as separate study units and as integrated teaching (questions 1, 8, 9). A Chi-square test was used to estimate differences between educator groups and student groups regarding individual items. All values were estimated as significant at the level of $P < 0.05$. Statistical analysis was complemented with relevant graphics.

4.5. Research ethics

The general principles of research ethics were taken into account in this study (Polit & Beck 2008, Tutkimuseettinen neuvottelukunta 2002). A written permission to carry out the study was obtained from the principals of the polytechnics, or in some cases from the directors of the nurse education units who had been authorized to grant permissions for studies carried out in their units. The principals or the directors of the units were mailed an application letter which included a description of the study, i.e. its purpose and aim, its design, and its participant target groups. The commitment to follow principles of anonymity, confidentiality and voluntary participation in the study was included in the letter as well. Paper copies of the research plan and the questionnaire accompanied the application letter.

Education in Finland is a public function. According to law, access to follow teaching may be restricted only for a justified reason (The Polytechnics Act 351/2003). Apart from some questions in participant demographics, the questions dealt with publicly available information and the overall risk of harm to participants was considered minimal (LoBiondo-Wood & Haber 1998).

Violations of principles of human dignity, justice and beneficence essential in research including human participants were not at stake. Self-determination concerning voluntary participation in the study respected participants' human dignity. Justice was maintained by protecting the participants' privacy by using anonymous questionnaires and treating the obtained data confidentially. This study did not expose the participants to serious harm, thus their beneficence was not violated. The participants were fully informed of these matters in the cover letter attached to the questionnaire. Hence, the requirement for written consent from participants was waived, and the returned questionnaire was regarded as their consent to participate. (Burns & Grove 2009, LoBiondo-Wood & Haber 1998). The reproduction policies of the publishers of the four original publications were duly checked to verify that the reprinting is permissible, which is the case.

5. RESULTS

The results of this study are reported in five parts according to the research questions: the first part describes nurse educators' and nursing students' demographic characteristics; the second, what is known about nurses' codes of ethics in practice and education; the third, participants' descriptions of the practices in teaching of the codes; the fourth, educators' and students' knowledge of the codes; and the fifth, participants' perceptions of the codes and of the development of their teaching. The results are presented also in Papers I, II, III, IV and V.

5.1. Participant characteristics

5.1.1. Nurse educators

A total of 183 nurse educators participated in this study. The educators' mean age was 51 years with an age range from 29 to 63 years. The majority of educators belonged to the age groups between 40 - 64 years (n = 158; 86 %), and the majority of them were women (n = 180; 98 %). The educators' basic professional health care education included all nursing specialty areas. The largest group was medical-surgical nurses (n = 82; 45 %).A master's degree in nursing was the most common highest educational attainment of the educators (n = 146, 80 %); nineteen educators (n = 19; 10%) had a PhD degree. The educators' mean teaching experience was 15 years ranging from 0.4 to 33 years. To the question concerning each educator's most taught teaching subject areas, the educators gave 571 responses of which only 18 (3 %) responses included ethics or philosophy. Educators' demographics are presented in detail in Paper III and Table 1 in Paper V.

The integration of ethics into theoretical nursing studies and clinical practice was the most common of different combinations of teaching formats (n = 64; 35 %). Almost equally favoured was a teaching format in which separate ethics study courses were used complementary to integration into theoretical nursing studies and clinical practice. The sole use of separate ethics study courses (n = 7; 4%) or integration only into clinical practice (n = 5; 3 %) were the least favoured teaching formats. Tabulation of individual teaching formats showed that integrating teaching into theoretical nursing studies was the most used teaching format (n =160; 87 %) The teaching formats are presented in Table 10. The mean length of time the educators had taught separate ethics study courses was 5 years ranging from 0.2 to 20 years, and an integrated teaching format 12 years ranging from 0.2 to 31 years.

Table 10. Educators' use of teaching formats

Teaching format	*n*	*%*
Combinations of teaching formats:		
Integration into theoretical nursing studies and clinical practice	64	35
Separate ethics study courses and integration into theoretical nursing studies and clinical practice	50	27
Integration into theoretical nursing studies	31	17
Separate ethics study courses and integration into theoretical nursing studies	15	8
Separate ethics study courses and integration into clinical practice	7	4
Separate ethics study courses	7	4
Integration into clinical practice	5	3
Uncompleted	4	2
Total	183	100
Individual teaching formats cited by educators alone or in combinations:		
Integration into theoretical nursing studies	160	87
Integration into practice	127	69
Separate ethics study courses	80	44

Educators had most commonly acquired their knowledge of the codes during their basic health care or basic academic education and through independent learning, e.g. reading and familiarizing themselves with relevant literature (n = 54; 30 %). Tabulation of individual methods showed that independent learning was the most used of the acquisition methods (n = 160, 87 %). Less than a third of the educators had participated in separate ethics studies (n = 58; 32 %). The educators' acquisition of knowledge is presented in Table 11. Twenty-six (14 %) educators had conducted research and eighteen (10 %) educators had participated in development work related to the codes.

Table 11. Educators' acquisition of knowledge of the codes

Acquisition method	*n*	*%*
Variations of acquisition methods:		
Basic and academic education, and independent learning	54	30
Basic, academic education, separate ethics studies and independent learning	27	15
Academic education and independent learning	24	13
Basic education and independent learning	13	7
Academic education, separate ethics studies and independent learning	10	5
All other combinations	55	30
Total	183	100
Individual methods cited by educators alone or in variations:		
Independent learning (e.g. literature)	160	87
Academic health care education	143	78
Basic health care education	121	66
Separate ethics studies	58	32
Other ways	17	9

A good half (n = 107; 59 %) of the educators mentioned that a visiting lecturer was not used at all or fairly little in teaching ethics or codes in their nurse education units. About one third (n = 57; 31%) said that a visiting lecturer was used to some extent.

5.1.2. Nursing students

A total of 214 nursing students participated in this study. Their mean age was 27 years with an age range from 21 to 51 years**.** The majority of the students belonged to the age group of 20 – 39 years, and the majority of them were women (n = 184; 86 %). The students' most common basic educational background was upper secondary school matriculation (n = 147; 68%). Half of the students (n = 107, 50%) had completed other studies either at vocational school, polytechnic, or university levels or had participated in apprenticeship training or completed courses in different lengths. The students' previous studies represented all educational sectors in the Finnish educational system apart from the natural sciences sector. Studies in the health care sector were the most prevalent (n = 70; 33 %). Forty-six (20 %) students had a qualification as a practical nurse. The previous studies comprised a total of 42 different educational programmes. Students' demographics are presented in detail in Paper IV and in Table 2 in Paper V.

Students perceived separate ethics study courses to be the most commonly used teaching format (n = 71; 33 %) in the teaching of the codes. Separate ethics study courses integrated into theoretical nursing studies (n = 45, 21 %) or integration into theoretical nursing studies only (n = 37, 17 %) were the students' perceptions of fairly much used teaching formats. Integrating teaching into clinical practice was not perceived to be common. Tabulation of individual teaching formats showed that the use of separate ethics study courses was the most used teaching format according to the students (Table 12). About half of the students had perceived that the use of separate ethics study courses was limited to one year or less. About half of the students mentioned that the integrated teaching format had been used from 2 to 4 years during their studies.

Table 12. Students' perceptions of the teaching formats

Teaching format	***n***	***%***
Combinations of teaching formats:		
Separate ethics study courses	71	33
Separate ethics study courses and integration into theoretical nursing studies	45	21
Integration into theoretical nursing studies	37	18
Separate ethics study courses and integration into theoretical nursing studies and clinical practice	36	17
Integration into theoretical nursing studies and clinical practice	13	6
Separate ethics study courses and integration into clinical practice	9	4
Missing	3	1
Total	214	100
Individual teaching formats cited by students alone or in combinations:		
Separate ethics study courses	161	75
Integration into theoretical nursing studies	132	62
Integration into clinical practice	59	28
No teaching at all	1	1

The majority of the students had acquired their knowledge of the codes either during their basic nursing education or during basic nursing education supplemented with independent learning, e.g. reading and familiarizing oneself with relevant literature. Tabulation of individual acquisition methods showed also that basic nursing education and independent learning had been the most common single methods. A few students also brought up the Internet, exams, group discussions and personal experiences as their sources of knowledge of the codes (n = 12, 6 %). Students' acquisition of knowledge is presented in Table 13.

Table 13. Students' acquisition of knowledge of the codes

Acquisition method	*n*	*%*
Variations of acquisition methods:	112	52
Basic nursing education	64	30
Basic nursing education and independent learning (e.g. literature)	8	4
Basic nursing education and separate ethics studies	9	4
Independent learning		
Basic nursing education, separate ethics studies and independent learning	4	2
All other variations	14	7
Missing	3	1
Total	214	100
Individual methods cited by students alone or in variations:		
Basic nursing education	195	91
Independent learning (e.g. literature)	76	36
Separate ethics studies	20	9
Other methods	10	5

Seventeen students (8 %) mentioned that they had done research related to the codes. Because the students were asked to provide only a general description of their research topics, it was not possible to detect in detail how the research was related to the codes. None of the students had participated in development work related to the codes.

The majority of the students (n = 194, 91 %) perceived that a visiting lecturer was used either not at all or fairly little in teaching of ethics or the codes. A representative from the Finnish Nurses Association, a university professor, a medical doctor, a nurse educator, or a patient were mentioned as lecturers, in which cases a visiting lecturer was used, or students could not remember the lecturer (n = 18; 8 %).

5.2. Empirical knowledge of nurses' codes of ethics in practice and education

A review of the literature revealed that empirical research on nurses' codes of ethics was scarce and practically negligible in the area of education. Research on the codes focused on five main domains of interest dealing with 1) the knowledge and use of

the codes, 2) the content and functions of the codes, 3) moral behaviour related to the codes, 4) the values related to the codes, and 5) education. Research indicated that nurses' knowledge and use of the codes was deficient and that nurses' moral response to ethical dilemmas was guided by personal experiences and environmental factors rather than the codes. However, nurses found the codes to have positive functions such as guiding nursing practice, providing professional standards and status and acting as a disciplinary tool. Use of the codes was both conscious and unconscious. Hindrances to using them were lack of knowledge, self-confidence, and professional recognition as well as inadequate education, although teaching of the codes was regarded as important. Nurses' moral behaviour and values were in congruence with the values embedded in the codes. Education seems to have a positive impact on the moral development of nurses.

Methodologically, research was fairly diverse, impairing comparison between the findings. The studies had been conducted in several countries representing varying nursing cultures, settings and educational systems. Quantitative research dominated. However, limitations such as small sample sizes or reliability and validity issues have limited the generalization of the findings. Nurses and nursing students were the largest groups of participants whereas research focusing on nurse educators or nursing leaders was scarce. These results are reported in detail in Paper I.

5.3. Practices in the teaching of ethics

Practices in the teaching of ethics comprised the content of teaching, and teaching and evaluation methods.

5.3.1. The content of teaching of the codes of ethics

Teaching of the content of the codes comprised five subsections: 1) Statements in the codes (the Finnish Nurses Association's Ethical Guidelines of Nursing 1996), 2) Ethical concepts in the codes, 3) Functions of the codes, 4) Codes of ethics of other health care professions and 5) Laws and agreements related to the codes.

1. Statements

The nurse educators' and nursing students' results indicated that teaching of the statements of the codes had been extensive. On a five-point Likert scale, 97 % (n = 29) of educators' and 80 % (n = 24) of students' item-related mean scores measured 3.00 or higher, and 17 (57 %) and 12 (40 %) mean scores 4.00 or higher. Educators' means ranged from 2.95 to 4.84 with standard deviations from 0.32 to 1.21, and item-related response rates from 96% to 98%. The students' mean scores ranged from 2.42

to 4.89 with standard deviations from 0.37 to 1.13, and item-related response rates from 96% to 99%. In teaching the statements, both groups most emphasized the nurse-patient relationship and least the social aspects of nursing. The smallest difference between mean scores at sum variable level was related to the mission of nurses (mean difference = 0.07) and the biggest to collegiality (mean difference = 0.59) in favour of educators. However, comparison between the groups showed statistically significant differences in all but one statement sum variable, viz. mission of nurses, and throughout the majority of statement items (n = 24; 80 %), in that educators had described their teaching as more extensive than what the students had perceived it to have been (t = 3.94 – 6.98, $P < 0.001$; $P_{x2} < 0.001$- 0.005). Teaching of the statements is presented in Table 14 and Figure 2, and teaching of all contents in Table 3 in Paper V.

Table 14. Educators' and students' descriptions of the extent of teaching of statements of the codes (n =30)

Statement	Theme*	Educators		Students		Mean Difference
		Mean	Sd	Mean	Sd	+ = *Pro educators*
The nurse is bound to confidentiality	*II*	4.84	0.52	4.89	0.37	- 0.05
The nurse respects human dignity of those under her/his care	*II*	4.79	0.54	4.66	0.55	+ 0.13
The nurse respects the autonomy of those under her/his care	*II*	4.69	0.59	4.51	0.69	+ 0.18
The nurse is responsible for the quality of nursing care	*III*	4.66	0.61	4.26	0.82	+ 0.40
The nurse has an obligation to develop her/his competence	*III*	4.62	0.66	4.33	0.76	+ 0.29
The nurse exercises impartiality in her/his work	*II*	4.58	0.68	4.34	0.79	+ 0.24
The mission of the nurse is to support those under her/his care	*I*	4.58	0.59	4.29	0.82	+ 0.29
The nurse collaborates with significant others of those in her/his care	*V*	4.54	0.72	4.25	0.76	+ 0.29
The nurse is personally responsible for her/his work	*III*	4.48	0.72	4.23	0.81	+ 0.25
The mission of the nurse is to alleviate suffering	*I*	4.37	0.82	4.24	0.83	+ 0.13
The nurse is responsible for the improvement of nursing care	*III*	4.33	0.77	3.85	0.94	+ 0.48
Nurses respect the expertise of their own and other professions	*IV*	4.31	0.77	3.85	1.00	+ 0.46
The nurse is responsible for her/his actions primarily to those under her/his care	*II*	4.30	0.80	3.78	0.94	+ 0.43
The mission of the nurse is to promote health	*I*	4.17	0.85	4.38	0.74	- 0.21
The nursing profession is responsible for the expertise of the profession	*VI*	4.13	0.98	3.60	1.01	+ 0.53
The mission of the nurse is to prevent illness	*I*	4.05	0.86	4.06	0.83	- 0.01
The nurse evaluates her/his own and others' competence when receiving and giving assignments	*III*	4.01	0.97	3.41	1.01	+ 0.60
Nurses support each other in decision-making concerning nursing care	*IV*	3.97	0.32	3.55	1.03	+ 0.42
Nurses supports each other in their endurance in work	*IV*	3.97	0.93	3.42	1.05	+ 0.55
The mission of the nurse concerns the whole population	*I*	3.93	1.03	3.79	1.04	+ 0.14
Nurses guard that no other nurse nor other professional act unethically toward patients	*IV*	3.91	0.96	3.18	1.12	+ 0.73
Nurses support each other in their professional development	*IV*	3.70	0.97	3.00	1.13	+ 0.70
Nurses see to it that the members of the nursing profession accomplish their mission in a dignified manner	*VI*	3.57	1.15	2.93	1.08	+ 0.64
The nurse cooperates with organizations relevant to patient care	*V*	3.55	1.01	3.08	0.97	+ 0.47
The nursing profession supports the ethical development of its members	*VI*	3.52	1.13	2.97	0.99	+ 0.81
The nursing profession controls that the humane nature of nursing is preserved	*VI*	3.42	1.13	2.95	1.05	+ 0.47
The nurse participates in discussion concerning the health at national and international levels	*V*	3.38	1.12	2.70	0.98	+ 0.68
The nurse participates in decision-making concerning health at national and international levels	*V*	3.20	1.12	2.51	0.98	+ 0.69
The professional organization of nurses functions actively to secure just social and ec and economic working conditions for its members	*VI*	3.19	1.21	3.31	1.11	- 0.12
The nurse bears global responsibility for the development of living conditions concerning health of human beings	*V*	2.95	1.19	2.42	1.02	+ 0.53
All	*I - VI*	4.06		3.69		+ 0.37

**I. The Mission of Nurses, II. Nurses and Patients, III. The Work and Professional Competence of Nurses, IV. Nurses and their Colleagues, V. Nurses and Society, VI. Nurses and Nursing Profession*

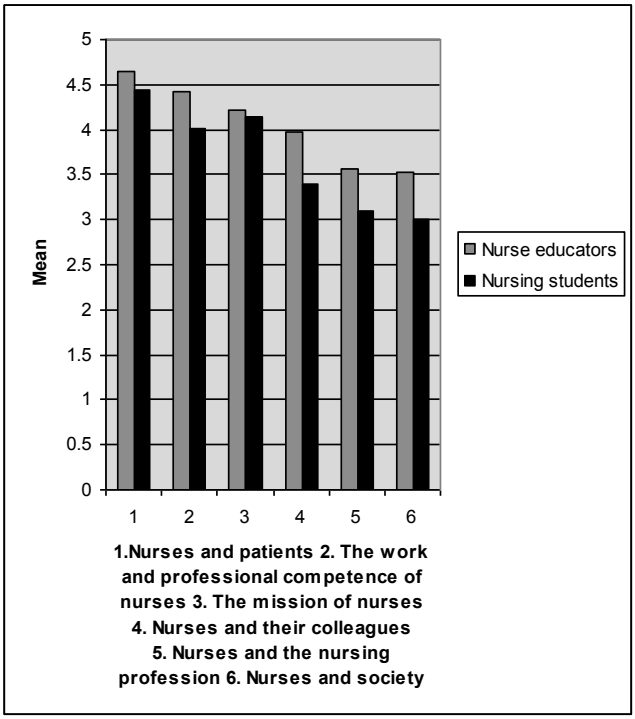


Figure 2. Teaching of the statements of the codes

2. Ethical concepts

Teaching of ethical concepts was described as particularly extensive by nurse educators and nursing students. Concerning all concepts (n = 9, 100 %), the mean scores of both groups measured 3.00 or higher, and in the case of seven (78 %) concepts the educators' and in the case of five (56 %) concepts the students' mean scores measured higher than 4.00. Educators' means ranged from 3.39 to 4.72 with standard deviations from 0.52 to 1.23, and item-related response rates from 97 % to 98 %. The students' mean scores ranged from 3.45 to 4.76 with standard deviations from 0.52 to 1.14 and item-related response rates from 98 % to 99 %. The most emphasized concept in both groups was confidentiality. Sanctity of life was highlighted the least. The smallest difference between scores was related to confidentiality (mean difference 0.04) and patients' rights in favour of students and the biggest to teaching of truth-telling (mean difference 0.36) in favour of educators. Nearly throughout all concept items, the educators' mean scores were higher than the students' scores, but statistically significant differences concerned the concepts of truth-telling, justice and responsibility/accountability in favour of the educators, indicating that the educators had described their teaching as more extensive than what the students had perceived it to have been ($P_{x2} < 0.002$-0.016). Teaching of the ethical concepts is presented in Table 15 and Figure 3, and in Table 3 in Paper V.

Table 15. Educators' and students' descriptions of teaching of the ethical concepts of the codes

Ethical Concept	Educators		Students		Mean difference
	Mean	Sd	Mean	Sd	+ = Pro educators
Confidentiality	4.72	0.56	4.76	0.52	- 0.04
Autonomy/Self-determination	4.47	0.71	4.37	0.69	+ 0.10
Privacy	4.44	0.79	4.39	0.66	+ 0.05
Justice	4.42	0.67	4.16	0.76	+ 0.26
Patients' rights	4.34	0.76	4.38	0.74	- 0.04
Truth-telling	4.20	0.82	3.84	0.93	+ 0.36
Responsibility/Accountability	4.08	1.04	3.85	1.02	+ 0.23
Duty	3.63	1.06	3.57	1.02	+ 0.06
Sanctity of Life	3.39	1.23	3.45	1.14	- 0.06
All concepts	4.19		4.09		+ 0.10

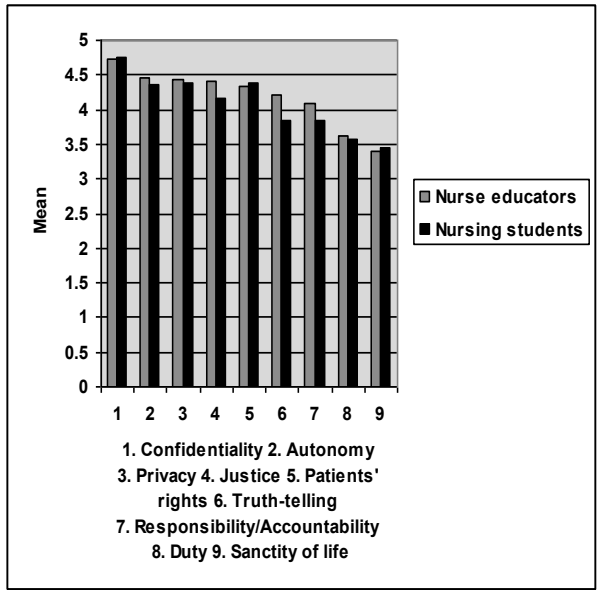


Figure 3. Teaching of the concepts of the codes

3. Functions

Teaching of the functions was described as moderately extensive. Concerning all functions (n = 32, 100%), all of the educators' (n = 32; 100 %) and nearly two thirds of the students' (n = 23, 72 %) mean scores exceeded the value of 3.00. None of the students' mean scores exceeded the value of 4.00, whereas from the educators' mean score values eight (25 %) were higher than 4.00. The educators' means ranged from 3.08 to 4.30 with standard deviations from 0.93 to 1.23 and item- related response rates from 97 % to 98 %. The students' mean scores ranged from 2.90 to 3.90 with standard deviations from 0.89 to 2.28 and item-related response rates from 98 % to 99 %. The most emphasized function was the ethical function and the least highlighted was the social function. The smallest difference between mean scores at the sum variable level was related to the duty function (mean difference = 0.24) and the biggest difference

to the educational function (mean difference = 0.49). Throughout all items related to the functions, the educators' mean scores were higher than the students' scores (t = 2.56-4.96, $P < 0.001 – 0.01$, $P_{x2} < 0.001$-0.05). Teaching of the functions is presented in Table 16 and Figure 4, and in Table 3 in Paper V.

Table 16. Educators' and students' descriptions of the extent of teaching of the functions of the codes

	Function category*	Educators		Students		Mean difference
		Mean	SD	Mean	SD	+ = *Pro educators*
To describe the ethical values of nursing	***IV***	4.30	0.98	3.90	0.97	+ 0.4
To describe the ethical responsibilities of the nurse	***IV***	4.29	0.93	3.90	0.93	+ 0.39
To provide the nurse with guidance in ethical decision-making	***III***	4.20	0.98	3.74	0.97	+ 0.46
To describe the professional values and ideals of nursing	***I***	4.18	1.03	3.68	1.00	+ 0.5
To teach nursing students to recognize moral and practical duties of nursing care	***VII***	4.10	0.93	3.59	1.02	+ 0.51
To develop the nurse's professional reasoning	***I***	4.09	1.01	3.70	0.90	+ 0.39
To develop nursing students' critical thinking	***VII***	4.06	0.94	3.64	2.28	+ 0.42
To describe the ethical nature of the goals of nursing	***IV***	4.01	1.03	3.53	1.00	+ 0.48
To give the nurse moral guiding principles for nursing care	***III***	3.98	0.96	3.74	0.99	+ 0.24
To express the legal responsibilities of the nurse	***V***	3.94	1.14	3.62	1.09	+ 0.32
To act as the standard for assessing the ethical practice of the nurse	***IV***	3.91	1.04	3.45	1.01	+ 0.46
To describe the moral duties related to the nurse's work	***VI***	3.90	0.99	3.59	0.98	+ 0.31
To describe the ethical standards of nursing	***IV***	3.89	1.02	3.40	1.00	+ 0.49
To describe the principles of the nurse's professional conduct	***I***	3.87	1.07	3.36	1.01	+ 0.51
To support the nurse in her/his work	***I***	3.86	1.03	3.59	0.98	+ 0.27
To act as the standard for assessing the quality of nursing care	***III***	3.84	1.01	3.39	0.95	+ 0.45
To support nursing students in their evaluation of their know-how by describing the criteria of ethically high-quality care	***VII***	3.78	1.06	3.16	1.08	+ 0.62
To express the basic mission of the nurse in society	***III***	3.49	1.14	2.96	1.07	+ 0.53
To describe the other than moral duties related to the nurse's work	***VI***	3.48	1.02	3.31	1.02	+ 0.17
To express the nurse's responsibilities and duties to society	***II***	3.44	1.17	3.13	1.11	+ 0.31
To act as criteria to assess professional misconduct	***V***	3.40	1.23	2.95	1.08	+ 0.45
To support nurse educators and clinical instructors in their teaching work by describing the criteria of ethically high quality care	***VII***	3.36	1.22	2.88	1.10	+ 0.48
To guide the content of curricula by describing the criteria of ethically high quality care	***VII***	3.34	1.19	3.00	1.05	+ 0.34
To express the nurses' basic function in society	***II***	3.26	1.19	3.20	0.98	+ 0.06
To unite the nursing profession	***I***	3.25	1.20	3.12	1.10	+ 0.13
To protect nurses from legal responsibility in assessing malpractice and misconduct	***V***	3.20	1.27	3.13	1.11	+ 0.07
To act as the justification to the nursing professions to provide nursing care	***V***	3.19	1.20	2.91	1.06	+ 0.28
To act as the instrument of self-regulation of the nursing profession	***V***	3.16	1.23	2.93	1.04	+ 0.23
To describe and promote the nurse's professional status in society	***I***	3.14	1.07	2.96	0.92	+ 0.18
To express the nursing profession's social standing	***II***	3.09	1.10	2.78	1.03	+ 0.31
To protect the nurse and the patient by declaring publicly what is expected of the nurse	***II***	3.09	1.14	2.86	1.08	+ 0.23
To act as a contract between the profession and the society governing the keeping of the professional rules	***II***	3.08	1.19	2.90	1.12	+ 0.18
All	***1 -VII***	3.66		3.31		+ 0.35

**I. The Professional Function, II. The Social Function, III. The Practical Function, IV. The Ethical Function, V. The Legal Function, VI. The duty Function, VII. The Educational Function*

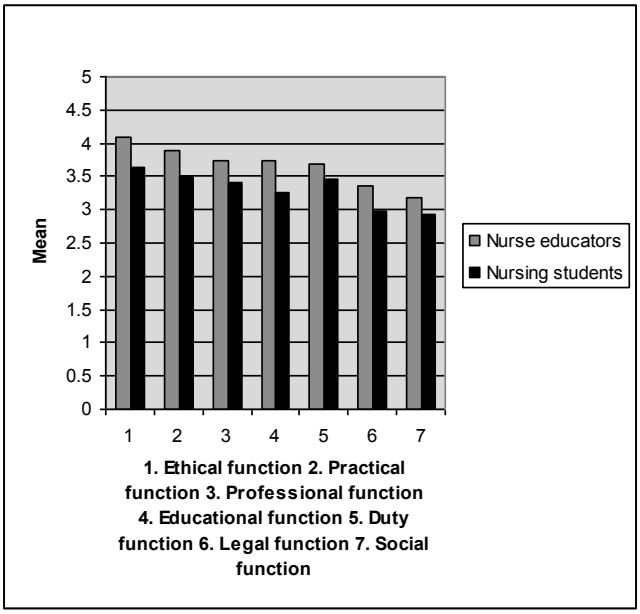


Figure 4. Teaching of the functions of the code

4. The codes of other health care professions

Teaching of the codes of other health care professions was modest. On a five-point Likert scale one (1 %) of the educators' and one (1 %) of the students' item-related mean scores exceeded the value of 3.00. The educators' means ranged from 1.51 to 3.31 with standard deviations from 0.97 to 1.74 and item-related response rates from 91 % to 98 %. The students' means ranged from 1.41 to 3.3 withstandard deviations from 0.83 to 1.41 and item-related response rates from 96 % to 98 %. However, in both groups the item regarding Shared Values in Health Care, Common Goals and Principles (ETENE 2002c) had low response rates, i.e. educators 20 % and students 6 %. In both groups the most taught code of ethics was the Code of Medical Ethics (2000) and the least taught was the International Code of Ethics for Midwives (1998). Regarding one half of the codes of other professions (n = 4, 50%), nursing students' perceptions of the extent of teaching exceeded that of the educators (mean differences 0.04-0.92, $P < 0.001$, $P_{x2} < 0.001$). Teaching of the codes of other health care professions is presented in Table 17 and Figure 5, and in Table 18.

Table17. Educators' and students' descriptions of teaching of the codes of other health care professions

Codes of Ethics	Educators		Students		Mean difference
	Mean	Sd	Mean	Sd	+ = *Pro educators*
Code of Medical Ethics (2000)	3.31	1.38	2.55	1.16	+ 0.76
Shared Values in health Care, Common goals and Principles (National Advisory Board on Health Care Ethics, ETENE (2000)	2.92	1.74	2.00	1.41	+ 0.92
The International Council of Nurses' Code of Ethics (ICN 2000)	2.26	1.22	3.03	1.22	- 0.77
The Ethical Principles of Child Care (1993)	2.17	1.14	1.72	0.87	+ 0.45
Code of Ethics for Nursing Leaders (2003)	1.71	1.13	1.91	1.00	- 0.20
Code of Ethics of Emergency Nurses (1997)	1.61	1.21	1.71	1.02	- 0.10
Code of Ethics for Practical Nurses (2000)	1.52	0.97	1.54	0.98	- 0.04
International Code of Ethics for Midwives (1998)	1.50	1.06	1.41	0.83	+ 0.09
All	2.23		1.98		+ 0.25

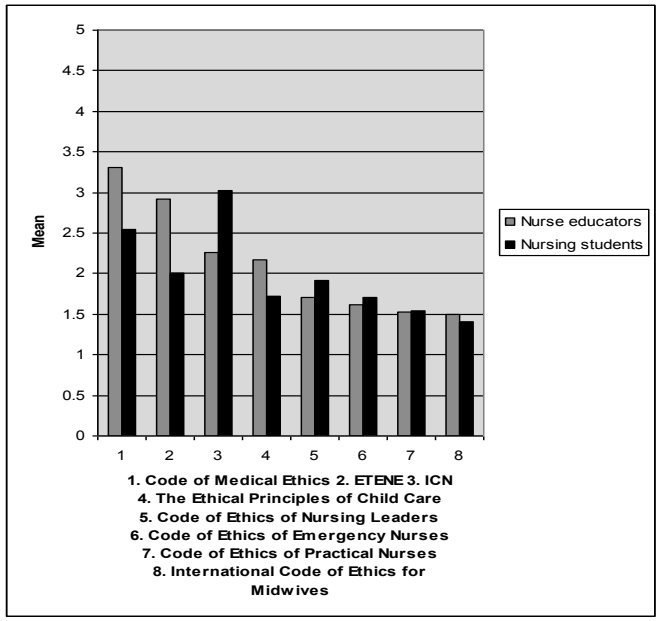


Figure 5. Teaching of the codes of other health care professions

5. Laws and agreements related to the codes

Laws and agreements were taught moderately. On a five-point Likert scale six (38 %) of both the educators' and students' item-related mean scores were higher than 3.00. The educators' means ranged from 2.12 to 4.4 with standard deviations from 0.79 to 1.42 and item-related response rates from 96 % to 98 %.The students' means ranged from 1.92 to 4.24 with standard deviations from 0.84 to 1.42. The students' item-related response rate was 98 %. However, in both groups the item regarding the Act on the Protection of Privacy in Electronic Communications (2000) had a low response rate, i.e. the educators 15 % and students 7 %. The most emphasized law dealt with patients' rights. The least taught law concerned medical research. The biggest mean difference concerned the Mental Health Act (1990) (mean difference 1.04) and the smallest difference concerned the Act of

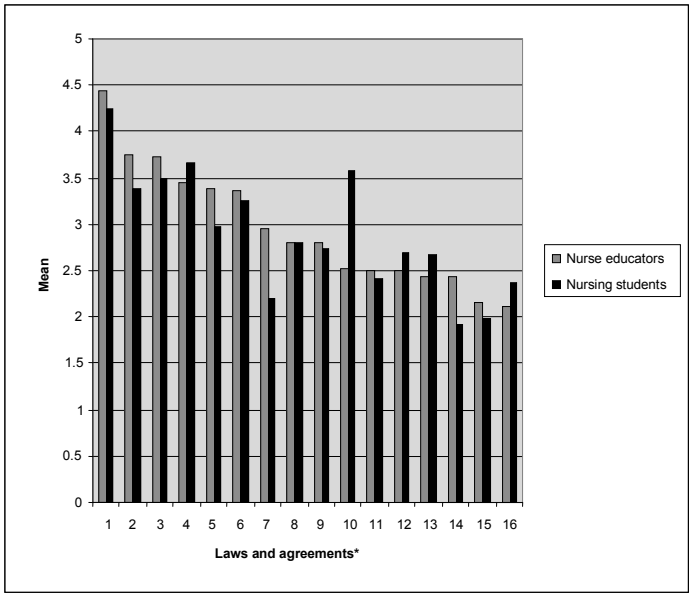
Table 18. Educators' and students' descriptions of teaching of the contents related to the codes

Item	Sum variable*/variable	Educators		Students			Sum variable related significance/ T-test P < 0.05	Item-related significance/ Chi-square P < 0.05
		Mean	*Sd*	*Mean*	*Sd*	*Mean difference +=Pro educators*		
	Codes of Ethics of other health care professions							
94	Code of Medical Ethics (2000)	3.31	1.38	2.55	1.16	+ 0.76		*P* = 0.001
95	Shared Values in Health Care, Common Goals and Principles (National Advisory Board on Health Care Ethics, ETENE 2000)	2.92	1.74	2.00	1.41	+ 0.92		
89	The International Council of Nurses' Code of Ethics (ICN 2000)	2.26	1.22	3.03	1.22	- 0.77		
93	The Ethical Principles of Child Care (1993)	2.17	1.14	1.72	0.87	+ 0.45		*P* < 0.001
91	Code of Ethics for Nursing Leaders (2003)	1.71	1.13	1.91	1.00	- 0.20		*P* < 0.001
96	Code of Ethics of Emergency Nurses (1997)	1.61	1.21	1.71	1.02	- 0.10		*P* < 0.001
92	Code of Ethics for Practical Nurses (2000)	1.52	0.97	1.54	0.98	- 0.04		
90	International Code of Ethics for Midwives (1998)	1.50	1.06	1.51	0.83	+ 0.09		
	Laws and agreements							
103	Act on the Status and Rights of the Patients 785/1992	4.44	0.80	4.24	0.84	+ 0.20		*P* = 0.016
	Act of Health Care Professions 559/1994	3.74	1.26	3.38	1.13	+ 0.36		*P* < 0.001
104	Patient Injury Act 585/1985	3.73	1.21	3.50	1.06	+ 0.23		*P* = 0.00 2
101	Primary Health Care Act 66/1972	3.45	1.15	3.66	0.95	- 0.21		*P* = 0.011
107	Act of Nursing Profession 554/1962	3.39	1.30	2.98	1.17	+ 0.41		*P* = 0.002
102	Act of Specialized Medical Care 1062/1989	3.36	1.24	3.25	1.14	+ 0.11		
111	Act on the Protection of Privacy in Electronic Communications 516/2004	2.96	1.22	2.20	1.42	+ 0.76		
105	Act of National Authority for Medicolegal Affairs 1074/1992	2.81	1.34	2.80	1.20	+ 0.01		
97	United Nations' Universal Declaration of Human Rights 10.12.1948	2.81	1.29	2.73	1.09	+ 0.08		
110	Mental Health Act 1116/1990	2.53	1.38	3.57	1.08	- 1.04		*P* < 0.001
112	Abortion Law 239/1970	2.51	1.35	2.41	1.18	+ 0.10		*P* < 0.001
99	Convention on the Rights of The Child 1989	2.50	1.42	2.70	1.12	- 0.20		*P* < 0.001
100	The Constitution of Finland 731/1999	2.44	1.16	2.68	1.12	- 0.24		*P* < 0.001
108	Decree on the National Advisory Board on Health Care Ethics 1347/1991	2.43	1.25	1.92	1.02	+ 0.51		*P* < 0.001
109	Medical Research Act 785/1999	2.16	1.20	1.98	1.03	+ 0.18		
98	European Convention of Human Rights 439/1990	2.12	1.14	2.38	0.96	- 0.26		*P* < 0.001

National Authority of Medicolegal Affairs (1992) (mean difference 0.01), which educators had taught less extensively than what the students perception was. However, the mean differences fluctuated, so that some laws and agreements were more emphasized by educators and some by students. Teaching of the laws and agreements is presented in Table 19 and Figure 6, and in Table 18.

Table 19. Educators' and students' perceptions of teaching of laws and agreements

Law/Agreement	Educators		Students		Mean difference
	Mean	Sd	Mean	Sd	+ = *Pro educators*
1. Act on the Status and Rights of the Patients 785/1992	4.44	0.80	4.24	0.84	+ 0.20
2. Act of Health Care Professions 559/1994	3.74	1.26	3.38	1.13	+ 0.36
3. Patient Injury Act 585/1985	3.73	1.21	3.50	1.06	+ 0.23
4. Primary Health Care Act 66/1972	3.45	1.15	3.66	0.95	- 0.21
5. Act of Nursing Profession (554/1962)	3.39	1.30	2.98	1.17	+ 0.41
6. Act of Specialized Medical Care 1062/1989	3.36	1.24	3.25	1.14	+ 0.11
7. Act on the Protection of Privacy in Electronic Communications 516/2004	2.96	1.22	2.20	1.42	+ 0.76
8. Act of National Authority for Medicolegal Affairs 1074/1992	2.81	1.34	2.80	1.20	+ 0.01
9. United Nations' Universal Declaration of Human Rights 10.12.1948	2.81	1.29	2.73	1.09	+ 0.08
10. Mental Health Act 1116/1990	2.53	1.38	3.57	1.08	- 1.04
11. Abortion Act 239/1970	2.51	1.35	2.41	1.18	+ 0.10
12. Convention on the Rights of The Child 1989	2.50	1.42	2.70	1.12	- 0.20
13. The Constitution of Finland 731/1999	2.44	1.16	2.68	1.12	- 0.24
14. Decree on the National Advisory Board on Health Care Ethics 1347/1991	2.43	1.25	1.92	1.02	+ 0.51
15. Medical Research Act 785/1999	2.16	1.20	1.98	1.03	+ 0.18
16. European Convention of Human Rights 439/1990	2.12	1.14	2.38	0.96	- 0.26
All	3.16		3.09		+ 0.07



**** Laws and agreements are listed in Table 21.***

Figure 6. Teaching of laws and agreements related to the codes

5.3.2. Teaching and evaluation methods

Teaching methods

A total of 180 (98%) nurse educators and 211 (99%) nursing students responded to the question concerning teaching methods. The educators' and students' descriptions of used teaching methods were somewhat different. Both groups described that the two most used methods had been discussion and lecture. However, according to the students' perception, educators had used less discussion than lecturing, whereas educators reported that they had used more discussion than lecturing. The educators' third choice of the used teaching method was a seminar, while the students' third choice was written assignments. The educators' least favoured teaching methods were games etc., computer-based teaching, and educational visits. The students' perceptions of the least-used methods were educational visits, games etc., and argumentation. Comparison between the groups showed statistically significant differences in all but one teaching method ($P_{x2} < 0.001 – 0.015$). Teaching methods are presented in Table 20 and in Figure 1 in Paper V.

Table 20. Educators' and students' descriptions of teaching methods

Teaching method	Educators %	Students %	Percentage difference + = Pro educators	Item-related significance/ Chi-square (x^2) Fisher's exact test P ≤ 0.05
Discussion (small group)	85	66	+ 19	*P* < 0.001
Lecture	72	92	- 20	*P* < 0.001
Seminar	46	25	+ 21	*P* < 0.001
Writing (essay, portfolio, diary)	43	52	- 9	
PBL	41	21	+ 20	*P* < 0.001
Argument	8	2	+ 6	*P* = 0.004
Educational visit	8	0	+ 8	*P* < 0.001
Computor-based teaching	7	31	- 24	*P* < 0.001
Games, Role plays, Simulations	6	1	+ 5	*P* = 0.015
Other	0	2	- 2	

Evaluation methods

A total of 177-179 (97-98%) nurse educators and 209-211 (98-99%) nursing students responded to the three questions concerning evaluation, i.e. evaluator, evaluation methods, and evaluation formats of student outcomes. In all these questions the groups' descriptions were somewhat different. The results are described in detail in Table 21 and Figures 2, 3 and 4 in Paper V.

Both educators and students named an educator as the most used student evaluator. However, according to students, an educator was used as an evaluator more often than what educators had described. Also, the students' view of the lack of an evaluator exceeded the educators' description. In other options, the educators' descriptions exceeded the students' perception. Regarding most options (n = 4, 80%), the differences between groups were statistically significant ($P_{x2} < 0.001 – 0.029$). Detailed results are presented in Table 21 and in Figure 2 in PaperV.

Table 21. Student outcome evaluation methods

Variable	Evaluation method	Educators %	Students %	Percentage difference + = Pro educators	Item-related significance/ Chi-square (x^2) Fisher's exact test $P \leq 0.05$
Evaluator	Educator	91	97	- 6	$P = 0.029$
	Student self	84	64	+ 20	$P < 0.001$
	Clinical instructor	64	45	+ 19	$P < 0.001$
	Peer student	40	25	+ 15	$P < 0.001$
	Nobody	3	7	- 4	
	Evaluation discussion	60	28	+ 32	$P < 0.001$
Evaluation method	Diary	48	37	+ 11	$P = 0.023$
	Essay as a home assignment	42	47	- 5	
	Essay in an exam session	29	34	- 5	
	Portfolio	22	6	+ 16	$P = 0.001$
	Other	10	9	+ 1	
	Oral exam	8	9	- 1	
	No evaluation	6	8	- 2	
	Performance assessment	5	0	+ 5	$P = 0.007$
	Multiple-choice exam	3	15	- 12	$P < 0.001$
Form of evaluation outcome	Oral feedback	68	19	+ 49	$P < 0.001$
	Passed/Failed	58	67	- 9	
	Numerical grade	50	65	- 15	$P = 0.040$
	Written feedback	48	25	+ 23	$P < 0.001$
	Other	2	1	+ 1	
	No feedback	2	7	- 5	$P = 0.023$

Educators and students also had different views about the use of evaluation methods. The educators' three most-used evaluation methods were discussion, diary, and essay as a home assignment. According to the students, the three most-used evaluation methods were essay as a home assignment, diary, and essay in an exam session. The educators' least-used evaluation methods were multiple-choice exam, performance assessment and no assessment at all, whereas the students' options as the least-used evaluation methods were performance assessment, portfolio, and no evaluation at all. In half (n = 5, 50%) of the evaluation methods, the differences in responses between the groups were statistically significant ($P_{x2} < 0.001 – 0.023$). Detailed results are presented in Table 21 and in Figure 3 in Paper V.

The educators' three most-used formats to report learning outcomes were oral feedback, pass/fail, numerical grade and written feedback. The students' three most-used formats of learning outcomes were pass/fail, numerical grade and written feedback. The educators' views of the use of oral and written feedback were much higher than the students' perceptions, whereas students regarded the use of pass/fail and numerical grade higher than the educators did. In more than half (n = 6, 67 %) of the evaluation formats, the differences in responses between the groups were statistically significant ($P_{x2} < 0.001 – 0.040$). Detailed results are presented in Table 21 and in Figure 4 in Paper V.

5.4. Nurse educators' and nursing students' demographic variables and their associations with the teaching of the codes

The educators' and students' demographic data and its relation to the teaching of nurses' codes of ethics are reported separately, because comparison between educators' and students' demographics was not relevant. Pearson's correlation coefficient, *t*-test and Chi-square-test were used in assessing the significance of demographic variables in the teaching of the codes. Variables were estimated significant at the level $P \leq 0.05$.

5.4.1. Nurse educators

The educators' age, teaching experience and implementation of integrated teaching in years had several statistically significant correlations with the extent of their teaching. However, the correlations were weak, Pearson's *r* values ranging from 0.15 to 0.26 with significance values from 0.045 to 0.001 (Table 22). The educators' sex, level of education and the time the educators had taught the codes as separate ethics study modules did not correlate with the extent of their teaching.

Table 22. Educators' demographic variables associated with teaching of the codes (*P <0.05*)

Sum variables	Age in years	Teaching experience in years	Integrated teaching in years
	Pearson's r		
Nurses and the nursing profession	$r = 0.26$ $P = 0.001$	$r = 0.22$ $P = 0.003$	$r = 0.26$ $P = 0.001$
Nurses and their colleagues		$r = 0.15$ $P = 0.044$	$r = 0.26$ $P = 0.001$
Nurses and society	$r = 0.21$ $P = 0.005$	$r = 0.22$ $P = 0.003$	$r = 0.20$ $P = 0.013$
The work and professional competence of nurses			$r = 0.19$ $P = 0.014$
Nurses and patients			$r = 0.18$ $P = 0.020$
The mission of nurses	$r = 0.18$ $P = 0.019$	$r = 0.17$ $P = 0.025$	
The educational function	$r = 0.17$ $P = 0.023$	$r = 0.25$ $P = 0.001$	$r = 0.25$ $P = 0.001$
The social function	$r = 0.18$ $P = 0.016$	$r = 0.22$ $P = 0.003$	$r = 0.24$ $P = 0.002$
The professional function		$r = 0.16$ $P = 0.035$	$r = 0.20$ $P = 0.010$
The legal function		$r = 0.18$ $P = 0.016$	$r = 0.20$ $P = 0.012$
The ethical function		$r = 0.17$ $P = 0.028$	$r = 0.19$ $P = 0.014$
The duty function			$r = 0.19$ $P = 0.016$
The practical function			$r = 0.18$ $P = 0.024$
Ethical concepts	$r = 0.22$ $P = 0.004$	$r = 0.21$ $P = 0.005$	$r = 0.26$ $P = 0.001$
Codes of ethics of other health care professions	$r = 0.16$ $P = 0.038$	$r = 0.15$ $P = 0.045$	$r = 0.18$ $P = 0.021$
Laws and agreement	$r = 0.24$ $P = 0.001$	$r = 0.24$ $P = 0.002$	$r = 0.19$ $P = 0.013$

The educators' basic professional education, teaching format, and acquisition of knowledge of the codes had significant impact on the extent of teaching of many functions, ethical concepts, codes of other health care professionals, as well as laws and agreements ($t = -1.971 - -3.899$, $P < 0.001$-0.050), but had less impact on teaching of the statements of the codes (Table 23). Item-related Chi-square –tests revealed several statistically significant values between the educators' demographics and teaching of the codes, but these associations had no practical relevance in terms of the teaching as a whole.

Table 23. Educators' demographic variables and sum variable *t*-tests

	Basic professional education			Teaching of the codes			Aquisition of knowledge of the codes				Research	Develop-ment work
	Nurse	Midwife	Health visitor	As separate ethics study courses	Integrated to theory	Integrated to clinical practice	Basic health care education	University education	Separate ethics studies	Independent learning		
Statements of nurses' codes of ethics												
The mission of nurses												
Nurse and patients												
The work and competence		*t* = 2.580 *P* = 0.011										
Nurses and collegues		*t* = 2.468 *P* = 0.015										
Nurses and society							*t* = - 2.895 *P* = 0.004					
Nurses and profession												
Functions of the codes												
Professional												
Social						*t* = - 2.679 *P* = 0.008			*t* = - 2.327 *P* = 0.021			
Practical								*t* = - 2.272 *P* = 0.024		*t* = - 2.839 *P* = 0.005		
Ethical				*t* = - 2.140 *P* = 0.034					*t* = - 1..971 *P* = 0.050	*t* = -3.682 *P* = 0.000		
Legal											*t* = 2.110 *P* = 0.036	
Duty												
Educational									*t* = - 2.591 *P* = 0.010	*t* = - 2.205 *P* = 0.029		
Concepts				t = - 2.194 P = 0.030					*t* = - 2.512 *P* = 0.013	*t* = - 2.522 *P* = 0.013		
Codes of ethics of other professions	*t* = 2.191 *P* = 0.030			*t* = - 3.984 *P* < 0.001			*t* = - 3.169 *P* = 0.002		*t* = - 2.740 *P* = 0.007			
Laws and agreements	*t* = 2.165 *P* = 0.032			*t* = - 3.899 *P* < 0.001			*t* = - 2.840 *P* = 0.005		*t* = - 3.431 *P* = 0.001	*t* = - 2.370 *P* = 0.019		*t* = 2.497 *P* = 0.013

5.4.2. Nursing students

Age and sex had no correlation with the students' perception of the extent of the teaching. The length of teaching formats, whether as separate study modules or as integrated teaching, had some significant positive correlations with the extent of teaching. Particularly, the length of integrated teaching correlated with the perception of teaching of nearly all the content matter areas except functions. Nevertheless, the correlations were weak, Pearson's *r*-values ranging from 0.15 to 0.6 with significance values from 0.05 to 0.001. Significant correlations are presented in Table 24.

Table 24. Students' demographic variables associated with teaching of the codes ($P < 0.05$)

Sum variables	Age in years	Separate teaching in years	Integrated teaching in years
	Pearson's r		
Nurses and the nursing profession			
Nurses and their colleagues			$r = 0.15$ $P = 0.034$ (Spearman's r)
Nurses and society			
The work and professional competence of nurses			$r = 0.26$ $P = 0.001$
Nurses and patients			$r = 0.25$ $P = 0.002$
The mission of nurses			$r = 0.21$ $P = 0.010$
The educational function		$r = 0.18$ $P = 0.032$ (Spearman's r)	
The social function			
The professional function			
The legal function			
The ethical function			
The duty function			
The practical function			
Ethical concepts			r = 0.22 $P = 0.007$
Codes of ethics of other health care professions			r = 0.20 $P = 0.014$
Laws and agreements*			r = 0.16 $P = 0.050$

The students' previous education and used teaching format had significant correlations with the perceived extent of the teaching. Students with lower educational backgrounds perceived the teaching of several content matter areas as more extensive (range from $t = -3.43$ to $t = -2.060$ and from $P = 0.001$ to 0.041) than students with higher educational backgrounds (range from $t = 6.41$ to $t = 1.99$ and from $P < 0.001$ to $P = 0.048$). Students who had participated in ethics teaching integrated into clinical training perceived teaching of several content matter areas as more extensive (range from t = - 3.20 to $t = -2.04$ and from $P = 0.002$ to $P = 0.043$) than students who had participated in teaching as separate study modules. Item-related Chi-square-tests revealed several statistically significant values between the students' demographics and perceived teaching the codes, but these associations had no practical relevance in terms of the teaching as a whole. Significant correlations are presented in Table 25.

Table 25. Students' demographic variables and sum variable *t*-tests ($P<0.05$)

Sum variable	*Basic education*			*Other education*		*Teaching of the codes*		*Acquisition of knowledge*	
	Comprehensive school	*Upper secondary school*	*Upper secondary matriculation*	*Polytechic*	*University*	*As separate ethics modules*	*As integrated to clinical training*	*During basic health care education*	*During separate ethics studies*
The mission of nurses				*t* = 2.276 *P* = 0.025					*t* = - 2.177 *P* = 0.031
ork and competence		*t* = 2.088 *P* = 0.036				*t* = -2.081 *P* = 0.039	*t* = -3.197 *P* = 0.002		
Nurses and collegues	*t* = -3.432 *P* = 0.001	*t* = 1.986 *P* = 0.048	*t* = 2.326 *P* = 0.021		*t* = 2.371 *P* = 0.020				
Nurses and society	*t* = -2.497 *P* = 0.013				*t* = 2.026 *P* = 0.045			*t* = - 2.354 *P* = 0.019	
Nurses and profession								*t* = - 2.039 *P* = 0.043	
Professional function					*t* = 4.629 *P* = 0.004			*t* = - 3.506 *P* = 0.001	
Social function								*t* = - 2.732 *P* = 0.007	
Practical function							*t* = -2.073 *P* = 0.040*		
Ethical function								*t* = - 3.422 *P* = 0.001	
Legal function	*t* = -2.257 *P* = 0.025							*t* = - 2.512 *P* = 0.013	
Duty function				*t* = 2.530 *P* = 0.013			*t* = -2.205 *P* = 0.029	*t* = - 2.589 *P* = 0.010	
Educational function		*t* = -2.231 *P* = 0.027	*t* = 2.317 *P* = 0.021	*t* = 2,697 *P* = 0.012*	*t* = 6.414 *P* <0.001			*t* = -2.852 *P* = 0.005	
Concepts								*t* = - 3.033 *P* = 0.003	
Codes of ethics of other professions	*t* = - 2.897 *P* = 0.004		*t* = 2.591 *P* = 0.010				*t* = - 2.417 *P* = 0.017		
Laws and agreements	*t* = - 2.060 *P* = 0.041		*t* = 2.511 *P* = 0.013				*t* = - 2.035 *P* = 0.043	*t* = *P* =	

5.5. Nurse educators' and nursing students' knowledge of the codes

5.5.1. Educators' adequacy of knowledge of the codes

The majority of educators (n = 154; 85%) assessed their own knowledge of the codes as adequate, and more than half of the students (n = 141; 66%) likewise assessed their educators' knowledge of the codes as adequate to teach nurses' codes of ethics (Table 26).

Table 26. Educators' and students' perceptions of the adequacy of knowledge

Adequacy of knowledge	Educators		Students	
	n	%	n	%
Adequate	154	84	141	66
Inadequate	11	6	21	10
Cannot say	18	10	47	22
Missing	0	0	5	2
Total	183	100	214	100

Comparison between educator groups revealed statistically significant differences in that for educators who assessed their knowledge as adequate (fully and almost degree), the overall teaching of the codes was significantly more extensive (F = 2.74 – 8.59; *P* = 0.045 – < 0.001) than the teaching of those educators who regarded their knowledge as inadequate. Comparison of student groups revealed that students who agreed that their educators' knowledge was adequate for teaching the codes (fully agree and almost agree) perceived that they had also been taught significantly more of all the subject matters of the codes (F = 3.76 – 12.44, *P* = 0.006 - < 0.001) than those students who disagreed or could not assess the adequacy of their educators' knowledge. (Table 27).

Table 27. Educators' and students' assessment of the educators' adequacy of knowledge to teach the codes associated with the extent of teaching ($P \leq 0.05$)

Adequacy of knowledge					
	Fully disagree	***Almost disagree***	***No agree or disagree***	***Almost agree***	***Fully agree***
Fully disagree					
Almost disagree					
No agree or disagree		Nurses and society **0.021** Nurses and the profession **0.022**			
Almost agree	Codes of other professions ***<0.001***	Professional competence **0.035**/ ***0.015*** Nurses and the profession **0.014**/ ***0.013*** Practical function ***0.038*** Ethical concepts **0.013**/ ***0.004***			
Fully agree	Professional competence ***0.021*** Nurses and colleagues ***0.050*** Codes of other professions ***<0.001*** Laws and agreements ***<0.001***	The mission of nurses **0.001**/ ***0.011*** Nurses and patients ***0.018*** Professional competence **0.009**/ ***0.001*** Nurses and colleagues **0.003**/***0.007*** Nurses and society **0.002**/ ***0.007*** Nurses and the profession **<0.001**/ ***<0.001*** Ethical concepts **0.001** Professional function **<0.001**/ ***0.001*** Social function **<0.001**/ ***0.001*** Practical Function **<0.001**/ ***<0.001*** Ethical function **0.036**/ ***0.001*** Legal function **0.003**/ ***0.004*** Duty function **0.022**/ ***0.037*** Laws and agreements ***<0.001***	The mission of nurses ***<0.001*** Nurses and patients ***<0.001*** Professional competence ***0.016*** Nurses and colleagues ***0.036*** Ethical concepts ***<0.001*** Professional function ***<0.001*** Social function ***0.005*** Practical function **0.025**/ ***<0.001*** Ethical function ***<0.001*** Legal function **0.029**/ ***0.003*** Duty function **0.014**/ ***0.012*** Educational function ***<0.001*** Codes of others professions ***0.013*** Laws and agreements ***<0.001***	Nurses and patients ***<0.001*** Nurses and society **0.016** The mission of nurses **0.026** Professional function **0.025**/ ***0.009*** Social function **0.026**/ ***0.037*** Practical function ***0.008*** Ethical function **0.018**/ ***0.022*** Educational function ***0.001*** Codes of other professions ***0.037*** Laws and agreements ***0.001***	

N.B. **Nurse educators in bold**/***Nursing students in italics***

Content analysis of the educators' and students' justifications concerning the adequacy of knowledge revealed differences between the groups. Personal motivation, interest, experience as a nurse and as an educator, and voluntary studies in ethics were the educators' justifications to explain the adequacy of their own knowledge. Those educators who regarded their knowledge inadequate expressed their need for additional education in ethics. Students justified the adequacy of the educators' knowledge by good and well-informed teaching, and by educators' theoretical and practical experiences of ethical situations in nursing. Those students who assessed the educators' knowledge as less adequate brought up the educators' lack of touch with nursing practice, the importance of the personal pedagogic qualities of educators, deficiencies in the use of effective teaching methods, and lack of time resources allocated to ethics education.

5.5.2. Students' knowledge of and skills to apply the codes

Educators (n = 183) assessed both their students' knowledge of the codes (Mean = 3.39; Sd = 0.94) and their skills to apply the codes (Mean = 3.44, Sd = 0.86) in practice as mediocre, as did the students in assessing their own knowledge of the codes (Mean = 3.37, Sd =0.78) and their own skills to apply the codes (Mean = 3.53, Sd = 0.80) in practice. However, the students' assessment of their own skills to apply the codes was slightly higher than their educators' assessment (Table 28, Figure 7).

Table 28. Educators' and students' assessment of students' knowledge of and skills to apply the codes

Knowledge and skills	**Educators**		**Students**		
	Mean	**Sd**	**Mean**	**Sd**	**Mean difference + = *Pro educators***
Knowledge of nurses' codes	3.39	0.94	3.37	0.78	+ 0.02
Skills to apply nurses' codes	3.44	0.86	3.53	0.80	- 0.19
Mean difference	0.05		0.16		

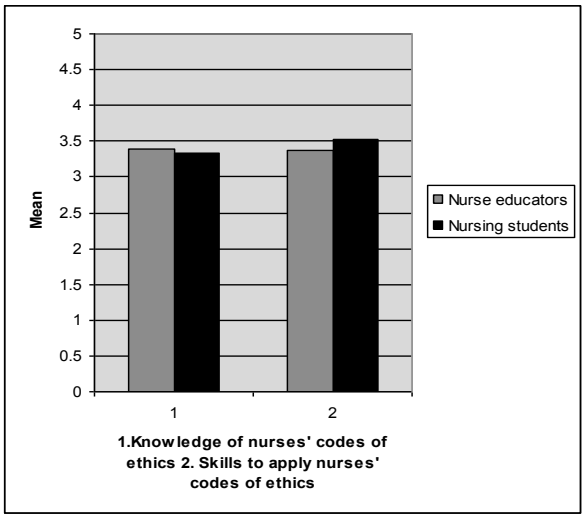


Figure 7. Knowledge and skills of the codes

5.6. Nurse educators' and nursing students' perceptions of the codes and the development of their teaching

Nurse educators and nursing students were asked four questions concerning their personal perceptions of the need of nurses' own codes of ethics, the applicability of the codes in the modern health care environment, the importance of the codes as an educational content in nurses' ethics education, and the participants' suggestions for possible development of the teaching of the codes. Three of the questions were structured but also provided an opportunity to complement the response with a brief justification, and one of the questions was fully open-ended. Descriptive statistics and inductive content analysis were used in the data analysis. A description of the content analysis of the justifications and the results of the analysis are described in detail in Paper II. Here the emerged categories are presented in Table 29.

Table 29. Categorization of educators' and students' responses to open ended questions

Question	*Main categories*	*Subcategories*
Do nurses need their own codes of ethics?	I. Nursing as an ethical endeavor	1. Working with humans 2. Core of nursing 3. Prevalence of ethical incidents
	II. Value basis of nursing	1. Guide to ethically high-quality nursing practice 2. Foundation of nursing values
	III. Nursing as a profession	1. Uniqueness of nursing 2. Professional growth and identity 3. Precondition of professional nursing 4. Precondition of independent profession
	IV. Codes of ethics as a guide	1. Guide to ethical thinking and decision-making 2. Guide to nursing practice
	V. The universal nature of health care ethics	1. Common codes for all health care workers
Do the codes apply in today's nursing context?	I. Positive applicability of the codes	1. Positive applicability of the codes
	II. Challenges of the codes	1.Changing health care environment 2. Out-datedness 3. Generality 4. Limitedness
	III. Universal and permanent nature of ethics and ethical values	1. Universal and permanent nature of ethics 2. Universal and permanent nature of humanity
	IV. Conflict between theory and practice	1. Lack of adequate resources 2. Difference between theory and practice
Are the nurses' codes an important part of nursing ethics education?	I. Professionalism	1. Basis of professionalism 2. Professional growth and identity
	II. Value basis of nursing	1.Ethical foundation of nursing 2. Guide to high-quality care
	III. Challenges of the codes	1. More resources and teaching 2. Importance of the context in teaching
	IV. Ethical decision-making	1.Enhancement and guide to ethical thinking and decision-making
How would you develop the teaching of the codes?	I. Teaching methods	1. Versatility 2. Importance of ethical discussions 3. Binding to context
	II. Integration of teaching	1. Horizontal and vertical integration throughout the education including clinical practice 2. Separate courses
	III. Allocation of resources	1. Lack of time and emphasis in the curriculum
	IV. Content of teaching	1. Importance of the codes as a content 2. Extension of the content

According to the results, there was a need for nurses' own codes of ethics, because nursing was seen as a moral practice, nurses' codes of ethics expressed the fundamental values of nursing, the codes were a hallmark of professionalism, and nurses' codes of ethics guided nurses' ethical decision-making and nursing practice. The applicability of the codes was also seen as mainly appropriate, because moral values embedded in the codes were permanent, universal and concerned all human beings. However, participants saw new challenges concerning the codes. The codes did not provide support for challenges brought about by the modern health care environment for being too out-dated, limited or

general. Participants expressed the lack of adequate resources and the difference between theory and practice as factors preventing their applicability.

The codes were regarded as an important content of nurses' ethics education, because the codes offered tools for professional growth and identity, values to enhance high quality care, and guidance in ethical decision-making. Suggestions for the development of the teaching of the codes dealt with the organization of ethics teaching, teaching methods, and allocation of resources. Ethics education should be implemented as integrated throughout nursing education, including clinical practice, but also complemented with separate ethics study courses. A more versatile use of teaching methods was needed as well as binding teaching to the nursing context. Discussion was seen as a good teaching method. Participants complained of a lack of emphasis on ethics in the curriculum and lack of time resources devoted to teaching ethics. These arguments concerning the codes and their teaching were repeatedly expressed in the justifications although there were some differences in emphasis between nurse educators and nursing students.

6. DISCUSSION

The purpose of this study was to analyze nursing ethics education from the perspective of nurses' codes of ethics in the basic nurse education programmes in polytechnics in Finland. The study started with a review of literature of nurses' codes of ethics in practice and education. The focus of the study was on nurse educators' and nursing students' descriptions of the practices of teaching ethics, i.e. the content of the teaching and its extent and the used teaching and evaluation methods, the participants' knowledge of nurses' codes and their perceptions of the codes and the development of their teaching. The study also explored associations between the participants' demographics and the teaching. This discussion proceeds according to the research questions. More detailed discussions are presented in Papers I, II, III, IV, and V.

6.1. Discussion of the results

Empirical knowledge of nurses' codes of ethics in practice and education

The literature review of empirical research dealing with nurses' codes of ethics provided little direct theoretical background for this study, because the share of educational research was particularly scarce. Research of the codes was also methodologically and culturally heterogeneous, impairing any generalization of the findings. Consequently, the review did not provide much substance to reflect upon the results of this study with earlier research. However, from the viewpoint of the teaching of the codes the review raised some thoughts. For example, does the deficient knowledge and use of the codes by nurses refer to some deficiencies in the teaching of the codes? In this study, as in earlier studies, the codes and their teaching have been regarded as important (e.g. Numminen 2000, Mannistö 2001, Ajanko 2003, Dinç & Görgülü 2002), but their teaching has also been assessed as wanting for various reasons (Tadd & al. 2006). Ethics education in general has been said to suffer from many uncertainties (e.g. Allmark 1995, Hussey 1996). In this context it is relevant to mention that also in this study the results indicated some confusion in that educators and students reported rather different practices of the use of teaching methods. It might be possible, of course, that the respondents answered according to their own preferences rather than describing the actual implementation of the methods (Nunnally & Bernstein 1994). However, clear instructions concerning the answering format did not lend support to this possibility. Consequently, the findings of this study suggest that the implementation of the teaching of ethics needs more attention.

Nevertheless, according to the literature review, nurses' values and moral behaviour seem to correspond with the values of the codes, unconscious and complemented with personal and social values though it may be. This unconscious commitment to the values of the codes could be seen as a positive point of departure for the teaching of the codes and enhancing students' awareness of the values embedded in the codes. A detailed discussion of the literature review is presented in Paper I.

Practices in the teaching of ethics

Based on the data of this study, teaching of the contents of the codes, apart from the codes of other health care professions, was extensive or moderately extensive. Earlier research has indicated that the codes were one of the most taught subjects in nursing ethics curricula (Numminen 2000, Dinç & Görgülü 2002), and their teaching was adequate, even excessive (Ajanko 2003, Görgülü & Dinç 2007). But nurses have also complained of inadequate teaching (e.g. Tadd et al. 2006). This suggests that there are differences in the extent of teaching between countries, nursing education institutions, and nursing cultures. According to earlier studies it seems that teaching of the codes has been paid a fair amount of attention in Finnish nurse education (Simula 1998, Numminen 2000, Ajanko 2003, Männistö 2001). However, quantity does not necessarily mean quality. In this study, the results gave a somewhat wanting impression of the educators' competence to teach ethics due to their lack of formal education in ethics proper. It should be noted here that the response rates in this study were low. Although low response rates have been acknowledged in many studies focusing on ethics (e.g. Ketefian 1981, Miller et al. 1991, Adams & Miller 1996, Numminen 2000, Ajanko 2003, Lipscomb & Snelling 2005, Görgülü & Dinç 2007, Brunou 2009), in this study the low response rates warrant caution in the interpretation of the results. Low response rates raise questions such as: What is the contribution of those educators who did not respond to the study, and what are non-responding students' thoughts about the codes and their teaching? The issue of educators' competence combined with the low response rates may indicate that the results of this study may not provide a fully realistic description of the teaching of the codes. These issues have been discussed in Papers II and III.

Teaching focused on issues that concerned the nurse's relationship with the patient or the nurse as a professional and as an individual. Issues that dealt with nursing in wider social spheres were less in focus. The result is in accordance with earlier literature (Whyte & Gajos 1995, Whyte & Gajos 1996, Gastmans 2002, Rassin 2008). So, it seems that the scope concerning the content of teaching is somewhat narrow. The reasons of this scope, such as the issues of the historical roles of nurses, the novice status of the students, and nurses as the largest group of health care professionals has been discussed in more detail in Papers II and III to suggest explanations for this scope.

Throughout the teaching contents, educators assessed their own teaching as more extensive than what the students perceived it to have been, although there were a few exceptions to this. Concerning most teaching contents, the differences were statistically significant. This result would seem rather natural, in that it is likely that educators know what they teach, whereas in the case of the students it is possible that recognizing ethics content in the integrated teaching format may sometimes be difficult for them. A recent Finnish study indicated that at least in the clinical context nursing students observed ethical issues in relation to the patient, the nursing staff or the student herself, but conscious recognition was random (Brunou 2009). This may apply to theoretical teaching as well, although theoretical teaching and clinical practice are different learning environments. The possibility of social desirability bias in ethics research, i.e. to respond in a socially acceptable way, should also be kept in mind (Nunnally & Burnstein 1994, Polit & Beck 2008). The relatively high values given on the Likert scale in this study may suggest this bias. This concerns particularly educators but students as well: For a nurse educator or a nurse, devaluing the importance of ethics in nursing care would most likely be regarded as unacceptable. Most likely this notion is consciously or unconsciously internalized during the professional socialization process in the case of most nurses. There are many other conceptions that nurses may internalize in the same way, such as subservience to the medical profession, for example concerning ethical decision-making (Kuhse 1997).

The most and the least emphasized teaching contents were basically the same in both participant groups. This suggests that educators truly teach what they have indicated in their responses, and the finding adds to the reliability of the study. The most highlighted teaching contents reflected essential principles and values of the Finnish health care system (Sosiaali-ja tervysministeriö 201, ETENE 2002b), documents concerning nursing students' qualifications in ethics knowledge (Opetusministeriö 2006), the teaching contents in the Finnish nursing ethics curricula (Nursing Curricula 2003, Appendix 9), and essential teaching contents in ethics discussed in international nursing literature (e.g. Allmark 1992, Hussey 1990, Seedhouse 1998, Scott 2000, Gastmans 2002, Woods 2005, Martin et al. 2003, Heikkinen & Leino-Kilpi 2004, Armstrong 2006, Leners et al. 2006, Vanlaere & Gastmans 2007).

The use of teaching methods was fairly conventional and narrow. This finding is in accordance with earlier Finnish studies (Puska 1998, Numminen 2000, Männistö 2001). Methods that required more active involvement in terms of resources, e.g. time, preparation, space facilities or educators' competence to master the method, were least favoured. However, there were statistically significant differences between educators' and students' descriptions concerning the extent of the use of each method and these differences were also greater than in the teaching content sections of the questionnaire. For example, educators mentioned discussion, seminar and problem-

based learning (PBL) as the most used method whereas students described lecturing, writing assignments and computer-based learning as the most prevalent methods. This finding suggests that educators used methods that are student-centred, interactive and require active involvement on the part of the student. In literature and studies, a context-based approach which utilizes a student's personal experiences has been acknowledged as an effective way to teach ethics (e.g. Scott 1996, Birkelund 2000, Holt & Long 1999, Webb & Warwick 1999, Gastmans 2002, Nolan & Markert 2002, Doane et al. 2004, Toiviainen 2005, Armstrong 2006, Yarborough & Klotz 2007). However, the students' descriptions suggest that teaching was educator-centred and preferred self-directed independent learning which was contradictory to the educators' descriptions. Perhaps this finding should not be interpreted too rigorously. First, it is unlikely that students actively bother themselves with the educators' didactic choices of each teaching session. In this sense a lecture is an easy method to recognize rather effortlessly, whereas an ethical discussion integrated with other teaching content may pass as an unnoticed method. Furthermore, in this study both the educators and the students found lack of resources, particularly time devoted to ethics teaching, as a cause for criticism. Consequently, to extend the otherwise scarce teaching time, this may force educators to resort to classroom teaching and written home assignments. Besides, written assignments foster students' ethical deliberation and critical thinking, which are essential abilities for quality ethical care (Cameron & Schaffer 1992, Foster et al. 1993, Bowman 1995, Seedhouse 1998, Webb & Warwick 1999, Nogueras 2002). But these findings dealing with teaching methods may also indicate some kind of uncertainty and perhaps an unsystematic approach in the implementation of the integrated teaching format.

The use of evaluation methods was conventional as well. Both groups recognized the educator as the main evaluator. Similarly with the use of teaching methods, there were discrepancies between the educators' and students' descriptions. According to the students' perceptions, the educators' use of interactive evaluation methods was not as extensive, and discussion and oral feed-back were much less used than what the educators had described. It is also worth noting that there were a small number of students who reported that they had neither been evaluated at all nor given feedback concerning ethics teaching. These results have also been discussed in Papers II and III.

The results suggest that there exists some uncertainty concerning the use of teaching and evaluation methods in ethics. This has been acknowledged in earlier literature (Allmark 1995, Hussey 1996). Therefore, the integrated teaching of ethics, referring to teaching which covers theoretical and clinical nursing studies, needs to be thoroughly and systematically addressed, aiming at development of integration which forms a red thread of ethics teaching throughout all of nursing education.

Participants' demographic variables and their association with teaching

Thee educators who participated in this study had a high mean age and fairly long teaching experience. But when these educators were asked their most taught teaching subject areas, only three per cent named ethics or philosophy. Whether this group of educators represents an average profile of a nursing ethics teacher raises a question of their competence in ethics and contribution to ethics teaching. Nevertheless, in this study the majority of educators assessed themselves competent to teach the codes. These issues have also been discussed in Paper II, but will be further addressed here. Could it be that educators underestimate the required competence level in teaching ethics or do not simply know what it should be? Furthermore, professional expertise in a field of nursing does not necessarily make one an expert in ethics (Kuhse 1997). For example, an expert nurse in surgical nursing does not make her an expert in ethical problems related to surgical nursing. This is compounded by the fact that in the integrated teaching format, educators also have to deal with teaching contents other than ethics. The issue of nurse educators' competence to teach ethics should be seriously discussed in the context of nursing ethics education. Ethics in nursing should not remain a catchword (Sellman 1996). Nurses need proper knowledge of ethics, because ethics is in the very heart of nursing and all health care work (Fowler 1989, Allmark 1992, Sellman 1996, Seedhouse 1998, Gastmans 2002, Andrews 2004).

Although the educators' demographic variables had numerous statistically significant single associations with teaching, only one variable revealed a significance that could be seen as consistent and relevant from a practical point of view: Educators who assessed their knowledge of the codes as adequate taught all areas of the codes more extensively than those who assessed their knowledge as less adequate. The other significant associations were with stray single items of teaching and had no obvious relevance with the overall teaching of the codes.

The students who participated in this study represented an average profile of a health care student in Finland (Statistic Finland 2007). Many of the students had completed previous professional studies, mainly in the health care sector. Some significant statistical differences were found also with students' demographic variables and the extent of teaching. The length of integrated teaching as well as integration of teaching into clinical practice seemed to have a positive impact on the students' perception of the extent of teaching. However, separate ethics study courses and integration into theory rather than into clinical practice were the students' perceptions of the prevalent teaching formats, as well as lecturing as the main teaching method. This implies that there is a discrepancy between the students' positive learning experience and teaching methods used. Furthermore, the students who had regarded their educators' knowledge as adequate to teach the codes also perceived the overall teaching of the codes to be

more extensive compared with the students who assessed their educators' knowledge as less adequate. This may imply that seemingly competent educators teach more than the less competent. However, it is good to reiterate here that students mentioned the educators' experience, good and well-informed teaching and personal pedagogic qualities as important justifications assessing their educators' adequacy of knowledge of the codes. A formal educational background in ethics was not an attribute in the students' assessment.

According to both participant groups a visiting lecturer was rarely used. Whether this means that nurse education units mainly consider themselves as competent in ethics or whether limited resources to ethics education act as a hindrance is uncertain. However, a presentation by a professional ethicist, a well known phenomenon in medical education (e.g. ETENE 2002a), might increase interest in and understanding of ethics. Such presentations could be simultaneously provided even to a larger group of students. Allocation of better resources and study facilities for ethics education might also attract professionals in health care ethics to seek employment in polytechnics.

Knowledge of the codes

To a large extent, the educators' acquisition of the knowledge of the codes and the adequacy of their knowledge to teach the codes was based on informal learning and experience. Interest, independent learning and practical experience may motivate the acquisition of knowledge, but they do not inform the content, breadth, or depth of such learning. It also refers to the issue discussed earlier, how ethics can be taught without formal qualifications in knowledge and skills when they are required in other teaching areas. This may lead to unsystematic teaching contents but also to refutable ethical relativism (Pellegrino 2002). However, this study described only the educators' subjective assessment of their own competence. It would also be relevant to evaluate the competence objectively. It seems to be a rather common human trait to think that if a person fulfils the generally accepted moral standards of society, it suffices in terms of knowledge of ethics and morality as well. However, in the context of professional nursing this does not apply, because ethical problems in nursing are different from those we encounter in our every-day lives (Hussey 1996). And finally, whether it is relevant to presume that ethics should be the expertise and responsibility of every nurse educator needs to be discussed as well.

The nursing students' knowledge of the codes originated from their basic nursing education but it was also complemented by independent learning, be it by the educator's recommendation of further reading or by the student's personal interest. Earlier studies support this finding (Nolan & Smith 1995, Nolan & Markert 2002). Students assessed their educators' knowledge to teach the codes mainly as adequate. As educators

themselves, students also justified the adequacy with their educators' experience. The positive correlation between competence and experience in nursing has been found e.g. by Benner (1984). Students also emphasized their educators' good knowledge base and pedagogic qualities. However, the students' knowledge of the codes and their ability to apply the codes was seen as average by both participant groups. Thus, the findings of this study and earlier studies create an interesting chain of thought which needs further considering: It implies a discrepancy between the extent of teaching, the perceived competence of educators and the student outcomes. According to this study, teaching of the codes was rather extensive and educators were seemingly rather competent to teach them. However, the students' knowledge of and skills to apply the codes were assessed as average and earlier studies have found that practising nurses' knowledge and use of the codes is deficient (e.g. Heikkinen & al. 2006, Strandell-Laine et al. 2005, Tadd et al. 2006, Heymans et al. 2007). If this is in keeping with reality, it raises the question what and where is the problem that students' and nurses' knowledge and skills do not seem to reach a higher level? One explanation can be found in studies dealing with nursing students' ethical decision-making, which have indicated that students' level of moral reasoning is mostly at the conventional level on the Kohlbergian scale, referring to an uncritical adaptation to prevailing moral norms and values in society. (e.g. Mustapha & Seybert 1989, Dierckx de Casterlé et al. 1997, Riesch et al. 2000, Auvinen et al. 2004, Kim et al. 2004, Juujärvi 2006, Numminen et al. 2007.) As referred to earlier in this discussion and the discussion in Paper II, nursing has a strong history concerning the subservient role of the nurse. It was the nurse's role to uncritically follow the medical profession's orders which gave no room for conscientious objection in matters ethical from the part of the nurse. It may well be that the socialization to the obedient role in relation to the medical profession and health care organizations still prevails in the nurse's conception of her role as an autonomous moral agent (e.g. Kuhse 1997, Yung 1997a, Yung 1997b).

Perceptions of the codes and the development of their teaching

According to the educators and the students, nurses need their own codes of ethics. Literature and earlier research support the participants' justifications for the need. The literature brings to attention the moral nature of nursing practice (Barrazetti et al. 2007). Nurses are committed to the values of the codes (Kelly 1991, Kelly1992, Weis & Schank 1997, Schank & Weis 2000, Schank & Weis 2001). The codes support nurses' ethical reflection and decision-making (Heikkinen & Leino-Kilpi 2004, Strandell-Laine et al. 2005, Vanlaere & Gastmans 2007). The codes also support professional identity and status (Verpeet & al. 2005, Tadd et al. 2006) and provide a basis for ethical nursing practice, and inform society and other disciplines about the domain of nursing (Esterhuizen 1996, Verpeet et al 2005, Heymans et. al. 2007). Moreover, the codes are

also strongly supported by ICN and national nurses' associations (Oulton 2000) and most basic text books in nursing ethics include the codes as the fundamental element of nurses' professional ethics (e.g. Kalkas-Sarvimäki 1995, Thompson et al. 2003, Davis et al. 2006, Butts & Rich 2008, Välimäki 2008a).

Participants saw the codes as the core of nursing ethics. However, this is a rather limited view of the ethical foundation of nursing. The codes were not seen in their wider context as a manifestation of other ethical discussion in society which has a strong impact on the development of the value base of nursing and consequently on the nursing codes. The codes are a result of this ongoing discussion and a normative document reflecting the outcomes of this discussion. Nursing does not happen in a vacuum. It is particularly this influence of the cultural and social environment, which also explains the differences between national codes of ethics and their need (e.g. Gastmans et al. 1998, Meulenbergs et al. 2004, Woods 2005). In this study the participants did not challenge the relevance of the codes, although many limitations of the professional codes have been acknowledged, also related to nurses' codes (e.g. Tadd 1994, Tschudin 2006, Pattison 2001, Pattison & Wainwright 2010). Limitations of the codes were discussed in section 2.1.7. of this study. It may also be reasonable to ask whether questioning the existence of the codes could be expected of every educator and student, or whether it is the task of the professionals in this field.

The codes' applicability to nursing practice was also positively acknowledged. Although applicability and application are two different things, it seems natural to think that these terms correlate in that positive applicability facilitates and enhances active application. However, earlier research has revealed that nurses' knowledge and application of the codes is deficient at all professional levels (Miller et al. 1991, Adams & Miller 1996, Wagner & Ronen 1996, Dinç & Ulusoy 1998). In ethical problem situations nurses rather rely on their personal values and experiences (Davis 1991, Schwartz 2004, Wilmot et al. 2002, Tadd et al. 2006), turn to their peers or supervisors (Edwards & Haddad 1988, Hariharan et al. 2006), and rarely use any ethical framework such as the codes in seeking help when encountering ethical problems (Gold et al. 1995, Miles & Burke 1996). This again reflects nurses' moral conventionalism (Kohlberg 1976). Thus, the positive views of the need and applicability of the codes found in this study and the deficient application indicated in other studies corroborate the notion that there are other factors that have an impact on the application than the codes themselves. And really, the hindrances to the use of the codes found in several studies are manifold, such as organization, multi-professional teamwork, the nursing profession including nurses themselves, health care policy, and patients' families. On the other hand, research has also indicated that nurses' use of the codes is partly unconscious. Nurses act according to professional values but do not necessarily recognize them as the values also embedded in the codes (Tadd et al. 2006, Strandell-Laine et al. 2005, Heikkinen et al.

2006, Heymans et al. 2007). Nevertheless, nurses' positive approach and knowledge of the barriers could be considered as good points of departure in developing of the teaching and application of the codes.

The participants saw the teaching of the codes as an important element in nursing ethics education. This is in accordance with earlier literature (Esterhuizen 1996, Hussey 1996, Numminen 2000, Heikkinen & Leino-Kilpi 2004, Verpeet et al. 2005, Meulenbergs et al. 2004). The importance was justified with the codes as the foundation of values, as the basis of professionalism, and as a support to ethical decision-making. However, in many cases the otherwise positive response had been left unjustified. Could this imply that the codes are perhaps accepted "mechanically" as a self-evident content, a must" to nursing ethics education without necessarily raising the need to contemplate and internalize their true meaning or even existence to ethical nursing practice? **(**Leino-Kilpi 2004, Verpeet & al. 2006).

However, the development of teaching was seen as a challenge. Critical though the participants' comments were, they were mostly expressed in positive tones as suggestions for improvement. In particular, teaching methods, integrated teaching and lack of resources were pointed out. The need for versatile use of teaching methods was highlighted, and there is literature supporting this view (e.g. Foster et al. 1993, Hussey 1996, Gastmans 2002). The best ways to teach ethics have been much discussed in health care ethics literature. Various methods of teaching ethics have been reported, and in most cases each method has resulted in positive outcomes in areas where they were supposed to enhance learning, e.g. critical thinking or moral sensitivity (e.g. Langford 1990, Pederson et al. 1990, Robb & Murray 1992, Begley 1995b, Giarratano 1997, Mysak 1997, Hubert 1999, Jaeger 2001, McAlpine et al. 2002, Metcalf & Yankou 2003, Fulton & Kellinger 2004, Garity 2008). According to the participants, the integrated teaching format was preferred as the best way to teach ethics and the codes. It should be integrated throughout the nursing curriculum from entry to exit. Although the integrated teaching format seems to be the prevalent tendency in ethics education, there is little scientific evidence of its effectiveness in nursing. There are some reports in which the integrated approach has been described on a small scale (e.g. Ryden et al. 1989) but research exploring the integrated teaching implemented throughout the nursing curriculum is lacking in nursing. Those defending the integrated model have emphasized the importance of a systematic approach to it (Gaul 1989). Ethics education in nursing is said to suffer from the lack of a systematic approach, therefore more research and consequently development is needed in this area (Allmark 1995, Leino-Kilpi 1999, Leino-Kilpi 2001, Leino-Kilpi 2004, Gastmans & Verpeet 2006).

The unsystematic integration manifested itself in this study in that educators' and students' views of the used teaching methods differed. As mentioned earlier, students

may have difficulties in distinguishing the ethics content in the integrated teaching. The participants also pointed out the importance of the context in teaching ethics. Research has indicated that binding teaching to a practice context and utilizing the students' own experiences in discussing ethics have proven a good point of departure (Nolan & Smith 1995, Scott 1996, Scott 1998, Männistö 2001, Gastmans 2002, Van der Arend & Smits 2003, Nolan & Markert 2002).

The participants also cited the lack of resources, particularly lack of time, and that the time for ethics education should be explicitly recorded in the curriculum. The lack of educational resources has also been acknowledged in literature (e.g. Hussey 1996).

6.2. Validity and reliability of the study

Validity of the data

An integrative literature review was conducted for this study to retrieve empirical data dealing with nurses' codes of ethics (Burns & Grove 2009). Interest was initially focused on studies concerning knowledge of the teaching of the codes in nurse education. The number of empirical studies directly focusing on nurses' codes proved to be scarce, let alone studies on the teaching. Therefore the searches were extended to include studies that had a relevant relation to the codes, i.e. studies in which values embedded in nurses' codes had been used as a framework in the instrument development. This increased the number of studies to fifty-four, which allowed for the conducting of a credible analysis of the relevant research (Cowles and Rodgers 1993). Nevertheless, for the heterogeneity of research methodologies and the total lack of randomized controlled trials, the data did not lend itself to systematic review (Evans & Pearson 2001, Polit & Beck 2008, Burns & Grove 2009). In the initial stage of the data searches both the MEDLINE and Cinahl databases were approached. However, the number of relevant studies found in the MEDLINE was larger than that of Cinahl and all relevant studies retrieved from Cinahl were also available in the MEDLINE. Therefore it was justified to resort to the use of the MEDLINE database only (Burnham & Shearer 1993, Okuma 1994, Brazier & Begley 2008). Additional studies were retrieved by checking the references of the included studies. Considering the reviewed empirical literature (Paper I), as a whole its contribution to provide supportive background for this study was limited, because educational research of the codes was minimal, and the other studies dealing with the codes did not directly provide evidence on the teaching of the codes. Methodologically, the overall quality of the included studies was rather heterogeneous, although more recent studies were of better quality than older ones. For the above reasons the literature review of this study (Chapter 2) was complemented with relevant theoretical literature retrieved from scientific nursing

journals discussing ethics education and the codes. Peer reviewed and of high quality though theoretical articles in scientific journals are today, they do not provide strictly empirical knowledge about the issue in question.

Eligibility criteria were used to define the essential characteristics of the target participant groups to ensure the representativeness of the participants and to minimize sampling error. This population study was targeted to all nurse educators and all nursing students meeting the eligibility criteria. However, these populations were defined as hypothetical because comprehensive lists of all of the participant groups were not available and the exact number of eligible participants remained unknown. (Burns & Grove 2009.) The identification of eligible participants was left to the appointed contact persons in nursing education units. However, this data collection procedure posed a threat to the validity of retrieved data in the case that all eligible participants would not have been identified (Polit & Beck 2008, Burns & Grove 2009). This issue is further discussed in the following section concerning validity and reliability of the research process and the limitations of the study.

Statistical power analysis was performed to estimate the sufficient number of participants. At the power level of 85% the sufficient number of participants in both groups was calculated to be 190. This number of participants was achieved in the case of the students but not quite for the educators, although a low response rate was anticipated based on the findings of earlier ethics studies (e.g. Numminen 2000, Ajanko 2003, Brunou 2009) and the study was therefore targeted to the whole populations of nurse educators and students fulfilling the eligibility criteria. The risk of a type II error increases with too small sample sizes (Burns & Grove 2009). Despite the low response rates of this study, the sample sizes were large enough to carry out proper statistical analyses. Moreover, the quality of the data provided by participating educators and students was good since the questionnaires were carefully completed. Of the educators' returned questionnaires, twenty-six were rejected due to the reason that these educators said that teaching ethics did not belong to their teaching agenda and thus they did not fulfil the eligibility criteria, and two of the students' questionnaires were rejected as incomplete. This incident may suggest that distribution of the questionnaires was not necessarily as stringent and controlled as it should have been. Calculation of refusal rate was not relevant as the exact number of eligible populations was unknown (Burns & Grove 2009).

Validity and reliability of the instrument

Validity and reliability constitute the overall validity of the instrument (Alkula et al. 1999). Instrument validity refers to the degree to which an instrument measures what it is meant to be measuring (Polit & Beck 2008, Burns & Grove 2009). However, the validity of an instrument is not an all-or-nothing phenomenon, but rather a matter of degree,

and therefore its validity is difficult to establish. This also means that no instrument is completely valid (Burns & Grove 2009).

In this study the content validity of the instrument was assessed. Content validity is concerned with the representativeness of the items in delineating the content of the measured concept. A content valid instrument includes items that cover the hypothetical content universe of the concept and provides answers to the research question. Questionnaires are instruments in which the content validity is often assessed, and which is based on logical rather than statistical evidence. Face validity is a subtype of content validity and refers to the extent to which the instrument gives the appearance of measuring the studied concept. It is an intuitive type of validity assessment in which the content is assessed in terms of intelligibility, readability and clarity, and whether it appears to reflect the concept. (LoBiondo-Wood & Haber 1998, Polit & Hungler 2008, Burns & Grove 2009.)

In this study face validity was used to assess the content validity of the instrument (Burns & Grove 2004). A total of 36 doctoral students in nursing science assessed the instrument's intelligibility and the clarity of its content in a pilot study carried out in January-February 2006. Revisions were made based on their suggestions. Although doctoral students can be regarded as experts in various areas of nursing and nurse education, they are not necessarily experts in ethics. The validity of the instrument might have benefited further if the instrument had also been submitted to the assessment of an expert panel of professionals in ethics, which was not the case.

Reliability is an important criterion in assessing the instrument's quality, referring to the degree of consistency and accuracy of its measurement. The major aspects of instrument reliability assessment are its stability, internal consistency, and equivalence. (Nunnally & Burnstein 1994, Polit & Beck 2008, Burns & Grove 2009.) Internal consistency is the best means of assessing sources of measurement errors in psychosocial instruments, e.g. the sampling of items (Nummenmaa & al. 1997, Polit & Hungler 2008, Burns & Grove 2009).

Cronbach's alpha coefficient is a commonly used statistical test of internal consistency in studies using a Likert-type measurement scale. The values of Cronbach's alpha range from 0.00 to 1.00. The alpha value of 0.70 is regarded as sufficient for an instrument in its early stage of development (LoBiondo-Wood & Haber 1998), although it should not be taken as a rule (Knapp & Brown 1995, Alkula & al. 1999).

To estimate the reliability of the instrument in this study, the homogeneity of the items was tested using Cronbach's alpha coefficient. Alpha values ranged from 0.75 to 0.94. Although these values are acceptable for a newly developed instrument, the practical interpretation of the alpha values indicates that the future use of the instrument needs

further development. For example, the lowest alpha value of 0.75 indicates that 25% of the variability of the respondents' answers would reflect random, extraneous fluctuations. This level of reliability of the instrument could be considered acceptable in this study for the reason that the measurement was not used to determine any "critical" function, e.g. admission to an educational institution (Burns & Grove 2009, Nunnally & Burnstein 1994).

Validity and reliability of the research process and limitations of the study

The overall validity and reliability of the entire study is crucial, because bias may occur in every stage of the research process (LoBiondo-Wood & Haber 1998, Burns & Grove 2009). In the following paragraphs such factors which may have posed threats to the validity and reliability of this study are discussed.

In terms of the overall validity and reliability, the sampling and data collection procedures of this study deserve rigorous criticism. Due to the weaknesses in these procedures, the nurse educators' and nursing students' response rates remained low. But, the problem of low response rates in ethics studies has been recognized (e.g., Numminen 2000, Ahern & McDonald 2002, Ajanko 2003, Lipscomb & Snelling 2005, Görgülü & Dinç 2007). Several reasons in this study may have contributed to this weakness. First, the aim to collect comprehensive national data was challenging. The researcher's personal visit to every education unit would have been impractical, time- consuming and expensive, and therefore the use of contact persons to arrange the data collection was justified. However, it remains unknown how conscientiously the estimation of the number of nurse educators and graduating students, and the distribution of the questionnaires were carried out, although the contact persons were well informed of what they were expected to do. It also seems that the estimation of the exact number of educators participating in teaching ethics in the integrated teaching format and the number of graduating students was problematic. In the integrated teaching format, teaching ethics could be regarded as the responsibility of most nurse educators without particularly appointing such educators by name. Thus, it may have been that all eligible educators did not recognize themselves as such, or they were not recognized as such by the contact persons, or that the educators who were explicitly known to teach ethics were selected as participants or wanted themselves to contribute to the study. As to the students, in Finnish polytechnics nursing students are allowed to decide their graduation time and therefore the students' graduation fluctuates depending on how they are able to complete their courses. Consequently, the number of completed questionnaires in this study may more closely describe the true size of the target groups than the number of requested questionnaires. Nevertheless, the data was retrieved from representative groups of 183 nurse educators and 214 nursing students which allowed the use of proper statistical methods. Second, the data collection was carried out at the end of the semester. The

purpose was to get the students' responses as close to their graduation as possible. A large number of the students were also completing their final clinical practice under the supervision of their clinical instructors. Thus, the questionnaires may not have reached all eligible students as was originally intended. The data collection period also coincided with the educators' heavy workload at the end of the semester. Third, polytechnics are also presently burdened with a multitude of research projects which has resulted in exhaustion in educators and students to respond. This weariness to respond has been acknowledged. Fourth, favourable responses in studies concerning th respondents' moral attitudes may sometimes cause social desirability response bias, tempting participants to give answers consistent with prevailing social norms or professional expectations (Nunnally & Burnstein 1994, Burns & Grove 2009, Polit & Beck 2008). This issue has been discussed earlier in this discussion. And finally, the participants may have found the questionnaire as tedious to answer due to its length. The questionnaire also focused solely on teaching of the codes, and differentiating the codes from other ethics content in the integrated teaching format may have been difficult.

The above-mentioned issues related to the sampling and data collection procedure may pose threats to the overall validity and reliability of the study. The possible selectivity of the participants refers to systematic bias and it threatens the internal and external validity of the study in that the findings may not fully reflect the real profile of the target groups and that the findings may not lend to generalization beyond the samples used in the study or, that they may not fully reflect the reality of the situation. Also the contextual factors related to the data collection period may impair both the internal and external validity of the study. The possible social desirability bias issue has an impairing impact on the construct validity of the study. (Burns & Grove 2009.) Thus, better control of the study environment, particularly concerning data collection, would have had a minimizing effect on threats to the overall validity and reliability of this study.

6.3. Implications for nursing ethics education

This study has several implications for nursing ethics education.

1. The positive attitudes towards nurses' codes and the codes as a teaching content offers a good point of departure for the development of their teaching.

2. The issues concerning the social aspects of nursing on a larger scale deserve more attention.

3. Nursing education units should invest serious effort to scrutinize in detail how ethics education actually is implemented. The foci should be on resource allocation, systematic organization of ethics teaching, including separate ethics courses, as well as integrated teaching.

4. More versatile use of teaching methods should be considered.

5. More attention should be paid to student outcome evaluation.

6. The competence requirements of educators in ethics should be defined and the use of professional ethicists should be considered.

6.4. Suggestions for further research

First, research should focus particularly on the education of ethics *including teaching of the codes.* The following aspects should be addressed:

1. The organization of ethics education in nursing curricula, particularly the integration of ethics into other theoretical nursing studies and clinical practice, and the impact of separate courses in ethics.

2. The teaching process of ethics education including goals, content, teaching and evaluation methods, and assessment of student outcomes.

3. The effectiveness of different teaching and evaluation methods in achieving the best learning outcomes in ethics.

4. The competence in terms of formal ethics education of those educators involved in the teaching of ethics, their role and duty to contribute to ethics teaching, particularly in the integrated teaching format (nurse educators, clinical instructors, nurse executives).

5. Comparison of students' learning outcomes in cases of using a professional ethicist or nurse educator without formal education alone or both kinds of teachers in teaching ethics

6. The factors which are influencing the process of transferring theoretical knowledge of the codes to clinical practice.

7. Comparison between students', educators' and clinical instructors' views of teaching the codes to recognize positive as well as adverse elements in the teaching of the codes.

Second, research of the meaning and functions of the codes should be further explored.

8. Views of the positive and negative elements in the codes should be studied in detail to further develop the codes to be more relevant to nurses and nursing students. Research should involve all levels of health care and extend beyond the nurse-patient relationship to cover other relationships in the codes, such as colleagues, other health care professions, organizations, and society.

9. The consistency of nurses' and nursing students' professional values with the values of the codes.

This might elucidate the meaning of the unconscious use of the codes and explain the contradiction of nurses' appreciation of the codes, but not using them.

Third, research dealing with the codes might benefit from the use of more varied methodological approaches.

9. Systematic reviews including the abundant theoretical scientific literature would improve the understanding of ethics teaching. The use of different types of triangulation methods would generate different kinds of knowledge that complement one another. Longitudinal designs would help in understanding the moral development of nurses and nursing students. Development of valid and reliable data collection instruments which could be used even globally might provide useful knowledge of the codes that concern all nurses worldwide. Random sampling, larger sample sizes and a larger spectrum of participants should be considered. Nurse educators, nurse executives, clinical instructors, nurse researches, nursing curricula, documents such as nursing philosophies of education and health care institutions, and nursing text-books have been scarcely studied.

7. CONCLUSIONS

The literature review revealed that empirical research focusing directly on nurses' codes of ethics is scarce and practically non-existent in the area of education, offering limited empirical background for this study.

According to this study, teaching of the codes themselves and of the ethical concepts embedded in the codes was extensive. Teaching of the functions and laws and agreements related to the codes was moderate, but teaching of the codes of other health care professions was modest. Teaching focused on themes dealing with the nurse-patient relationship. Teaching of themes discussing nursing in wider social contexts was less prominent. Educators and students emphasized the same teaching contents but the differences between educators' and students' responses regarding the extent of the teaching were statistically significant in that educators described their teaching to be more extensive than what students had perceived it to have been.

The use of teaching and evaluation methods was conventional and narrow. There were contradictory views between educators' and students' descriptions in this matter. Differences between the responses were statistically significant. According to the educators, their use of methods was interactive, student-centred and integrated into other theoretical nursing studies and clinical practice. However, the students' perception was that the use of methods was individually oriented, educator-centred and preferred separate ethics education courses rather than integration into theoretical nursing studies or clinical practice.

Most of the educators regarded their knowledge of the codes as adequate for teaching the codes. Also the students regarded their educators' knowledge as adequate. Both educators and students themselves assessed the students' knowledge of and ability to apply the codes in nursing practice as mediocre.

According to the educators' and students' views, nurses need their own codes. The codes are mainly applicable in practice and an important element of nursing ethics education. However, teaching of the codes should be developed by allocation of more time resources, using more versatile teaching methods and preferring a well organized, integrated teaching format.

However, the study also warrants caution in the interpretation of the results for the following reasons: First, the participants may have represented biased groups, i.e. those educators and students who are interested in ethics and who have internalized the importance of ethics in nursing. Second, the low response rates in both participant groups provide no knowledge about non-responding educators' contribution to teaching the

codes and non-responding students' perceptions of the codes and their teaching. Third, the educators' lack of formal studies in ethics raises the question of their competence to provide high quality ethics education. Fourth, the results also indicated some kind of confusion in the implementation of the teaching in addition to fairly narrow approaches in terms of the choice of teaching content, and teaching and evaluation methods. Based on the above-mentioned reasons it may be realistic to assume that this study does not yet provide a fully realistic description of the teaching of nurses' codes of ethics. Rather, it suggests that teaching may not be as extensive and high quality as this study indicates. Teaching of ethics begs for further research.

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Helsinki, September 2010

Olivia Numminen

APPENDICES 1-9

Appendix 1. The Nightingale Pledge (1893)

The "Nightingale Pledge"

The Nightingale Pledge was composed by Lystra Gretter, an instructor of nursing at the old Harper Hospital in Detroit, Michigan, and was first used by its graduating class in the spring of 1893. It is an adaptation of the Hippocratic Oath taken by physicians.

~~~

I solemnly pledge myself before God and in the presence of this assembly, to pass my life in purity and to practice my profession faithfully. I will abstain from whatever is deleterious and mischievous, and will not take or knowingly administer any harmful drug. I will do all in my power to maintain and elevate the standard of my profession, and will hold in confidence all personal matters committed to my keeping and all family affairs coming to my knowledge in the practice of my calling. With loyalty will I endeavor to aid the physician, in his work, and devote myself to the welfare of those committed to my care.

~~~

Reference: http://www.countryjoe.com/nightingale/pledge.htm

Appendix 2. The Hippocratic Oath (2002)

A Modern Version of the Hippocratic Oath

I swear to fulfill, to the best of my ability and judgment, this covenant:

I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.

I will apply, for the benefit of the sick, all measures which are required, avoiding those twin traps of overtreatment and therapeutic nihilism.

I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.

I will not be ashamed to say "I know not," nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery.

I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.

I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.

I will prevent disease whenever I can, for prevention is preferable to cure.

I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.

If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.

The classical version of the Hippocratic Oath is from the translation from the Greek by Ludwig Edelstein. From The Hippocratic Oath: Text, Translation, and Interpretation, by Ludwig Edelstein. Baltimore: Johns Hopkins Press, 1943.

The modern version of the Hippocratic Oath was written in 1964 by Louis Lasagna, Dean of the School of Medicine at Tufts University.

Reference: http://www.pbs.org/wgbh/nova/doctors/oath_modern.html

Appendix 3. The ICN Code of Ethics for Nurses (2006)

THE ICN CODE OF ETHICS FOR NURSES
PREAMBLE

Nurses have four fundamental responsibilities: to promote health, to prevent illness, to restore health and to alleviate suffering. The need for nursing is universal. Inherent in nursing is respect for human rights, including cultural rights, the right to life and choice, to dignity and to be treated with respect. Nursing care is respectful of and unrestricted by considerations of age, colour, creed, culture, disability or illness, gender, sexual orientation, nationality, politics, race or social status. Nurses render health services to the individual, the family and the community and co-ordinate their services with those of related groups.

THE ICN CODE

The *ICN Code of Ethics for Nurses* has four principal elements that outline the standards of ethical conduct.

ELEMENTS OF THE CODE

1. NURSES AND PEOPLE

The nurse's primary professional responsibility is to people requiring nursing care. In providing care, the nurse promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected. The nurse ensures that the individual receives sufficient information on which to base consent for care and related treatment. The nurse holds in confidence personal information and uses judgement in sharing this information. The nurse shares with society the responsibility for initiating and supporting action to meet the health and social needs of the public, in particular those of vulnerable populations. The nurse also shares responsibility to sustain and protect the natural environment from depletion, pollution, degradation and destruction.

2. NURSES AND PRACTICE

The nurse carries personal responsibility and accountability for nursing practice, and for maintaining competence by continual learning. The nurse maintains a standard of personal health such that the ability to provide care is not compromised. The nurse uses judgement regarding individual competence when accepting and delegating responsibility. The nurse at all times maintains standards of personal conduct which reflect well on the profession and enhance public confidence. The nurse, in providing care, ensures that use of technology and scientific advances are compatible with the safety, dignity and rights of people.

3. NURSES AND THE PROFESSION

The nurse assumes the major role in determining and implementing acceptable standards of clinical nursing practice, management, research and education. The nurse is active in developing a core of research-based professional knowledge. The nurse, acting through the professional organisation, participates in creating and maintaining safe, equitable social and economic working conditions in nursing.

4. NURSES AND CO-WORKERS

The nurse sustains a co-operative relationship with co-workers in nursing and other fields. The nurse takes appropriate action to safeguard individuals, families and communities when their health is endangered by a co-worker or any other person.

SUGGESTIONS FOR USE OF THE *ICN CODE OF ETHICS FOR NURSES*

The *ICN Code of Ethics for Nurses* is a guide for action based on social values and needs. It will have meaning only as a living document if applied to the realities of nursing and health care in a changing society. To achieve its purpose the *Code* must be understood, internalised and used by nurses in all aspects of their work. It must be available to students and nurses throughout their study and work lives.

APPLYING THE ELEMENTS OF THE *ICN CODE OF ETHICS FOR NURSES*
The four elements of the *ICN Code of Ethics for Nurses* : nurses and people, nurses and practice, nurses and the profession, and nurses and co-workers, give a framework for the standards of conduct. The following chart will assist nurses to translate the standards into action. Nurses and nursing students can therefore:

- Study the standards under each element of the *Code*.
- Reflect on what each standard means to you. Think about how you can apply ethics in your nursing domain: practice, education, research or management.
- Discuss the *Code* with co-workers and others.
- Use a specific example from experience to identify ethical dilemmas and standards of conduct as outlined in the *Code*. Identify how you would resolve the dilemmas.
- Work in groups to clarify ethical decision making and reach a consensus on standards of ethical conduct.
- Collaborate with your national nurses' association, co-workers, and others in the continuous application of ethical standards in nursing practice, education, management and research.

Element of the Code # 1: NURSES AND PEOPLE
Practitioners and Managers

Provide care that respects human rights and is sensitive to the values, customs and beliefs of all people. Provide continuing education in ethical issues. Provide sufficient information to permit informed consent and the right to choose or refuse treatment. Use recording and information management systems that ensure confidentiality. Develop and monitor environmental safety in the workplace.

Educators and Researchers
In curriculum include references to human rights, equity, justice, solidarity as the basis for access to care. Provide teaching and learning opportunities for ethical issues and decision making. Provide teaching/learning opportunities related to informed consent. Introduce into curriculum concepts of privacy and confidentiality. Sensitise students to the importance of social action in current concerns.

National Nurses' Associations
Develop position statements and guidelines that support human rights and ethical standards. Lobby for involvement of nurses in ethics review committees. Provide guidelines, position statements and continuing education related to informed consent. Incorporate issues of confidentiality and privacy into a national code of ethics for nurses. Advocate for safe and healthy environment.

Element of the Code # 2: NURSES AND PRACTICE
Practitioners and Managers
Establish standards of care and a work setting that promotes safety and quality care. Establish systems for professional appraisal, continuing education and systematic renewal of licensure to practice. Monitor and promote the personal health of nursing staff in relation to their competence for practice.

Educators and Researchers
Provide teaching/learning opportunities that foster life long learning and competence for practice. Conduct and disseminate research that shows links between continual learning and competence to practice. Promote the importance of personal health and illustrate its relation to other values.

National Nurses' Associations
Provide access to continuing education, through journals, conferences, distance education, etc. Lobby to ensure continuing education opportunities and quality care standards. Promote healthy lifestyles for nursing professionals. Lobby for healthy work places and services for nurses.

Element of the Code # 3: NURSES AND THE PROFESSION
Practitioners and Managers
Set standards for nursing practice, research, education and management. Foster workplace support of the conduct, dissemination and utilisation of research related to nursing and health. Promote participation in national nurses' associations so as to create favourable socio-economic conditions for nurses.

Educators and Researchers
Provide teaching/learning opportunities in setting standards for nursing practice, research, education and management. Conduct, disseminate and utilise research to advance the nursing profession. Sensitise learners to the importance of professional nursing associations.

National Nurses' Associations
Collaborate with others to set standards for nursing education, practice, research and management.

Develop position statements, guidelines and standards related to nursing research. Lobby for fair social and economic working conditions in nursing. Develop position statements and guidelines in workplace issues.

Element of the Code #4: NURSES AND CO-WORKERS
Practitioners and Managers
Create awareness of specific and overlapping functions and the potential for interdisciplinary tensions. Develop workplace systems that support common professional ethical values and behaviour. Develop mechanisms to safeguard the individual, family or community when their care is endangered by health care personnel.

Educators and Researchers
Develop understanding of the roles of other workers. Communicate nursing ethics to other professions. Instil in learners the need to safeguard the individual, family or community when care is endangered by health care personnel.

National Nurses' Associations
Stimulate co-operation with other related disciplines. Develop awareness of ethical issues of other professions. Provide guidelines, position statements and discussion for a related to safeguarding people when their care is endangered by health care personnel.

DISSEMINATION OF THE *ICN CODE OF ETHICS FOR NURSES*
To be effective the *ICN Code of Ethics for Nurses* must be familiar to nurses. We encourage you to help with its dissemination to schools of nursing, practising nurses, the nursing press and other mass media. The Code should also be disseminated to other health professions, the general public, consumer and policy-making groups, human rights organisations and employers of nurses.

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Reference: http://www.icn.ch/about-icn/code-of-ethics-for-nurses/b site: www.icn.ch

Appendix 4. The Finnish Nurses Association's Ethical Guidelines of Nursing (1996)

Ethical Guidelines of Nursing

The aim of the ethical guidelines of nursing is to provide support for all nurses in their everyday decision-making concerning ethical questions of nursing. Oriented to all nurses, other personnel within health care, and the general public, these guidelines express the mission of nurses in society and the general principles of nursing.

I The mission of nurses

The mission of the nurse is to promote and maintain the health of population, prevent illness, and alleviate suffering.

The nurse helps people of all ages in different situations. The nurse serves individuals, families, and communities. The nurse aims to support and increase the personal resources of individuals and improve their quality of life.

II Nurses and patients

The nurse is responsible to her actions, first of all, to the patients who need her help and Care. The nurse protects human life and improves the individual well-being of patients. The nurse encounters her patients as valuable human beings and creates a nursing environment which takes into consideration the values, convictions and traditions of individuals.

The nurse respects the autonomy and self-determination of the patient and gives him an opportunity to participate in decisions concerning his own care. The nurse realizes that all the information given by the patient is confidential and she uses judgment in sharing this information with other people involved in nursing.

The nurse treats the patient as a fellow human being; she listens to the patient and empathizes with him. The relationship between nurse and patient is based upon open interaction and mutual trust.

The nurse exercises impartiality in her work. She treats every patient equally well according to the individual needs of the patient irrespective of the illness, sex, age, creed, language, traditions, race, colour, political opinion or social status of the patient.

III The work and professional competence of nurses

The nurse is personally responsible for her work. She evaluates her own and others' competence when receiving her assignments and when giving assignments to others. Professional nurse has an obligation to continuously develop her competence.

Nurses working in the same unit are jointly responsible for the optimal quality of nursing and the continuous improvement of the quality of nursing in their unit.

IV Nurses and their colleagues

Nurses support each other in the decision-making concerning the care of patients, and their own work capacity and professional development.

Nurses respect the expertise of other professions as well as their own. They aim at fruitful cooperation with other professionals involved in care.

Nurses see to it that no professional involved in care acts unethically toward patients.

V Nurses and society

The nurse participates in discussion and decision-making concerning the health, quality of life and well-being of people, both on national and international levels.
The nurse collaborates with the families and significant others of patients; she encourages the families' participation in the care. The nurse functions actively in empowering people in issues of health. She cooperates with volunteer workers, disabled people's organizations and patient associations.

The nurse participates in the work of international health organizations in the exchange of professional

knowledge and skills. She bears global responsibility for the development of living conditions concerning health and social affairs,
and she promotes equality, tolerance and joint responsibility.

VI Nurses and the nursing profession

Nurses see to it that the members of the nursing profession accomplish their mission in a dignified manner. The nursing profession supports the moral and ethical development of its members, and controls that the humane nature of nursing is preserved.

Nurses look after the well-being of the members of their profession. Their professional organization will function actively in order to secure just social and economic working conditions for its members.

Nurses are responsible for the expertise of their profession. They are active in developing a core of professional knowledge, and they enhance nursing education and the scientific base of nursing. The enhancement of nursing expertise should be reflected in the improved well-being of population.

Association on September 28, 1996. These Ethical Guidelines of Nursing have been approved by the Assembly of the Finnish Nurses

Reference:
http://www.sairaanhoitajaliitto.fi/sairaanhoitajan tyo ja hoitotyon/sairaanhoitajan tyo/sairaanhoita

Appendix 5. Data matrix of empirical research on nurses' codes of ethics

Author/s, year and country	*Purpose*	*Sample*	*Framework related to the codes of ethics*	*Main findings*
CODES OF ETHICS IN NURSING EDUCATION				
Killeen 1986, USA	To analyse the relevant ethics content of all fundamental nursing text books published between 1960 - 1985, including the codes	N = 42 Text books	ANA (American Nurses' Association) Code for nurses (1976) and Interpretative statements of the codes ICN (International Council of Nurses) Code of ethics (1973) (Guidelines for ethical decision-making)	45 % (n = 19) of text books did not contain the codes. The first text including the codes was published in 1977. From the remaining texts, six included only the codes, 17 texts elaborated the codes with a discussion. Implications for education: 1. Increase ethics n nursing textbooks 2. Inclusion of courses of ethics in nursing curricula 3. Educate faculty to understand the importance of ethics to students 4. Choice of books focusing on ethics
Simula J. 1998, Finland	To explore health care students' knowledge and conceptions of the status and rights of the patients	N = 280 Health care students	Patients rights reflected in legislation on patients rights.	Health care students regarded patients' rights as important but their teaching was superficial.
Nummінen O. 2000, Finland	To explore nursing ethics education from the perspectives of nurse educators.	N = 146 Nurse educators	The Finnish Nurses Association 's Ethical Guidelines of Nursing (1996)	Educators' teaching of nurses' codes of ethics was extensive
Zahner 2000,USA	To analyse the ethics content of community nursing text books published between 1916- 1998, including the codes	N = 44 Text books	ANA (American Nurses' Association) Code for nurses (1985) (Ethical theories of Utilitarianism Deontology Human rights Distributive justice)	The codes were first discussed in 1979 in community nursing text books. Implications for education: 1. The ANA codes should be included in community nursing health textbooks, because the codes concern all nurses but discussed also in community nursing context.
Dinç & Görgülü 2002, Turkey	To describe students' views about ethics content in the curriculum, including the codes, the examination system and ethics teachers.	N = 113 Nursing students	The ICN Code for Nurses (2000)	A total 84 (86 %) of participating students (n = 98) regarded teaching of the codes as adequate and 13 (13 %) as moderate. Majority of students regarded using the codes as useful in developing their ethical decision-making skills. Examination system was regarded as adequate

				by average 73% and as moderate by 23%. Ethics teachers teaching skills were regarded as adequate by average 89% and as moderate y 8% of the participating students.
Ajanko S. 2003	To explore health care students' moral reasoning	N = 29 health care students	The Finnish Nurses Association 's Ethical Guidelines of Nursing (1996)	Students' regarded teaching of the codes even too extensive. Their moral reasoning remained at intermediate level.
Heikkinen A, Leino-Kilpi H. 2004.	To describe teaching of nurses' codes of ethics in health education in Finland.	N = 55 patients, practicing nurses, educators, nurse managers	The Finnish Nurses Association's Ethical Guidelines of Nurses (1996)	Teaching ethics is important. The codes gave support to ethical decision-making. They are a part of professional identity and provide the society with knowledge of nursing values and quality of care. All had been taught about the codes. A part regarded teaching as adequate, the other part regarded it has been approached at too general level and they felt their competence to apply the codes as inadequate. Teaching in theory was not enough but needed clinical situations to practice the use of the codes. Positive attitude of the superior nurse or clinical instructor was seen as important. Positive attitudes encouraged to discuss difficult situations The attitude of the superiors needed improvement. Professional education was the most important time to familiarize students' with the codes. but only clinical experience opens the way to true understanding of ethical issues. Help from colleagues was appreciated but was also experienced as a sign of incompetence. There was a need for continuing education. Those who had studied ethics by themselves said that knowledge of the codes was needed in their daily practice. 1. The basic knowledge f the codes is acquired during basic education and clinical internment 2. Deepening of knowledge is needs practice experience, development as a person and continuous education 3. The codes gave support to ethical decision-making and support

				professional identity
Lipscomb & Snelling 2005, UK	To explore educators' evaluation of the moral content of student assignments	N = 27 Nurse educators	UKCC (United Kingdom Central Council) Code of Professional Conduct for the Nurse, Midwife and health visitor (1992)	Educators used the codes as justification in evaluating the moral content of students' assignments papers suggesting that the codes' could be used also as a punitive tool in cases of "unacceptable" opinions presented by students.
Kalb & O'Connor-Von 2007, USA	To describe beginning master's degree nursing students ethics related knowledge focusing on respect for human dignity inherent in the codes	N = 63 Nursing students	ANA (American Nurses' Association) Code for nurses (2001)	Students had diverse perspectives of human dignity. Education should embrace fuller appreciation concerning human dignity. Education should be based on students' previous knowledge and experience and be consistent with the codes.
Lui et al. 2008, Hong Kong/China	To explore students' perceptions of the professional codes.	N = 263 Nursing students	The Code of Professional Conduct in Hong Kong	Most statements of the codes are important. To provide safe and competent care was the most important item. There were differences in perceptions between students on different levels of studies.
Görgülü S, Dinç L. 2007, Turkey	To study the current status of ethics education in Turkish nursing education programs	n = 31 nursing schools		
CODES OF ETHICS IN PRACTICE				
Nurses' knowledge and use of the codes of ethics				
Edwards & Haddad 1988, USA	To assess nurses' educational needs and the impact of education on nurses' ability to perceive ethical problems	N = 155 Nurses	No framework	Although 80 % of nurses had had education in ethics during their basic nursing education, nearly 70 % had not read the codes. Nurses turned to their peers in solving ethical problems. Family and religion were the most influential factors in forming their ethical values.
Davis 1990, USA	To explore nurses' knowledge of the codes and the use of the codes related to informed consent	N = 27 Nurses	ANA (American Nurses' Association) Code for nurses (1976) Concept of Informed consent	None of the nurses knew the content of the codes. Their practice was guided by values developed through clinical, personal, research and professional socialization related experiences. Nursing education had had little impact on this development apart from teaching of legal aspects and use of versatile methods to solve ethical problems
Miller et al. 1991, USA	To explore nurses' professional behaviour including owning a copy of the codes	N = 514 Nurses	Miller's model of professionalism (1988)	About 60 % of nurses did not know about the codes. Nurses' educational background had no significant impact on nurses' knowledge. 55 %

				regarded adherence to the codes as a behaviour of a professional nurse.
Gold et al. 1995, USA	To explore nurses' ability to identify and encounter ethical problems	N = 12 Nurses		Nurses did not recognize encountered problems as ethical, and solved these problems without institutional guidelines or the codes. Nurses did not use any decision-making framework nor did they seek collegial help.
Whyte & Gajos 1995, UK	To describe nurses' knowledge of the statements of the codes.	N = 87 Nurses, midwives and health visitors	UKCC (United Kingdom Central Council) Code of Professional Conduct for the Nurse, Midwife and health visitor (1992)	Nurses identified correctly 73 % of the authentic statements of the codes. Best known were statements related to the nurse-patient relationship and nurses' personal responsibility. The least known were related to the nurse's responsibility towards other nurses and authorities.
Adams & Miller 1996, USA	To explore administrative level nurses' professional behaviour including owning a copy of the codes	N = 279 Nurse middle managers (n =135) Nurse executives (n = 144)	Miller's Wheel of Professionalism (1988)	The degree of executives' professionalism was greater than middle managers' in all other areas except in knowledge of the codes and autonomy. 45% of executives and 39 % of middle managers possessed a copy of the codes.
Miles & Burke 1996, UK	To explore nurses' views and practices related to guidelines on DNR including the codes	N = 15 Nurses (n = 8), Other health care professionals (n = 7)		Nurses and health care professionals had a poor awareness of guidelines concerning DNR including the codes
Tabak & Reches 1996, Israel	To explore nurses' and students' attitudes and knowledge of ethics including the codes	N = 200 Nurses (n = 50), Midwives (n = 50), Nursing students (n = 100)	The Israeli code of conduct (1994) Ethical concepts of Human dignity Patients' rights Privacy Confidentiality Truth Advocacy	Of nurses and midwives 68% had knowledge of ethics and 61% knew the codes.. Of nursing students 98 % had knowledge of ethics and 98 % knew the codes. Students had more knowledge of ethics than nurses and midwives, perhaps due to better teaching of ethics compared to previous unsystematic teaching. Knowledge of ethics and codes was still lacking, although there was a strong awareness of patients' rights such as confidentiality, dignity and high quality care. All consulted their superiors in case of uncertainty
Wagner & Ronen 1996, Israel	To explore nurses' extent of identifying ethical problems using the codes as a framework	N = 745 Nurses	The Israeli Code of Ethics (1994	Nurses are unfamiliar with their codes. 31% of nurses were able to recall correctly any statement from the Israeli Code of Ethics. 30% had turned to the codes for support. The most predominant factor in shaping ethical attitudes was the own

				family. In decisions nurses sought support from their peers
Whyte & Gajos 1996, UK	To describe nurses' knowledge of the statements of the codes.	N = 344 Nurses and midwives	UKCC (United Kingdom Central Council) Code of Professional Conduct for the Nurse, Midwife and health visitor (1992) Bloom's Taxonomy (1956)	Respondents had a relatively high mean of correct identifications of the statements, but they had also gaps in the ability to recognize the statements and to whom they were accountable. Respondents did not use the codes to inform their decision-making. The best recognized statements were related to a nurse's personal accountability and the least to responsibility of others.
Dinç & Ulusoy 1998, Turkey	To explore nurses' response to ethical problems using the codes as a framework	N = 200 Nurses	ICN (International Council of Nurses) Code of ethics (1973)	Nurses attitudes towards ethical problems did not meet the expectations required of nurses by the ICN Code for Nurses highlighting the fact that nursing education should cover professional ethics more comprehensively
Simula J. 1998, Finland	To explore health care students' knowledge and conceptions of the status and rights of the patients	N = 280 Health care students	Patients rights reflected in legislation on patients rights.	Health care students regarded patients' rights as important but their teaching was superficial.
Wagner & Tabak 1998, Israel	To identify nurses' encountered ethical problems and to explore their knowledge of the codes.	N = 330 Nurses	ICN (International Council of Nurses) Code of ethics (1973)	32% of nurses recalled any statement from the codes. 30% of nurses sought guidance from the codes in ethical problems. No significant difference was found between the nurse groups in knowledge of the codes.
Han & Ahn 2000, Korea	To identify students' encountered ethical problems and describe students' ethical decision-making	N = 100 Nursing students	Code of Ethics for Korean nurses (1983)	Students applied the preamble and some of the clauses of the codes in ethical decision-making. Safeguarding the patient, respecting of rights and maintaining high standards of care were the most applied statements of the codes
Granot & Tabak 2002, Israel	To explore students' perceptions regarding obligations of the codes.	N = 178 Nursing students (n = 162), Faculty members (n = 16)	The Israeli code of ethics for nurses (1994)	Clinical and ethical knowledge is significantly related to nursing students' development of ethical behaviour.
Wilmot et al. 2002, UK	To explore nurses' and care staff's ways to deal with conflict between ethical principles	N = 12 Nurses and care staff	Ethical principles of Autonomy, Utility, and Preservation of life	Nurses and care staff least emphasized the codes as an influencing factor on their moral stand in conflicts between ethical principles. Nurses' moral commitment was in their personal experience, personality and the surrounding care culture.
Biton & Tabak 2003, Israel	To explore the relationship between the use of the codes and nurses' work	N = 158 Nurses	Israeli Code of Ethics (1994)	The possibility to apply the codes in nursing practice had a positive impact on nurses' work

	satisfaction			satisfaction
Weiner & Tabak 2003, Israel	To explore nurses' knowledge of the codes and use of patient restraints in different health care settings	N = 200 Nurses and nursing aids		The health care setting did not have effect on the nurses' knowledge level of the codes or law of patients' rights, but it had an effect on the knowledge level of guidelines concerning restraints.
Schwarz 2004, USA	To explore nurses' response to request of assisted suicide	N = 10 Nurses		To persistent requests for help in dying nurses cited professional obligations, personal values and fears, but not the codes of ethics or ANA position statement intended to guide in end-of-life decisions. Nurses did not seek collegial support either. One informant stated that ANA code is not enough, there is a higher code.
Strandell-Laine et al. 2005, Finland	To explore how nursing staff define the purpose and use of the codes	N = 35 Nurses, midwives and health visitors	The Finnish Nurses Association Ethical Guidelines for Nurses (1996)	The purpose to the nurse: Guidance and support to nursing practice, and value basis/foundation of nursing Purpose to the patient: Patients' best interest and good nursing practice. Use of the codes: Conscious use: Define value basis of nursing, clarify the nurse's task Unconscious use: Internalized action, application of values Barriers to use: 1)Organization (ideology, resources, lack of support), 2)codes themselves (vagueness) 3)multidisciplinary team (value conflicts, lack of cooperation, lack of discussion), 4)nurses themselves (lack of professional competence)
Hariharan et al. 2006, West Indies	To explore health care professionals' knowledge, attitudes and practices related to ethics	N = 159 Nurses (n = 85), health care professionals (n = 75)		Nearly 28% of the nurses did not know the codes. Nurses preferred colleagues, supervisors, and heads of department in solving ethical problems. The less knowledge the nurses had, the less they recognized ethical problems or see ethics as an important element in care. Focus should be in education.
Heikkinen et al. 2006, Finland, Italy, Greece	To explore nurses' use of the codes and the barriers to their use	N = 135 Nurses	The Finnish Nurses Association Ethical Guidelines for Nurses (1996) Hellenic National Nurses' Association's Code of ethics for	Use: Conscious: Clarify nursing as an ethical practice, bases for ethical reflection, for ethical decision-making, and tam work with colleagues Unconscious: Internalization of codes' values,

			Nurses (2001) The Italian Code of deontology for Nurses (1999)	applying values inherent in the codes Barriers: 1. Codes themselves (complicated structure, too general, ambiguous structure, too idealistic) 2. Nurses themselves 3. Lack of awareness of the codes (competence, collaboration) 4. Multiprofessional teamwork (lack of discussion, cooperation, value conflicts), 5. Patient families (value conflicts) 6. Organization (values) 7. Nursing profession (incoherent education, lack of respect for nursing profession) 8. Society/health care policy (lack of resources and professional recognition, changes in health care system. Barriers represented micro, meso, and macro levels of nursing.
Memarian et al. 2007, Iran	To identify factors that influence the clinical competence of nurses perceived by nursing professionals	N = 36 Nurses, nurse educators, nurse managers and members of Nursing Council		Ethical conduct based on commitment to professional ethics is a significant characteristic of a competent nursing care.
The content and function of the codes of ethics				
Meulenbergs et al. 2004, Belgium	To explore the functions of the codes in the current nursing context	N = Not reported		Due to the nursing profession's growing multidisciplinary nature, the dominance of economics, legal frameworks of health care environment, the codes have to accommodate to new health care context. The codes need to focus more on the moral aspects of nursing instead of focusing on "professionalism" or acting as a disciplinary measure. The codes should be integrated closely to nursing education and practice.
Verpeet et al. 2005, Belgium	To explore nurses' views on the content and functions of the codes	N = 50 Nurses	"Potential" Codes of ethics for nurses	The codes could fill several functions: 1) to confirm and support professional identity, 2) to clarify nursing domain and nurses' responsibilities, 3) to give confidence, support, and security 4) support nurses in their relationships with patients *and other and themselves,* and guide nurses' professional moral practice. Opinions differed on disciplinary function and legalization of the codes.

				In content attention should be paid to a nurse's personality and the relationship based nature of nursing. Nurses' views should be taken into account in development of the codes for them to function optimally. KS. Page 193
Tadd et al. 2006, UK, Finland, Italy, Greece, Poland, The Netherlands	To explore nurses' views on the content and functions of the codes	N= 311 Nurses	UKCC (United Kingdom Central Council) Code of Professional Conduct for the Nurse, Midwife and health visitor (1992) The Finnish Nurses Association Ethical Guidelines for Nurses (1996) Greece Poland The Italian Code of Deontology for Nurses (1999) the Netherlands	Nurses lack knowledge of the codes, do not use or know how to use them, and rely on personal values and experiences in ethical situations. Nevertheless nurses could name many functions of the codes such as guiding the practice, providing professional standards, endorsing professional identity, promoting professional status, protecting the public and functioning as a disciplinary measure. Codes seemed irrelevant to nurses' daily work because they were too ideal, they did not provide clear answers although they clarified actions. Nurses claimed to use the codes unconsciously because the codes were contained already "within" nurses as nursing values. Barriers to the use of the codes were lack of knowledge and confidence to use them, inadequate education, lack of knowledge of what it is to be a professional, lack of resources, professional conflicts and lack of professional recognition.
Verpeet et al. 2006, Belgium	To explore nurses' views of the development, dissemination and implementation of the codes	N = 50 Nurses	"Hypotethical" codes of ethics	The codes would be useful, should be useful and practical, and known to nurses and others Development: Nurse-based, practical, clear, continuously developed. Dissemination: Nurses (education, practice), institution (management), society, different medias Implementation: Head nurses in hospital
Barrazetti et al. 2007, Italy	To explore nurses' awareness of the content and functions of the codes and the codes' impact on nursing practice	N = 49 Nurses	The Italian Code of deontology for Nurses (1999)	The codes had a significant impact on nurses' view on the professional autonomy and responsibility, and on bringing into attention the moral nature of nursing and the codes' function

				as a guideline.
Dobrowolska et al. 2007, Poland	To identify nurses' moral duties and obligations in ICN, UKCC, Irish and Polish codes.	N = 4 Codes of ethics	Codes of ethics: ICN UKCC (United Kingdom Central Council) Code of Professional Conduct for the Nurse, Midwife and health visitor (1992) Irish Polish	The identified duties and obligations were: Respect for humans, right to knowledge and informed consent, confidentiality, professional competence, cooperation with others, and maintaining professional standards and professional prestige. The emphasis of each obligation varies between the codes. The first priority is the patient and his rights
Heymans et al. 2007, The Netherlands	To explore nurses' experience and views of the content and functions of the codes	N = 39 Nurses	Dutch Codes for Nurses (Nieuwe Unie 91), CFO, Cristian Code	Nurses found the codes as important but they were unfamiliar with them. Knowledge and use of the codes was limited. The use of the codes is unconscious. They serve as a guideline and define the profession. Important content of nursing education.
Nurses' moral behaviour related to the codes of ethics				
Ketefian 1981, USA	To explore the relationship between nurses' moral reasoning and moral behaviour	N = 79 Nurses	ANA (American Nurses' Association) Code for nurses (1976)	The sound moral reasoning process is related to moral behaviour measured by JAND based on ANA Codes. Education has an important impact on the development of moral reasoning skills and consequently moral behaviour. Changes are needed in development, style of writing and education for the codes become meaningful to nurses.
Cassidy & Oddi 1988, USA	To explore nursing students' differences in perception of ethical problems and their attitudes of autonomy	N = 130 Nursing students (4 groups)	ANA (American Nurses' Association) Code for nurses (1976)	No differences were found among student groups on perceptions of idealistic and realistic moral behaviour measured by JAND based on ANA Codes. Age and ethics course or seminar did not have an impact on idealistic or realistic moral behaviour.
Cassidy & Oddi 1991, USA	To explore nursing students' differences in perception of ethical problems and their attitudes of autonomy	N = 147 Nursing students (4 groups)	ANA (American Nurses' Association) Code for nurses (1976) Kohlberg (1978	Age and formal education had a positive effect on attitudes towards autonomy. There was a lack of significant findings on JAND scores among groups (Cassidy & Oddi 1991)
Ketefian 1985, USA	To explore the relationship between professional and bureaucratic role conceptions and moral behaviour	N = 217 Nurses	ANA (American Nurses' Association) Code for nurses (1976) Kohlberg (1978)	Different types of professional and bureaucratic role conceptions held by nurses were positively or negatively related to nurses' moral behaviour measured by JAND based on ANA Codes. Professional categorical role conception was

				positively related to moral behaviour. Professional normative role conception and professional role discrepancy were negatively related to moral behaviour. Bureaucratic role discrepancy was positively related to moral behaviour.
Gaul 1989, USA	To explore the relationship of and difference in ethical choice and ethical action between different student groups	N = 54 Nursing students	ANA (American Nurses' Association) Code for nurses (1976)	Students taking a separate course in nursing ethics performed higher levels of moral development than the control group measured by JAND based on ANA Codes. The results support the need for a course in nursing ethics in baccalaureate curricula. Integration of ethical content throughout the curricula does not achieve the same results as a free-standing course in nursing ethics.
Yung 1997a, Hong Kong/China	To explore the relationship between ethical decision-making and learning climate of students in two different educational programs	N = 221 Nursing students	ANA (American Nurses' Association) Code for nurses (1976)	The degree students scored significantly lower in the ethical decision-making than the certificate students. No significant difference was found in the perception of learning climate between the groups but the learning climate enhancing autonomy was found to correlate positively with ethical decision-making in degree students measured by JAND based on ANA Codes
Yung 1997b, Hong Kong/China	To explore the relationship between three role conception types to students' moral behaviour	N = 221 Nursing students	ANA (American Nurses' Association) Code for nurses (1976)	In degree students the higher the ideal professional role conception, the higher the ideal ethical behaviour. In practice, however the service role orientation gave a better prediction of the ethical behaviour in both certificate and degree students measured by JAND based on ANA Codes. Nursing education should therefore cultivate the traditional loyalty to humanitarian patient care and emphasize the importance of direct nursing care to patients. The professional and bureaucratic role discrepancies together had a negative effect on actual ethical behaviour of the degree students. Thus the professional values that have been developed through socialisation in nurse education programmes could benefit patients only when degree students in particular could adapt successfully to the demands of bureaucratic organizations

Turner & Bechtel 1998, USA	To explore 'a guided design' teaching method in ethical decision-making and moral reasoning using JAND instrument	N = 145 Nursing students	ANA (American Nurses' Association) Code for nurses (1976)	The results showed a significant different in ethical decision-making after instruction, but no difference in moral reasoning measured by JAND based on ANA Codes.
Nurses' values related to the codes of ethics				
Schank & Weis 1989, USA	To explore the relationship between professional values of two student groups and values of the codes	N = 199 Nursing students	ANA (American Nurses' Association) Code for nurses (1985)	In both respondent groups the most identified values related to nurse-patient related issues rather than social issues of the profession measured by an instrument based on ANA Codes. Secular or non-secular educational background had no impact on values.
Kelly 1991, USA	To explore what students internalize as professional values	N = 12 Nursing students	UKCC (United Kingdom Central Council) Code of Professional Conduct for the Nurse, Midwife and health visitor (1982)	Nursing students' values espoused values of the codes (UKCC 1982), i.e. respect for humans and caring regarded as good nursing. Good role modelling would help new nurses to keep their "faith" in hospital nursing career.
Kelly 1992, USA	To explore students' perceptions of professional ethics	N = 23 Nursing students	ANA (American Nurses' Association) Code for nurses (1985)	Nursing students did not evidence an ambiguous professional role. Their values espoused values of the codes (ANA), i.e. respect for humans and caring regarded as good nursing. Good nursing is outlined in the codes. Nurse educators have an ethical obligation to respect and care for their students. Posing as role models the students learn what the nurse-patient relationship ought to be.
Weis & Schank 1997, UK, USA	To explore the congruence of professional values of UK and USA students related to the codes	N = 130 Nursing students	ANA (American Nurses' Association) Code for nurses (1985)	There is congruence of professional values among nursing students from USA and UK. The minor differences may relate to cultural differences in education and practice.
Schank & Weis 1996, USA	To explore the inherence of the values of the codes in nursing in institutions' philosophies of nursing	N = 10 Health care institutions' nursing directors and vice presidents	ANA (American Nurses' Association) Code for nurses (1985)	The influence of family values and significant professional experiences were the most frequently reported determinants of management style. The nursing philosophies reflected statements of ANA Codes in various amounts, but none of them included them all. Every philosophy spoke of nurse-patient relationship (respect and accountability). Statements related to meet the health requirements of public were least represented in institutions' nursing philosophies The philosophies also reflected the personal values of the interviewees.
Schank & Weis	To explore the congruence of	N = 31	ANA (American Nurses'	There are more similarities than differences in

2000, USA,UK	professional values of UK and USA nursing educators	Nurse educators	Association) Code for nurses (1985)	professional values between British and America nurse educators. There exists strong consensus in statements relating to nurse- patient relationship. Differences are related to social aspects of the codes focusing on nurses' responsibility to the profession and society. The differences may be explained by differences in cultural, educational, and the health care systems.
Schank & Weis 2001, USA	To explore the professional values of nurses and nursing students	N = 51 Nursing students (n = 29), Nurses (n = 22)	ANA (American Nurses' Association) Code for nurses (1985)	The nurses rated behaviours reflecting values in the codes (ANA) as more important than students. The study implies that the code is part of nurses' value system. Nursing education begins the value formation for practice which continues as a professional socialization process in practice.
Ahern & McDonald 2002, Australia	To explore nurses' beliefs about whistle-blowing	N= 95 Nurses	Western Australian Nurses' Code of Practice (1995) Canadian Nurses' Association Code of Ethics (1996) ?	Whistleblowers believed in patient advocacy and that nurses are primarily responsible to the patient as stated in the codes Non-whistleblowers believed in traditional role of nurses as subordinates to doctors and the organization
Martin et al. 2003, USA	To explore differences between in professional values between student groups in two educational programmes	N = 1450 Nursing students	ANA (American Nurses' Association) Code for nurses (1985)	Regardless of educational program, professional values were significantly related to sex and ethnicity, women scoring higher, Asian/Pacific students scoring generally lower in relation to certain values although both student groups did not differ significantly in the total score. Awareness of the need of strong professional value base should be recognised in nursing education. Education should consider various kinds of educational approaches in values education related to students demographic variables (sex and ethnicity)
Leners et al. 2006, USA	To explore students' learning and change of professional values from entry to exit of nursing educational program	N = 159 Nursing students	ANA (American Nurses' Association) Code for nurses (1985)	Students' overall total scores increased from entry to exit. Thus education had a positive impact on value formation. The most appreciated values related to nurse-patient relationship, i.e. nursing competence, high quality care, responsibility, clients' privacy and protection of patients' rights. The least appreciated values were related to social values, i.e. allocation of

				resources, institutional decision-making, research, peers, and consumer education. Thus, related values were most appreciated, and less emphasized
Rassin, 2008, Israel	To explore nurses' professional and personal values	N = 323 Nurses	Israeli Code (1996 and 2004)	The 3 most important code based values were human dignity, equality and prevention of suffering. The top 10 values were related to nurse-patient relationship. The least important values were related to update professional knowledge, professional loyalty, e.g. to follow the codes, and professional excellence., promote the profession etc.

Appendix 6. Kyselylomake hoitotyön opettajille

”Sairaanhoitajan eettisten ohjeiden opetus hoitotyön koulutuksessa”

Kyselylomake terveysalan opettajille

Turun yliopisto
Hoitotieteen laitos
20014 Turun yliopisto

Hyvä terveysalan opettaja,

Opiskelen Turun yliopiston lääketieteellisen tiedekunnan hoitotieteen jatkokoulutuksessa. Väitöskirjatutkimukseni aihe on sairaanhoitajan eettisten ohjeiden opetus (Sairaanhoitajan eettiset ohjeet, Suomen sairaanhoitajaliitto 28.9.1996). Tutkimuksen tarkoituksena on kuvata sairaanhoitajan eettisten ohjeiden opetusta tällä hetkellä Suomen ammattikorkeakouluissa. Ammattikorkeakoulujen hoitotyön etiikan opetusta on toistaiseksi tutkittu vähän. Tämän kuvailevan, vertailevan poikittaistutkimuksen tarkoituksena on tunnistaa vahvuuksia ja mahdollisia ongelmakohtia sairaanhoitajan eettisten ohjeiden opetuksessa. Tuloksia voidaan hyödyntää opetussuunnitelmien kehittämisessä, käytännön- ja teoriaopetuksen integroinnissa sekä sairaanhoitajan eettisten ohjeiden opetuksen kuvaamisessa muille terveydenhuollon ammattiryhmille.

Tutkimuksen kohderyhmänä ovat Suomen ammattikorkeakoulujen sairaanhoitajakoulutuksessa toimivat **opettajat, jotka opettavat sairaanhoitajan eettisiä ohjeita joko muuhun hoitotyön opetukseen integroituna ja/tai erillisillä etiikan opintojaksoilla.** Toisena kohderyhmänä ovat valmistuvat sairaanhoitajaopiskelijat, ja kolmantena kohderyhmänä käytännön hoitotyössä toimivat sairaanhoitajaopiskelijoita ohjaavat hoitajat. Pyydän kohteliaimmin, että **Sinä opettajaryhmän edustajana** vastaat oheiseen kyselylomakkeeseen. Kysely koskee sekä integroituna että erillisinä etiikan opintojaksoina toteutettua sairaanhoitajan eettisten ohjeiden opetusta.

Kyselyyn vastataan nimettömänä. Kaikki vastaukset käsitellään luottamuksellisesti eikä yksittäisiä vastauksia ole mahdollista tunnistaa tutkimusraportista. Tulokset esitetään pääosin tilastollisesti. Osallistumisesi tutkimukseen on vapaaehtoista. Tutkimuksen onnistumisen kannalta jokaisen opettajan osuus on kuitenkin tärkeä ja osallistumalla edistät myös oman tieteenalamme tutkimusta. Tässä kyselyssä ei ole oikeita tai vääriä vastauksia. Tärkeintä on, että vastauksesi **kuvaavat Sinun opetustasi sellaisena kuin sitä toteutat.** Vastaan tarvittaessa mielelläni tutkimusta koskeviin kysymyksiisi. Tutkimusta ja kyselyä koskevat huomiosi voit myös kirjata joko kysymyksen viereiseen marginaaliin tai kyselyn loppuun varattuun tilaan.

Pyydän ystävällisesti, että palautat vastauksesi oheisessa vastauskuoressa _____ **2006 mennessä tutkimuksen tekijälle.** Tutkimusraportti toimitetaan sen valmistuttua osallistuneille ammattikorkeakouluille ja kliinisille yksiköille.

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Kiitän Sinua yhteistyöstä.

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SAIRAANHOITAJAN EETTISTEN OHJEIDEN OPETUS HOITOTYÖN KOULUTUKSESSA

Kyselytutkimus terveysalan opettajille

TÄMÄ KYSELY KOSKEE SAIRAANHOITAJAN EETTISTEN OHJEIDEN OPETUSTA, JOTA TOTEUTETAAN JOKO ERILLISEN ETIIKAN OPETUSJAKSON YHTEYDESSÄ TAI INTEGROITUNA MUUHUN HOITOTYÖN TEOREETTISEEN TAI HOITOTYÖN KÄYTÄNNÖN OPETUKSEEN.

I. TAUSTATIEDOT ***(Ympyröi ja/tai kirjoita yksi tai useampi vaihtoehto)***

1. Ikä _____vuotta

2. Sukupuoli 1. Nainen 2. Mies

3. Ammatillinen peruskoulutus
1. Sairaanhoitaja, suuntautumisala/erikoistumisala_____
2. Kätilö
3. Terveydenhoitaja
4. Muu ammatillinen peruskoulutus, mikä_____

4. Korkein tutkintosi
1. Sairaanhoidon opettaja
2. Terveydenhuollon/Terveystieteiden maisteri
3. Terveydenhuollon/Terveystieteiden lisensiaatti
4. Terveydenhuollon/Terveystieteiden tohtori
5. Muu, mikä _____

5. Kuinka monta vuotta olet toiminut terveysalan opettajana? _____vuotta,
jos vähemmän kuin vuoden, niin _____kuukautta

6. Mainitse ne hoitotyön alueet, joita eniten opetat (esim. perioperatiivinen hoitotyö)
1._____ 4. _____
2._____ 5._____
3._____ 6._____

7. Olen opettanut sairaanhoitajan eettisiä ohjeita:
1. Erillisinä etiikan opintojaksoina/luentoina
2. Integroituna hoitotyön teoreettiseen opetukseen
3. Integroituna hoitotyön kliiniseen harjoitteluun
4. Opetustyöni ei ole edellyttänyt lainkaan sairaanhoitajien eettisten ohjeiden opetusta
(Huom! Jos valitsit vaihtoehdon 4, Sinun ei tarvitse jatkaa kyselyyn vastaamista. On kuitenkin tärkeää, että palautat kyselylomakkeen siitä huolimatta oheisessa palautuskuoressa tilastollista analyysiä varten)

8. Kuinka monta vuotta olet opettanut sairaanhoitajan eettisiä ohjeita erillisinä opintojaksoina? _____
vuotta, jos vähemmän kuin vuoden, niin _____kuukautta

9. Kuinka monta vuotta olet opettanut sairaanhoitajan eettisiä ohjeita integroituna opetuksena? _____
vuotta, jos vähemmän kuin vuoden, niin _____kuukautta

(Ympyröi ja/tai kirjoita <u>yksi tai useampi</u> vaihtoehto)

10. Miten olet hankkinut sairaanhoitajan eettisten ohjeiden opetuksessa tarvittavat tietosi?

1. Terveydenhuollon ammatillisessa peruskoulutuksessa
2. Terveydenhuollon yliopistokoulutuksessa
3. Erillisessä etiikkaa käsittelevässä koulutuksessa
4. Itseopiskeluna (esim. kirjallisuuteen perehtymällä)
5. Muulla tavoin, miten? _____

11. Oletko tehnyt opinnäytetyösi tai muuta tutkimusta sairaanhoitajan eettisiin ohjeisiin liittyvästä aiheesta?

1. Kyllä 2. En

Jos vastasit kyllä, tutkimuksesi aihepiiri: _____

sekä tutkinto tai tilanne, johon kyseinen tutkimustyösi liittyi: _____

12. Oletko toiminut sairaanhoitajan eettisiin ohjeisiin liittyvässä kehittämistyössä?

1. Kyllä 2. En

Jos vastasit kyllä, kehittämistyösi aihepiiri_____

13. Koulutusyksikössäni sairaanhoitajan eettisten ohjeiden opetuksessa käytetään vierailevaa luennoitsijaa/opettajaa

1. Ei lainkaan
2. Melko vähän
3. Jonkin verran
4. Melko paljon
5. Erittäin paljon

Kuka? (esim. eetikko, Sairaanhoitajaliiton edustaja)_____

II. MIELIPITEESI SAIRAANHOITAJAN EETTISISTÄ OHJEISTA

Seuraavassa kysytään mielipidettäsi Suomen sairaanhoitajaliiton (1996) sairaanhoitajan eettisistä ohjeista ja niiden opettamisesta. Jokaisen väittämän kohdalla vastaa vaihtoehtoon, joka parhaiten kuvaa mielipidettäsi väittämästä ja perustele vastauksesi lyhyesti.

1. Täysin eri mieltä
2. Jokseenkin eri mieltä
3. En samaa enkä eri mieltä
4. Jokseenkin samaa mieltä
5. Täysin samaa mieltä

14. Sairaanhoitajat tarvitsevat omat eettiset ohjeet **1 2 3 4 5**

Perustele vastauksesi lyhyesti _____

_____

1. Täysin eri mieltä
2. Jokseenkin eri mieltä
3. En samaa enkä eri mieltä
4. Jokseenkin samaa mieltä
5. Täysin samaa mieltä

15. Sairaanhoitajan eettiset ohjeet soveltuvat nykypäivän hoitotodellisuuteen **1 2 3 4 5**

Perustele vastauksesi lyhyesti _____

_____

16. Sairaanhoitajan eettisten ohjeiden opettaminen opiskelijoille on tärkeä osa etiikan opetusta **1 2 3 4 5**

Perustele vastauksesi lyhyesti _____

_____

17. Arvioin tietoni riittäviksi opettamaan sairaanhoitajan eettisiä ohjeita **1 2 3 4 5**

Perustele vastauksesi lyhyesti _____

_____

III. SAIRAANHOITAJAN EETTISET OHJEET

Sairaanhoitajan eettiset ohjeet ovat osa sairaanhoitajan eettistä tietoperustaa. Eettisten ohjeiden sisältöjä voidaan kuitenkin opetuksessa painottaa eri tavoin. Seuraavassa on lueteltu keskeisiä sisältöjä Suomen sairaanhoitajaliiton (1996) eettisistä ohjeista. Arvioi missä määrin olet opettanut lueteltuja eettisten ohjeiden sisältöjä opiskelijoillesi. Ympyröi jokaisen sisällön kohdalla se vaihtoehto (vain yksi), joka parhaiten vastaa opetustasi.

<u>Olen opettanut:</u>
1. En lainkaan
2. Melko vähän
3. Jonkin verran
4. Melko paljon
5. Erittäin paljon

I Sairaanhoitajan tehtävä

18. Sairaanhoitajan tehtävä on terveyden edistäminen **1 2 3 4 5**

19. Sairaanhoitajan tehtävä on sairauden ehkäiseminen **1 2 3 4 5**

20. Sairaanhoitajan tehtävä on kärsimyksen lievittäminen **1 2 3 4 5**

21. Sairaanhoitajan tehtävä on hoidettavien tukeminen **1 2 3 4 5**

22. Sairaanhoitajan tehtävä koskee koko väestöä **1 2 3 4 5**

	Olen opettanut: 1. En lainkaan 2. Melko vähän 3. Jonkin verran 4. Melko paljon 5. Erittäin paljon
II Sairaanhoitaja ja potilas	
23. Sairaanhoitaja on toiminnastaan vastuussa ensisijaisesti potilaalleen	**1 2 3 4 5**
24. Sairaanhoitaja kunnioittaa hoidettavan ihmisarvoa	**1 2 3 4 5**
25. Sairaanhoitaja kunnioittaa hoidettavan itsemääräämisoikeutta	**1 2 3 4 5**
26. Sairaanhoitajaa sitoo vaitiolovelvollisuus	**1 2 3 4 5**
27. Sairaanhoitaja toimii hoitaessaan oikeudenmukaisesti	**1 2 3 4 5**
III Sairaanhoitajan työ ja ammattitaito	
28. Sairaanhoitaja on vastuussa tekemästään työstä henkilökohtaisesti	**1 2 3 4 5**
29. Sairaanhoitaja arvioi oman ja muiden pätevyyden ottaessaan tehtäviä tai jakaessaan niitä muille	**1 2 3 4 5**
30. Sairaanhoitajan velvollisuutena on kehittää ammattitaitoaan	**1 2 3 4 5**
31. Sairaanhoitaja on vastuussa tekemänsä hoitotyön laadusta	**1 2 3 4 5**
32. Sairaanhoitajan vastuulla on hoitotyön laadun parantaminen	**1 2 3 4 5**
IV Sairaanhoitaja ja työtoverit	
33. Sairaanhoitaja tukee kollegojaan hoitoa koskevassa päätöksenteossa	**1 2 3 4 5**
34. Sairaanhoitaja tukee kollegojensa työssä jaksamista	**1 2 3 4 5**
35. Sairaanhoitaja tukee kollegojensa ammatillista kehittymistä	**1 2 3 4 5**
36. Sairaanhoitaja kunnioittaa oman ja muiden ammattiryhmien asiantuntemusta	**1 2 3 4 5**
37. Sairaanhoitaja valvoo, etteivät oman ja muiden ammattiryhmien jäsenet toimi epäeettisesti	**1 2 3 4 5**

	Olen opettanut: 1. En lainkaan 2. Melko vähän 3. Jonkin verran 4. Melko paljon 5. Erittäin paljon
V Sairaanhoitaja ja yhteiskunta	
38. Sairaanhoitaja osallistuu terveyttä koskevaan keskusteluun kansallisesti ja kansainvälisesti	**1 2 3 4 5**
39. Sairaanhoitaja osallistuu terveyttä koskevaan päätöksentekoon kansallisesti ja kansainvälisesti	**1 2 3 4 5**
40. Sairaanhoitaja toimii yhteistyössä hoidettavan läheisten kanssa	**1 2 3 4 5**
41. Sairaanhoitaja toimii yhteistyössä erilaisten järjestöjen kanssa	**1 2 3 4 5**
42. Sairaanhoitaja kantaa vastuuta ihmiskunnan terveyteen liittyvien elinolojen kehittämisestä maailmanlaajuisesti	**1 2 3 4 5**
VI Sairaanhoitaja ja ammattikunta	
43. Sairaanhoitaja huolehtii ammattikunnan yhteiskunnallisen tehtävän arvokkuuden ylläpitämisestä	**1 2 3 4 5**
44. Sairaanhoitajien ammattikunta tukee sairaanhoitajien eettistä kehitystä	**1 2 3 4 5**
45. Sairaanhoitajien ammattikunta valvoo, että hoitajan ihmisläheinen auttamistehtävä säilyy	**1 2 3 4 5**
46. Sairaanhoitajien ammattijärjestö huolehtii ammattikunnalle kuuluvista eduista	**1 2 3 4 5**
47. Sairaanhoitajakunta vastaa oman alansa asiantuntijuudesta	**1 2 3 4 5**

IV. SAIRAANHOITAJAN EETTISTEN OHJEIDEN KÄSITTEET

Sairaanhoitajan eettiset ohjeet sisältävät useita hoitotyötä ohjaavia eettisiä käsitteitä. Arvioi missä määrin olet opettanut alla lueteltuja eettisiä käsitteitä opiskelijoillesi selvittäen niiden keskeisen merkityksen myös sairaanhoitajan eettisissä ohjeissa. Ympyröi jokaisen sisällön kohdalla se vaihtoehto (vain yksi), joka parhaiten vastaa opetustasi.

	Olen opettanut: **1. En lainkaan** **2. Melko vähän** **3. Jonkin verran** **4. Melko paljon** **5. Erittäin paljon**
48. Potilaan oikeudet ovat sekä laillisia että moraalisia oikeuksia. Ne sisältävät oikeuden hyvään hoitoon, hoitoon pääsyyn, tiedonsaantiin, itsemääräämiseen, oikeuden hoitovirheestä muistuttamiseen ja oikeuden tietojen salassa pysymiseen.	**1 2 3 4 5**
49. Yksityisyys on ihmisen itsemääräämisoikeuden kunnioittamiseen perustuva oikeus fyysiseen suojaan ja velvollisuus häntä koskevan tiedon salassapitoon.	**1 2 3 4 5**
50. Totuuden puhuminen on ihmisen ja hänen itsemääräämisoikeutensa kunnioittamiseen sekä hoitosuhteen luottamuksellisuuteen perustuva velvollisuus rehellisyyteen.	**1 2 3 4 5**
51. Oikeudenmukaisuus on velvollisuus kohdella ihmisiä tasapuolisesti syrjimättä heitä moraalisesti kestämättömin perustein (esim. ikä, sukupuoli) ja velvollisuus pyrkiä jakamaan käytettävissä olevat voimavarat tasapuolisesti.	**1 2 3 4 5**
52. Itsemääräämisoikeus on velvollisuus kunnioittaa ihmisen oikeutta ja kykyä vapaasti määrätä omista asioistaan hänen toiveidensa ja arvojensa mukaisesti.	**1 2 3 4 5**
53. Vaitiolovelvollisuus on velvollisuus olla antamatta tietoa toisesta ihmisestä ilman hänen antamaansa lupaa sellaisille osapuolille, joille tieto ei kuulu.	**1 2 3 4 5**
54. Velvollisuus on oikeana pidetty toiminta, mitä yksilöltä voidaan vaatia joko laillisin tai moraalisin perustein.	**1 2 3 4 5**
55. Elämän pyhyys on velvollisuus ylläpitää ihmiselämää perustuen ajatukseen, että ihmiselämän tuhoaminen on moraalisesti väärin.	**1 2 3 4 5**
56. Vastuu/Edesvastuu on ihmisen vastuu omasta toiminnastaan, joka sisältää vastuun tehdystä teosta ja vastuun henkilölle, johon toiminta on kohdistunut, ns. tehtävävastuu ja ihmisvastuu.	**1 2 3 4 5**

V. SAIRAANHOITAJAN EETTISTEN OHJEIDEN TARKOITUKSET

Sairaanhoitajan eettisillä ohjeilla on useita tarkoituksia. Arvioi missä määrin olet opettanut alla lueteltuja sairaanhoitajien eettisiin ohjeisiin liittyviä tarkoituksia opiskelijoillesi. Ympyröi jokaisen tarkoituksen kohdalla se vaihtoehto (vain yksi), joka parhaiten vastaa opetustasi.

	Olen opettanut: **1. En lainkaan** **2. Melko vähän** **3. Jonkin verran** **4. Melko paljon** **5. Erittäin paljon**
I. Ammatillinen tarkoitus	
57. Kuvata ja edistää sairaanhoitajan ammatillista asemaa yhteiskunnassa	**1 2 3 4 5**
58. Kuvata sairaanhoitajan ammatillisen käyttäytymisen periaatteet	**1 2 3 4 5**
59. Kuvata hoitotyön ammatilliset arvot ja ihanteet	**1 2 3 4 5**
60. Kehittää sairaanhoitajan ammatillista ajattelua	**1 2 3 4 5**
61. Tukea sairaanhoitajaa työssään	**1 2 3 4 5**
62. Yhdistää sairaanhoitajien ammattikuntaa	**1 2 3 4 5**
II. Yhteiskunnallinen tarkoitus	
63. Ilmaista sairaanhoitajan perustehtävä yhteiskunnalle	**1 2 3 4 5**
64. Ilmaista sairaanhoitajien vastuut ja velvollisuudet yhteiskunnalle	**1 2 3 4 5**
65. Ilmaista sairaanhoitajien ammattikunnan yhteiskunnallinen asema	**1 2 3 4 5**
66. Suojella sairaanhoitajaa ja potilasta ilmaisemalla julkisesti sairaanhoitajaan kohdistuvat odotukset	**1 2 3 4 5**
67. Toimia sairaanhoitajien ammattikunnan ja yhteiskunnan välisenä sopimuksena ammattia koskevien sääntöjen noudattamisesta	**1 2 3 4 5**

Olen opettanut:
1. En lainkaan
2. Melko vähän
3. Jonkin verran
4. Melko paljon
5. Erittäin paljon

III. Käytäntöön liittyvä tarkoitus

68. Antaa sairaanhoitajalle ohjeita eettiseen päätöksentekoon **1 2 3 4 5**

69. Antaa sairaanhoitajalle moraalisia ohjeita hoitotyöhön **1 2 3 4 5**

70. Ilmaista sairaanhoitajan perustehtävä yhteiskunnassa **1 2 3 4 5**

71. Toimia hoitotyön laadun arviointiperusteena **1 2 3 4 5**

IV. Eettinen tarkoitus

72. Kuvata hoitotyön eettiset arvot **1 2 3 4 5**

73. Kuvata hoitotyön päämäärien eettistä luonnetta **1 2 3 4 5**

74. Kuvata sairaanhoitajan eettiset vastuut **1 2 3 4 5**

75. Toimia sairaanhoitajan toiminnan eettisyyden arviointiperusteena **1 2 3 4 5**

76. Kuvata hoitotyön eettiset laatuvaatimukset **1 2 3 4 5**

V. Laillinen tarkoitus

77. Ilmaista sairaanhoitajan toiminnan lailliset vastuut **1 2 3 4 5**

78. Toimia sairaanhoitajien ammattikunnan itsesäätelyn välineenä **1 2 3 4 5**

79. Toimia sairaanhoitajien ammattikunnan toiminnan oikeuttajana **1 2 3 4 5**

80. Toimia ammatillisten väärinkäytöksien arvioinnin kriteerinä **1 2 3 4 5**

81. Suojata sairaanhoitajia lailliselta vastuulta hoitovirheitä ja väärinkäytöksiä arvioitaessa **1 2 3 4 5**

VI. Velvoittava tarkoitus

82. Kuvata sairaanhoitajan työhön liittyvät moraaliset velvollisuudet **1 2 3 4 5**

83. Kuvata sairaanhoitajan työhön liittyvät muut velvollisuudet **1 2 3 4 5**

Olen opettanut:
1. En lainkaan
2. Melko vähän
3. Jonkin verran
4. Melko paljon
5. Erittäin paljon

VII. Koulutuksellinen/kasvatuksellinen tarkoitus

84. Ohjata opetussuunnitelmien sisältöjä kuvaamalla eettisesti korkeatasoisen hoidon kriteerit **1 2 3 4 5**

85. Tukea hoitotyön opettajia ja ohjaajia opetustyössä kuvaamalla eettisesti korkeatasoisen hoidon kriteerit **1 2 3 4 5**

86. Tukea sairaanhoitajaopiskelijoita arvioimaan osaamistaan kuvaamalla eettisesti korkeatasoisen hoidon kriteerit **1 2 3 4 5**

87. Kehittää sairaanhoitajaopiskelijoiden kriittistä ajattelua **1 2 3 4 5**

88. Opettaa sairaanhoitajaopiskelijat tunnistamaan hoitotyön moraalisia ja käytäntöön liittyviä velvollisuuksia **1 2 3 4 5**

VI. TERVEYDENHUOLLON MUIDEN AMMATTIEN EETTISET OHJEET

Terveydenhuollon monilla ammattikunnilla on omat eettiset ohjeensa. Lisäksi on kaikkia terveydenhuollon ammattikuntia koskeva yhteinen arvopohja, yhteiset tavoitteet ja periaatteet (ETENE 2000). Arvioi missä määrin olet opettanut eri ammattikuntien ja terveydenhuollon yhteisiä eettisiä ohjeita opiskelijoillesi. Ympyröi jokaisen eettisen ohjeiston kohdalla se vaihtoehto (vain yksi), joka parhaiten vastaa opetustasi.

Olen opettanut:
1. En lainkaan
2. Melko vähän
3. Jonkin verran
4. Melko paljon
5. Erittäin paljon

89. Kansainvälisen Sairaanhoitajaliiton eettiset ohjeet (ICN 2000) **1 2 3 4 5**

90. Kätilötyön eettiset ja laadulliset perusteet (1998) **1 2 3 4 5**

91. Hoitotyön johtajan eettiset ohjeet (2003) **1 2 3 4 5**

92. Lähihoitajan eettiset ohjeet (2000) **1 2 3 4 5**

93. Lastenhoidon eettiset periaatteet (1993) **1 2 3 4 5**

94. Lääkärin eettiset ohjeet (2000) **1 2 3 4 5**

95. Terveydenhuollon yhteinen arvopohja, yhteiset tavoitteet ja periaatteet (Terveydenhuollon eettinen neuvottelukunta, ETENE 2000) **1 2 3 4 5**

96. Muu, mikä_____ **1 2 3 4 5**

VII. EETTISTEN OHJEIDEN KANNALTA KESKEISET LAIT JA SOPIMUKSET

Terveydenhuollon lainsäädäntö sisältää monia lakeja, ja sopimuksia, jotka ovat terveydenhuollon ammattikuntien eettisten ohjeiden kannalta tärkeitä. Arvioi missä määrin olet opettanut alla lueteltuja lakeja ja sopimuksia opiskelijoillesi selvittäen niiden merkitystä sairaanhoitajan eettisten ohjeiden näkökulmasta. Ympyröi jokaisen lain kohdalla se vaihtoehto (vain yksi), joka parhaiten vastaa opetustasi.

Olen opettanut:
1. En lainkaan
2. Melko vähän
3. Jonkin verran
4. Melko paljon
5. Erittäin paljon

97. YK:n yleismaailmallinen ihmisoikeuksien julistus 10.12.1948	**1**	**2**	**3**	**4**	**5**
98. Euroopan ihmisoikeussopimus 439/1990	**1**	**2**	**3**	**4**	**5**
99. Lapsen oikeuksia koskeva yleissopimus 1989	**1**	**2**	**3**	**4**	**5**
100. Suomen perustuslaki 731/1999	**1**	**2**	**3**	**4**	**5**
101. Kansanterveyslaki 66/1972	**1**	**2**	**3**	**4**	**5**
102. Erikoissairaanhoitolaki 1062/1989	**1**	**2**	**3**	**4**	**5**
103. Laki potilaan asemasta ja oikeuksista 785/1992	**1**	**2**	**3**	**4**	**5**
104. Potilasvahinkolaki 585/1985	**1**	**2**	**3**	**4**	**5**
105. Laki terveydenhuollon oikeusturvakeskuksesta 1074/1992	**1**	**2**	**3**	**4**	**5**
106. Laki terveydenhuollon ammattihenkilöstöstä 559/1994	**1**	**2**	**3**	**4**	**5**
107. Laki sairaanhoitotoimen harjoittamisesta 554/1962	**1**	**2**	**3**	**4**	**5**
108. Asetus tutkimuseettisestä neuvottelukunnasta 1347/1991	**1**	**2**	**3**	**4**	**5**
109. Laki lääketieteellisestä tutkimuksesta 785/1999	**1**	**2**	**3**	**4**	**5**
110. Mielenterveyslaki 1116/1990	**1**	**2**	**3**	**4**	**5**
111. Sähköisen viestinnän tietosuojalaki 516/2004	**1**	**2**	**3**	**4**	**5**
112. Muu, mikä _____	**1**	**2**	**3**	**4**	**5**

VIII. EETTISTEN OHJEIDEN OPETUKSEN MENETELMÄT

Seuraavat kysymykset liittyvät eettisten ohjeiden opetuksessa käytettyihin menetelmiin. Ympyröi seuraavista vaihtoehdoista 3 eniten käyttämääsi opetusmenetelmää.

113. Opetusmenetelmä

a) Luento

b) Keskustelu (pienryhmäkeskustelu, dialogi)

c) Väittely (esim. argumentoiva väittely)

d) Kirjoittaminen (essee, portfolio, päiväkirja)

e) Pelit, roolipelit, simulaatiot (esim. ”valeoikeudenkäynti”)

f) Tietotekniikan käyttö (esim, internet/intranet)

g) Ongelmakeskeinen oppiminen (Problem Based Learning)

h) Seminaari/seminaarialustus

i) Opintokäynnit

j) Muu, mikä_____

IX. EETTISTEN OHJEIDEN OPETUKSEN OPPIMISTULOSTEN ARVIOINTI

Seuraavat kysymykset liittyvät opiskelijoiden sairaanhoitajan eettisten ohjeiden opetuksen oppimistulosten arviointiin. Ympyröi jokaisen kysymyksen kohdalla enintään 3 eniten käyttämääsi arviointimenetelmää (Kysymykset 114 -116).

114. Oppimistulosten arvioijana on

a) Opettaja

b) Toinen/toiset opiskelijat (vertaisarviointi)

c) Opiskelija itse

d) Käytännön harjoittelun ohjaajat

e) Ei kukaan

f) Joku muu, kuka_____

115. Oppimistulosten arviointitapa on

a) Esseen kirjoittaminen kuulustelutilaisuudessa

b) Esseen kirjoittaminen kotitehtävänä

c) Monivalintakoe

d) Suullinen kuulustelu

e) Arviointikeskustelu

f) Näyttökoe (esim. videointi)

g) Portfolio

h) Oppimispäiväkirja

i) Ei lainkaan arviointia

j) Muu, mikä _____

116. Oppimistulosten arvioinnin toteutusmuoto on:

a) Numeerinen arvosana

b) Kirjallinen palaute

c) Hyväksytty/hylätty arvosana

d) Suullinen palaute

e) Ei lainkaan palautetta

f) Muu, mikä_____

117. Arvioi vielä valmistuvien sairaanhoitajaopiskelijoiden tietoja sairaanhoitajan eettisistä ohjeista

Pidän sairaanhoitajaopiskelijoiden tietoja:

1. Erittäin huonoina

2. Melko huonoina

3. Keskitasoisina

4. Melko hyvinä

5. Erittäin hyvinä

0. En osaa sanoa

118. Arvioi myös valmistuvien sairaanhoitajaopiskelijoiden taitoja soveltaa sairaanhoitajan eettisiä ohjeita käytännön hoitotyössä

Pidän sairaanhoitajaopiskelijoiden taitoja:

1. Erittäin huonoina

2. Melko huonoina

3. Keskitasoisina

4. Melko hyvinä

5. Erittäin hyvinä

0. En osaa sanoa

119. Kuvaile lyhyesti, miten kehittäisit sairaanhoitajien eettisten ohjeiden opetusta_____

_____

_____

_____

_____

120. Mitä muuta haluaisit sanoa sairaanhoitajan eettisten ohjeiden opetuksesta? _____

_____

_____

_____

_____

Kiitos arvokkaista vastauksistasi!

Appendix 7. Kyselylomake sairaanhoitajaopiskelijoille

”Sairaanhoitajan eettisten ohjeiden opetus hoitotyön koulutuksessa”

Kyselylomake sairaanhoitajaopiskelijoille

Turun yliopisto
Hoitotieteen laitos
20014 Turun yliopisto

Hyvä sairaanhoitajaopiskelija,

Opiskelen Turun yliopiston lääketieteellisen tiedekunnan hoitotieteen jatkokoulutuksessa. Väitöskirjatutkimukseni aihe on sairaanhoitajan eettisten ohjeiden opetus (Sairaanhoitajan eettiset ohjeet, Suomen sairaanhoitajaliitto 28.9.1996). Tutkimuksen tarkoituksena on kuvata sairaanhoitajan eettisten ohjeiden opetusta tällä hetkellä Suomen ammattikorkeakouluissa. Ammattikorkeakoulujen hoitotyön etiikan opetusta on toistaiseksi tutkittu vähän. Tämän kuvailevan, vertailevan poikittaistutkimuksen tarkoituksena on tunnistaa vahvuuksia ja mahdollisia ongelmakohtia sairaanhoitajan eettisten ohjeiden opetuksessa. Tuloksia voidaan hyödyntää opetussuunnitelmien kehittämisessä, käytännön- ja teoriaopetuksen integroinnissa sekä sairaanhoitajan eettisten ohjeiden opetuksen kuvaamisessa muille terveydenhuollon ammattiryhmille.

Tutkimuksen kohderyhmänä ovat Suomen ammattikorkeakoulujen sairaanhoitajakoulutuksessa toimivat opettajat, jotka opettavat sairaanhoitajan eettisiä ohjeita joko muuhun hoitotyön opetukseen integroituna ja/tai erillisillä etiikan opintojaksoilla ja toisena kohderyhmänä ovat **valmistuvat sairaanhoitajaopiskelijat.** Pyydän kohteliaimmin, että **Sinä opiskelijaryhmän edustajana** vastaat oheiseen kyselylomakkeeseen. Kysely koskee sekä integroituna että erillisinä etiikan opintojaksoina toteutettua sairaanhoitajan eettisten ohjeiden opetusta.

Kyselyyn vastataan nimettömänä. Kaikki vastaukset käsitellään luottamuksellisesti eikä yksittäisiä vastauksia ole mahdollista tunnistaa tutkimusraportista. Tulokset esitetään pääosin tilastollisesti. Osallistumisesi tutkimukseen on vapaaehtoista. Tutkimuksen onnistumisen kannalta jokaisen opiskelijan osuus on kuitenkin tärkeä ja osallistumalla edistät myös oman tieteenalamme tutkimusta. Tässä kyselyssä ei ole oikeita tai vääriä vastauksia. Tärkeintä on, että vastauksesi **kuvaavat Sinun saamaasi sairaanhoitajan eettisten ohjeiden opetusta sairaanhoitajakoulutuksesi aikana.** Lomake saattaa tuntua haastavalta. Siinä tapauksessa lomakkeen täytön ajoittaminen useammalle päivälle on suositeltavaa. Vastaan tarvittaessa mielelläni tutkimusta koskeviin kysymyksiisi. Tutkimusta ja kyselyä koskevat huomiosi voit myös kirjata kyselyn loppuun varattuun tilaan.

Pyydän ystävällisesti, että palautat vastauksesi minulle sähköpostina tai voit myös tulostaa kaavakkeen ja postittaa täytetyn kaavakkeen _____ **2006 mennessä minulle alla olevaan osoitteeseen.** Tutkimusraportti toimitetaan sen valmistuttua osallistuneille ammattikorkeakouluille ja kliinisille yksiköille.

Tutkimukseni ohjaajina toimivat professori Helena Leino-Kilpi Turun yliopistosta (puh: 02–333 8404) ja professori Arie van der Arend Maastrichtin yliopistosta.

Kiitän Sinua yhteistyöstä.

Olivia Numminen
esh, TtM, hoitotieteen jatko-opiskelija
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SAIRAANHOITAJAN EETTISTEN OHJEIDEN OPETUS HOITOTYÖN KOULUTUKSESSA

Kyselytutkimus sairaanhoitajaopiskelijoille

TÄMÄ KYSELY KOSKEE SAIRAANHOITAJAN EETTISTEN OHJEIDEN OPETUSTA, JOTA TOTEUTETAAN JOKO ERILLISEN ETIIKAN OPETUSJAKSON YHTEYDESSÄ TAI INTEGROITUNA MUUHUN HOITOTYÖN TEOREETTISEEN TAI HOITOTYÖN KÄYTÄNNÖN OPETUKSEEN.

I. TAUSTATIEDOT ***(Ympyröi ja/tai kirjoita yksi tai useampi vaihtoehto)***

1. Ikä vuotta

2. Sukupuoli 1. Nainen 2. Mies

3. Koulutus (Ympyröi ainoastaan korkein tutkinto)
1. Kansakoulu
2. Keskikoulu
3. Peruskoulu
4. Lukio
5. Ylioppilastutkinto

4. Muu koulutus ja ammatillinen koulutus (kuin nykyinen sairaanhoitajakoulutus)
1. Ammattikoulu
2. Ammattikorkeakoulu
3. Yliopisto
4. Muu koulutus

Jos vastasit kyllä joihinkin kohdista 1-4, kerro lyhyesti, mitä olet opiskellut ja mitä tutkintoja suorittanut:_____

6. Mainitse se hoitotyön alue, jota pääasiallisesti opiskelet (esim. perioperatiivinen hoitotyö): _____

7. Sinulle on opetettu sairaanhoitajan eettisiä ohjeita
1. Erillisinä etiikan opintojaksoina/luentoina
2. Integroituna hoitotyön teoreettiseen opetukseen
3. Integroituna hoitotyön kliiniseen harjoitteluun
4. Sairaanhoitajaopintoni eivät ole sisältäneet lainkaan sairaanhoitajien eettisten ohjeiden opetusta (Huom! Jos valitsit vaihtoehdon 4, Sinun ei tarvitse jatkaa kyselyyn vastaamista. On kuitenkin tärkeää, että palautat kyselylomakkeen tähän kysymykseen saakka täytettynä tilastollista analyysiä varten)

8. Kuinka monena opiskeluvuotenasi Sinulle on opetettu sairaanhoitajan eettisiä ohjeita erillisinä opintojaksoina? _____ vuotena, jos vähemmän kuin yhtenä vuotena, niin _____ kuukautena

9. Kuinka monena opiskeluvuotenasi Sinulle on opetettu sairaanhoitajan eettisiä ohjeita integroituna opetuksena? _____ vuotena, jos vähemmän kuin yhtenä vuotena, niin _____ kuukautena

(Ympyröi ja/tai kirjoita yksi tai useampi vaihtoehto)

10. Miten olet hankkinut sairaanhoitajan eettisiä ohjeita koskevat tietosi?

1. Terveydenhuollon ammatillisessa peruskoulutuksessa (sairaanhoitajakoulutus)
2. Erillisessä etiikkaa käsittelevässä koulutuksessa
3. Erillisessä etiikkaa käsittelevässä koulutuksessa
4. Itseopiskeluna (esim. kirjallisuuteen perehtymällä)
5. Muulla tavoin, miten?:_____

11. Oletko tehnyt opinnäytetyösi tai muuta tutkimusta sairaanhoitajan eettisiin ohjeisiin liittyvästä aiheesta?

1. Kyllä 2. En

Jos vastasit kyllä, tutkimuksesi aihepiiri: _____

sekä tutkinto ja/tai tilanne, johon kyseinen tutkimustyösi liittyi: _____

12. Oletko toiminut sairaanhoitajan eettisiin ohjeisiin liittyvässä kehittämistyössä?

1. Kyllä 2. En

Jos vastasit kyllä, kehittämistyösi aihepiiri:_____

13. Koulutusyksikössäsi sairaanhoitajan eettisten ohjeiden opetuksessa käytetään vierailevaa luennoitsijaa/opettajaa

1. Ei lainkaan
2. Melko vähän
3. Jonkin verran
4. Melko paljon
5. Erittäin paljon

Kuka? (esim. eetikko, Sairaanhoitajaliiton edustaja):_____

II. MIELIPITEESI SAIRAANHOITAJAN EETTISISTÄ OHJEISTA

Seuraavassa kysytään mielipidettäsi Suomen sairaanhoitajaliiton (1996) sairaanhoitajan eettisistä ohjeista ja niiden opettamisesta. Jokaisen väittämän kohdalla vastaa vaihtoehtoon, joka parhaiten kuvaa mielipidettäsi väittämästä ja perustele vastauksesi lyhyesti.

1. Täysin eri mieltä
2. Jokseenkin eri mieltä
3. En samaa enkä eri mieltä
4. Jokseenkin samaa mieltä
5. Täysin samaa mieltä

14. Sairaanhoitajat tarvitsevat omat eettiset ohjeet **1 2 3 4 5**

Perustele vastauksesi lyhyesti:_____

1. Täysin eri mieltä
2. Jokseenkin eri mieltä
3. En samaa enkä eri mieltä
4. Jokseenkin samaa mieltä
5. Täysin samaa mieltä

15. Sairaanhoitajan eettiset ohjeet soveltuvat nykypäivän hoitotodellisuuteen **1 2 3 4 5**

Perustele vastauksesi lyhyesti:_____

16. Sairaanhoitajan eettisten ohjeiden opettaminen opiskelijoille on tärkeä osa etiikan opetusta **1 2 3 4 5**

Perustele vastauksesi lyhyesti: _____

17. Arvioin opettajieni tiedot riittäviksi opettamaan sairaanhoitajan eettisiä ohjeita **1 2 3 4 5**

Perustele vastauksesi lyhyesti: _____

III. SAIRAANHOITAJAN EETTISET OHJEET

Sairaanhoitajan eettiset ohjeet ovat osa sairaanhoitajan eettistä tietoperustaa. Eettisten ohjeiden sisältöjä voidaan kuitenkin opetuksessa painottaa eri tavoin. Seuraavassa on lueteltu keskeisiä sisältöjä Suomen sairaanhoitajaliiton (1996) eettisistä ohjeista. Arvioi missä määrin Sinulle on opetettu alla lueteltuja eettisten ohjeiden sisältöjä. Ympyröi jokaisen sisällön kohdalla se vaihtoehto (vain yksi), joka parhaiten vastaa saamaasi opetusta.

Minulle on opetettu:
1. Ei lainkaan
2. Melko vähän
3. Jonkin verran
4. Melko paljon
5. Erittäin paljon

I Sairaanhoitajan tehtävä

18. Sairaanhoitajan tehtävä on terveyden edistäminen **1 2 3 4 5**

19. Sairaanhoitajan tehtävä on sairauden ehkäiseminen **1 2 3 4 5**

20. Sairaanhoitajan tehtävä on kärsimyksen lievittäminen **1 2 3 4 5**

21. Sairaanhoitajan tehtävä on hoidettavien tukeminen **1 2 3 4 5**

22. Sairaanhoitajan tehtävä koskee koko väestöä **1 2 3 4 5**

	Minulle on opetettu: 1. Ei lainkaan 2. Melko vähän 3. Jonkin verran 4. Melko paljon 5. Erittäin paljon
II Sairaanhoitaja ja potilas	
23. Sairaanhoitaja on toiminnastaan vastuussa ensisijaisesti potilaalleen	**1 2 3 4 5**
24. Sairaanhoitaja kunnioittaa hoidettavan ihmisarvoa	**1 2 3 4 5**
25. Sairaanhoitaja kunnioittaa hoidettavan itsemääräämisoikeutta	**1 2 3 4 5**
26. Sairaanhoitajaa sitoo vaitiolovelvollisuus	**1 2 3 4 5**
27. Sairaanhoitaja toimii hoitaessaan oikeudenmukaisesti	**1 2 3 4 5**
III Sairaanhoitajan työ ja ammattitaito	
28. Sairaanhoitaja on vastuussa tekemästään työstä henkilökohtaisesti	**1 2 3 4 5**
29. Sairaanhoitaja arvioi oman ja muiden pätevyyden ottaessaan tehtäviä tai jakaessaan niitä muille	**1 2 3 4 5**
30. Sairaanhoitajan velvollisuutena on kehittää ammattitaitoaan	**1 2 3 4 5**
31. Sairaanhoitaja on vastuussa tekemänsä hoitotyön laadusta	**1 2 3 4 5**
32. Sairaanhoitajan vastuulla on hoitotyön laadun parantaminen	**1 2 3 4 5**
IV Sairaanhoitaja ja työtoverit	
33. Sairaanhoitaja tukee kollegojaan hoitoa koskevassa päätöksenteossa	**1 2 3 4 5**
34. Sairaanhoitaja tukee kollegojensa työssä jaksamista	**1 2 3 4 5**
35. Sairaanhoitaja tukee kollegojensa ammatillista kehittymistä	**1 2 3 4 5**
36. Sairaanhoitaja kunnioittaa oman ja muiden ammattiryhmien asiantuntemusta	**1 2 3 4 5**
37. Sairaanhoitaja valvoo, etteivät oman ja muiden ammattiryhmien jäsenet toimi epäeettisesti	**1 2 3 4 5**

	Minulle on opetettu: 1. Ei lainkaan 2. Melko vähän 3. Jonkin verran 4. Melko paljon 5. Erittäin paljon
V Sairaanhoitaja ja yhteiskunta	
38. Sairaanhoitaja osallistuu terveyttä koskevaan keskusteluun kansallisesti ja kansainvälisesti	**1 2 3 4 5**
39. Sairaanhoitaja osallistuu terveyttä koskevaan päätöksentekoon kansallisesti ja kansainvälisesti	**1 2 3 4 5**
40. Sairaanhoitaja toimii yhteistyössä hoidettavan läheisten kanssa	**1 2 3 4 5**
41. Sairaanhoitaja toimii yhteistyössä erilaisten järjestöjen kanssa	**1 2 3 4 5**
42. Sairaanhoitaja kantaa vastuuta ihmiskunnan terveyteen liittyvien elinolojen kehittämisestä maailmanlaajuisesti	**1 2 3 4 5**
VI Sairaanhoitaja ja ammattikunta	
43. Sairaanhoitaja huolehtii ammattikunnan yhteiskunnallisen tehtävän arvokkuuden ylläpitämisestä	**1 2 3 4 5**
44. Sairaanhoitajien ammattikunta tukee sairaanhoitajien hoitajien eettistä kehitystä	**1 2 3 4 5**
45. Sairaanhoitajien ammattikunta valvoo, että hoitajan ihmisläheinen auttamistehtävä säilyy	**1 2 3 4 5**
46. Sairaanhoitajien ammattijärjestö huolehtii ammattikunnalle kuuluvista eduista	**1 2 3 4 5**
47. Sairaanhoitajakunta vastaa oman alansa asiantuntijuudesta	**1 2 3 4 5**

IV. SAIRAANHOITAJAN EETTISTEN OHJEIDEN KÄSITTEET

Sairaanhoitajan eettiset ohjeet sisältävät useita hoitotyötä ohjaavia eettisiä käsitteitä. Arvioi missä määrin Sinulle on opetettu alla lueteltuja eettisiä käsitteitä selvittäen niiden keskeistä merkitystä myös sairaanhoitajan eettisissä ohjeissa. Ympyröi jokaisen sisällön kohdalla se vaihtoehto (vain yksi), joka parhaiten vastaa saamaasi opetusta.

	Minulle on opetettu: 1. Ei lainkaan 2. Melko vähän 3. Jonkin verran 4. Melko paljon 5. Erittäin paljon
48. Potilaan oikeudet ovat sekä laillisia että moraalisia oikeuksia. Ne sisältävät oikeuden hyvään hoitoon, hoitoon pääsyyn, tiedonsaantiin, itsemääräämiseen, oikeuden hoitovirheestä muistuttamiseen ja oikeuden tietojen salassa pysymiseen.	1 2 3 4 5
49. Yksityisyys on ihmisen itsemääräämisoikeuden kunnioittamiseen perustuva oikeus fyysiseen suojaan ja velvollisuus häntä koskevan tiedon salassapitoon.	1 2 3 4 5
50. Totuuden puhuminen on ihmisen ja hänen itsemääräämisoikeutensa kunnioittamiseen sekä hoitosuhteen luottamuksellisuuteen perustuva velvollisuus rehellisyyteen.	1 2 3 4 5
51. Oikeudenmukaisuus on velvollisuus kohdella ihmisiä tasapuolisesti syrjimättä heitä moraalisesti kestämättömin perustein (esim. ikä, sukupuoli) ja velvollisuus pyrkiä jakamaan käytettävissä olevat voimavarat tasapuolisesti.	1 2 3 4 5
52. Itsemääräämisoikeus on velvollisuus kunnioittaa ihmisen oikeutta ja kykyä vapaasti määrätä omista asioistaan hänen toiveidensa ja arvojensa mukaisesti.	1 2 3 4 5
53. Vaitiolovelvollisuus on velvollisuus olla antamatta tietoa toisesta ihmisestä ilman hänen antamaansa lupaa sellaisille osapuolille, joille tieto ei kuulu.	1 2 3 4 5
54. Velvollisuus on oikeana pidetty toiminta, mitä yksilöltä voidaan vaatia joko laillisin tai moraalisin perustein.	1 2 3 4 5
55. Elämän pyhyys on velvollisuus ylläpitää ihmiselämää perustuen ajatukseen, että ihmiselämän tuhoaminen on moraalisesti väärin.	1 2 3 4 5
56. Vastuu/Edesvastuu on ihmisen vastuu omasta toiminnastaan, joka sisältää vastuun tehdystä teosta ja vastuun henkilölle, johon toiminta on kohdistunut, ns. tehtävävastuu ja ihmisvastuu.	1 2 3 4 5

V. SAIRAANHOITAJAN EETTISTEN OHJEIDEN TARKOITUKSET

Sairaanhoitajan eettisillä ohjeilla on useita tarkoituksia. Arvioi missä määrin Sinulle on opetettu alla lueteltuja sairaanhoitajien eettisiin ohjeisiin liittyviä tarkoituksia. Ympyröi jokaisen tarkoituksen kohdalla se vaihtoehto (vain yksi), joka parhaiten vastaa saamaasi opetusta.

	Minulle on opetettu: 1. Ei lainkaan 2. Melko vähän 3. Jonkin verran 4. Melko paljon 5. Erittäin paljon
I. Ammatillinen tarkoitus	
57. Kuvata ja edistää sairaanhoitajan ammatillista asemaa yhteiskunnassa	1 2 3 4 5
58. Kuvata sairaanhoitajan ammatillisen käyttäytymisen periaatteet	1 2 3 4 5
59. Kuvata hoitotyön ammatilliset arvot ja ihanteet	1 2 3 4 5
60. Kehittää sairaanhoitajan ammatillista ajattelua	1 2 3 4 5
61. Tukea sairaanhoitajaa työssään	1 2 3 4 5
62. Yhdistää sairaanhoitajien ammattikuntaa.	1 2 3 4 5
II. Yhteiskunnallinen tarkoitus	
63. Ilmaista sairaanhoitajan perustehtävä yhteiskunnalle	1 2 3 4 5
64. Ilmaista sairaanhoitajien vastuut ja velvollisuudet yhteiskunnalle	1 2 3 4 5
65. Ilmaista sairaanhoitajien ammattikunnan yhteiskunnallinen asema	1 2 3 4 5
66. Suojella sairaanhoitajaa ja potilasta ilmaisemalla julkisesti sairaanhoitajaan kohdistuvat odotukset	1 2 3 4 5
67. Toimia sairaanhoitajien ammattikunnan ja yhteiskunnan välisenä sopimuksena ammattia koskevien sääntöjen noudattamisesta	1 2 3 4 5

Minulle on opetettu:
1. Ei lainkaan
2. Melko vähän
3. Jonkin verran
4. Melko paljon
5. Erittäin paljon

III. Käytäntöön liittyvä tarkoitus

68. Antaa sairaanhoitajalle ohjeita eettiseen päätöksentekoon	**1**	**2**	**3**	**4**	**5**
69. Antaa sairaanhoitajalle moraalisia ohjeita hoitotyöhön .	**1**	**2**	**3**	**4**	**5**
70. Ilmaista sairaanhoitajan perustehtävän yhteiskunnassa	**1**	**2**	**3**	**4**	**5**
71. Toimia hoitotyön laadun arviointiperusteena	**1**	**2**	**3**	**4**	**5**

IV. Eettinen tarkoitus

72. Kuvata hoitotyön eettiset arvot	**1**	**2**	**3**	**4**	**5**
73. Kuvata hoitotyön päämäärien eettistä luonnetta	**1**	**2**	**3**	**4**	**5**
74. Kuvata sairaanhoitajan eettiset vastuut	**1**	**2**	**3**	**4**	**5**
75. Toimia sairaanhoitajan toiminnan eettisyyden arviointiperusteena	**1**	**2**	**3**	**4**	**5**
76. Kuvata hoitotyön eettiset laatuvaatimukset	**1**	**2**	**3**	**4**	**5**

V. Laillinen tarkoitus

77. Ilmaista sairaanhoitajan toiminnan lailliset vastuut	**1**	**2**	**3**	**4**	**5**
78. Toimia sairaanhoitajien ammattikunnan itsesäätelyn välineenä	**1**	**2**	**3**	**4**	**5**
79. Toimia sairaanhoitajien ammattikunnan toiminnan oikeuttajana	**1**	**2**	**3**	**4**	**5**
80. Toimia ammatillisten väärinkäytöksien arvioinnin kriteerinä	**1**	**2**	**3**	**4**	**5**
81. Suojata sairaanhoitajia lailliselta vastuulta hoitovirheitä ja väärinkäytöksiä arvioitaessa	**1**	**2**	**3**	**4**	**5**

VI. Velvoittava tarkoitus

82. Kuvata sairaanhoitajan työhön liittyvät moraaliset velvollisuudet	**1**	**2**	**3**	**4**	**5**
83. Kuvata sairaanhoitajan työhön liittyvät muut velvollisuudet	**1**	**2**	**3**	**4**	**5**

Minulle on opetettu:
1. Ei lainkaan
2. Melko vähän
3. Jonkin verran
4. Melko paljon
5. Erittäin paljon

VII. Koulutuksellinen/kasvatuksellinen tarkoitus

84. Ohjata opetussuunnitelmien sisältöjä kuvaamalla eettisesti korkeatasoisen hoidon kriteerit	**1**	**2**	**3**	**4**	**5**
85. Tukea hoitotyön opettajia ja ohjaajia opetustyössä kuvaamalla eettisesti korkeatasoisen hoidon kriteerit	**1**	**2**	**3**	**4**	**5**
86. Tukea sairaanhoitajaopiskelijoita arvioimaan osaamistaan kuvaamalla eettisesti korkeatasoisen hoidon kriteerit	**1**	**2**	**3**	**4**	**5**
87. Kehittää sairaanhoitajaopiskelijoiden kriittistä ajattelua	**1**	**2**	**3**	**4**	**5**
88. Opettaa sairaanhoitajaopiskelijat tunnistamaan hoitotyön moraalisia ja käytäntöön liittyviä velvollisuuksia	**1**	**2**	**3**	**4**	**5**

VI. TERVEYDENHUOLLON MUIDEN AMMATTIEN EETTISET OHJEET

Terveydenhuollon monilla ammattikunnilla on omat eettiset ohjeensa. Lisäksi on kaikkia terveydenhuollon ammattikuntia koskeva yhteinen arvopohja, yhteiset tavoitteet ja periaatteet (ETENE 2000). Arvioi missä määrin Sinulle on opetettu eri ammattikuntien ja terveydenhuollon yhteisiä eettisiä ohjeita (ETENE 2000). Ympyröi jokaisen eettisen ohjeiston kohdalla se vaihtoehto (vain yksi), joka parhaiten vastaa saamaasi opetusta.

Minulle on opetettu:
1. Ei lainkaan
2. Melko vähän
3. Jonkin verran
4. Melko paljon
5. Erittäin paljon

89. Kansainvälisen Sairaanhoitajaliiton eettiset ohjeet (ICN 2000)					
90. Kätilötyön eettiset ja laadulliset perusteet (1998)	**1**	**2**	**3**	**4**	**5**
91. Hoitotyön johtajan eettiset ohjeet (2003)	**1**	**2**	**3**	**4**	**5**
92. Lähihoitajan eettiset ohjeet (2000)	**1**	**2**	**3**	**4**	**5**
93. Lastenhoidon eettiset periaatteet (1993)	**1**	**2**	**3**	**4**	**5**
94. Lääkärin eettiset ohjeet (2000)	**1**	**2**	**3**	**4**	**5**
95. Terveydenhuollon yhteinen arvopohja, yhteiset tavoitteet ja periaatteet (Terveydenhuollon eettinen neuvottelukunta ETENE 2000)	**1**	**2**	**3**	**4**	**5**

96. Muu, mikä**?:**_____

VII. EETTISTEN OHJEIDEN KANNALTA KESKEISET LAIT JA SOPIMUKSET

Terveydenhuollon lainsäädäntö sisältää monia lakeja ja sopimuksia, jotka ovat terveydenhuollon ammattikuntien eettisten ohjeiden kannalta tärkeitä. Arvioi missä määrin Sinulle on opetettu alla lueteltuja lakeja ja sopimuksia selvittäen niiden merkitystä sairaanhoitajan eettisten ohjeiden näkökulmasta. Ympyröi jokaisen lain ja sopimuksen kohdalla se vaihtoehto (vain yksi), joka parhaiten vastaa saamaasi opetusta.

	Minulle on opetettu: **1. Ei lainkaan** **2. Melko vähän** **3. Jonkin verran** **4. Melko paljon** **5. Erittäin paljon**
97. YK:n yleismaailmallinen ihmisoikeuksien julistus 10.12.1948	**1 2 3 4 5**
98. Euroopan ihmisoikeussopimus 439/1990	**1 2 3 4 5**
99. Lapsen oikeuksia koskeva yleissopimus 1989	**1 2 3 4 5**
100. Suomen perustuslaki 731/1999 **101.** Kansanterveyslaki 66/1972	**1 2 3 4 5**
102. Erikoissairaanhoitolaki 1062/1989	**1 2 3 4 5**
103. Laki potilaan asemasta ja oikeuksista 785/1992	**1 2 3 4 5**
104. Potilasvahinkolaki 585/1985	**1 2 3 4 5**
105. Laki terveydenhuollon oikeusturvakeskuksesta 1074/1992	**1 2 3 4 5**
106. Laki terveydenhuollon ammattihenkilöstöstä 559/1994	**1 2 3 4 5**
107. Laki sairaanhoitotoimen harjoittamisesta 554/1962	**1 2 3 4 5**
108. Asetus tutkimuseettisestä neuvottelukunnasta 1347/1991	**1 2 3 4 5**
109. Laki lääketieteellisestä tutkimuksesta 785/1999	**1 2 3 4 5**
110. Mielenterveyslaki 1116/1990	**1 2 3 4 5**
111. Sähköisen viestinnän tietosuojalaki 516/2004	**1 2 3 4 5**
112. Muu, mikä?:_____	**1 2 3 4 5**

VIII. EETTISTEN OHJEIDEN OPETUKSEN MENETELMÄT

Seuraavat kysymykset liittyvät eettisten ohjeiden opetuksessa käytettyihin menetelmiin. Ympyröi seuraavista vaihtoehdoista 3 opettajiesi eniten käyttämää opetusmenetelmää.

113. Opetusmenetelmä

a) Luento

b) Keskustelu (pienryhmäkeskustelu, dialogi)

c) Väittely (esim. argumentoiva väittely)

d) Kirjoittaminen (essee, portfolio, päiväkirja)

e) Pelit, roolipelit, simulaatiot (esim. ”valeoikeudenkäynti”)

f) Tietotekniikan käyttö (esim, internet/intranet)

g) Ongelmakeskeinen oppiminen (Problem Based Learning)

h) Seminaari/seminaarialustus

i) Opintokäynnit

j) Muu, mikä?:_____

ETTISTEN OHJEIDEN OPETUKSEN OPPIMISTULOSTEN ARVIOINTI

Seuraavat kysymykset liittyvät opiskelijoiden eettisten ohjeiden opetuksen oppimistulosten arviointiin. Ympyröi jokaisen kysymyksen kohdalla enintään 3 opettajiesi eniten käyttämää arviointimenetelmää (Kysymykset 114 -116).

114. Oppimistulosten arvioijana on

a) Opettaja

b) Toinen/toiset opiskelijat (vertaisarviointi)

c) Opiskelija itse

d) Käytännön harjoittelun ohjaajat

e) Ei kukaan

f) Joku muu, kuka?:_____

115. Oppimistulosten arviointitapa on

a) Esseen kirjoittaminen kuulustelutilaisuudessa

b) Esseen kirjoittaminen kotitehtävänä

c) Monivalintakoe

d) Suullinen kuulustelu

e) Arviointikeskustelu

f) Näyttökoe (esim. videointi)

g) Portfolio

h) Oppimispäiväkirja

i) Ei lainkaan arviointia

j) Muu, mikä?:_____

116. Oppimistulosten arvioinnin toteutusmuoto on:

a) Numeerinen arvosana

b) Kirjallinen palaute

c) Hyväksytty/hylätty arvosana

d) Suullinen palaute

e) Ei lainkaan palautetta

f) Muu, mikä?:_____

117. Arvioi vielä omia <u>TIETOJASI</u> sairaanhoitajan eettisistä ohjeista

Pidän tietojani sairaanhoitajan eettisistä ohjeista:

1. Erittäin huonoina

2. Melko huonoina

3. Keskitasoisina

4. Melko hyvinä

5. Erittäin hyvinä

0. En osaa sanoa

118 Arvioi myös omia <u>TAITOJASI</u> soveltaa sairaanhoitajan eettisiä ohjeita käytännön hoitotyössä

Pidän taitojani soveltaa sairaanhoitajan eettisiä ohjeita:

1. Erittäin huonoina

2. Melko huonoina

3. Keskitasoisina

4. Melko hyvinä

5. Erittäin hyvinä

0. En osaa sanoa

119. Kuvaile lyhyesti, miten kehittäisit sairaanhoitajan eettisten ohjeiden opetusta:

120. Mitä muuta haluaisit sanoa sairaanhoitajan eettisten ohjeiden opetuksesta?

Kiitos arvokkaista vastauksistasi!

Appendix 8. Questionnaire for nurse educators

1

"Teaching of Nurses' Codes of Ethics in Basic Nursing Education"

A Questionnaire for Nurse Educators

2

University of Turku
Department of Nursing Science
20014 University of Turku

Dear nurse educator,

I am currently a doctoral student in the Department of Nursing Science in the Faculty of Medicine in University of Turku. The topic of my doctoral study is the teaching of nurses' codes of ethics (Ethical Guidelines of Nursing, The Finnish Nurses Association 28.9.1996). The purpose of the study is to describe the current teaching of nurses' codes of ethics in the polytechnics in Finland. Research focusing on ethics education in nursing has been scarce thus far. The aim of this descriptive, comparative, cross-sectional study is to recognize strengths and possible problems in the teaching of nurses' codes of ethics. The findings can be utilized in the development of nursing curricula, in the integration of theoretical teaching and clinical instruction, and in describing the teaching of codes of ethics to other health care professions.

One target group of this study is the nurse educators in the polytechnics, who teach nurses' codes of ethics either as integrated to other nursing studies and/or teach them as separate ethics study units and the second target group is the graduating nursing students. As a representative of the nurse educator group, please, would you kindly complete the questionnaire. The questionnaire concerns the integrated teaching as well as the separate courses in the teaching of nurses' codes of ethics.

The questionnaire is completely anonymous. All responses are treated confidentially and recognition of a single response in the study report will not be possible. The results are mainly reported statistically. Your participation in the study is voluntary. For the successful completion of the study the participation of every nurse educator is important and by participating you also promote the research of our own scientific field. This questionnaire does not have right or wrong responses. It is most important that you describe your teaching as you implement it. I will be pleased to answer any questions concerning the questionnaire you may have. If you have any comments concerning the study or the questionnaire you can write them in the margin or in the space at the end of the questionnaire.

Please, would you kindly return your response in the enclosed envelope by _____2006 to the researcher. The research report will be sent to all polytechnics that participated in the study.

The supervisors of my study are Professor Helena Leino-Kilpi, University of Turku, Finland
and Professor Arie van der Arend, University of Maastricht, The Netherlands.

Thank you for your kind cooperation

Olivia Numminen, RN, MNSc,
Luotsikatu 9 D 11, 00160 Helsinki
Tel: 09-622 71033 (home), E-mail: j.o.numminen@welho.com

TEACHING OF NURSES' CODES OF ETHICS IN BASIC NURSING EDUCATION

A Questionnaire for Nurse Educators

THIS QUESTIONNAIRE CONCERNS THE TEACHING OF NURSES' CODES OF ETHICS, WHICH IS IMPLEMENTED EITHER AS SEPARATE ETHICS STUDY UNITS OR AS INTEGRATED TO OTHER THEORETICAL OR CLINICAL TEACHING OF NURSING.

I. DEMOGRAPHIC DATA ***(Please, circle and/or write one or several choices)***

1. Age_____years

2. Sex 1. Female 2.Male

3. Basic professional education
1. Nurse, specialty_____
2. Midwife
3. Health visitor
4. Other professional basic education, which_____

4. Your highest degree
1. Nurse educator (former college level education)
2. Master of Health Care/Health Sciences
3. Licentiate of Health Care/ Health Sciences
4. Doctor (PhD) of Health Care/Health Sciences
5. Other, which_____

5. How many years have you worked as a nurse educator? _____years, if less than a year, _____months

6. Please, mention those nursing subject areas that you teach most (e.g. perioperative nursing)
1. _____ 4._____
2._____ 5._____
3._____ 6._____

7. I have taught nurses' codes of ethics:
1. As separate ethics study units/lectures
2. As integrated to theoretical nursing studies
3. As integrated to clinical training
4. My teaching has not required teaching of nurses' codes of ethics
(N.B. If you chose the alternative 4, you do not have to continue answering this questionnaire. However, it is important that you return the questionnaire in the enclosed envelope for statistical analysis)

8. How many years have you taught nurses' codes of ethics as separate ethics study units?_____years, if less than a year_____months

9. How many years have you taught nurses' codes of ethics as an integrated teaching?_____years, if less than a year_____months

10. How have you acquired the knowledge required in teaching nurses' codes of ethics?

1. In the basic professional health care education
2. In the university health care education
3. In the separate ethics education
4. As self-directed learning (e.g. familiarizing yourself with literature)
5. In some other way, how?_____

11. Have you done your thesis or other research related to nurses' codes of ethics?

1. Yes 2. No
If you answered yes, the subject area of your study: _____
and the degree or situation to which your study was related:_____

12. Have you worked in development work related to nurses' codes of ethics?
1. Yes 2. No
If you answered yes, the subject area of your development work:_____

13. In my study unit we use a visiting lecturer/teacher to teach nurses' codes of ethics

1. Not at all
2. Fairly little
3. To some extent
4. Fairly much
5. Very much

If you answered yes, who? (E.g. ethicist, a representative from The Finnish Nurses Association)_____

II. YOUR OPINIONS OF NURSES' ETHICAL CODES OF CONDUCT

The following questions ask your opinions of the Ethical Guidelines for Nurses issued by The Finnish Nurses' Association (1996) and their teaching. In each question choose the alternative, which best reflects your opinion of the question and justify your answer briefly.

1. Fully disagree
2. Almost disagree
3. Not agree nor disagree
4. Almost agree
5. Fully agree

14. The nurses need their own codes of ethics **1 2 3 4 5**

Please, justify your answer briefly_____

15. Nurses' codes of ethics apply in today's nursing context? **1 2 3 4 5**

Please, justify your answer briefly_____

16. Teaching of nurses' codes of ethics to nursing students is an important element of nurses' ethics education? **1 2 3 4 5**

Please, justify your answer briefly_____

17. I assess my knowledge adequate to teach nurses' codes of ethics **1 2 3 4 5**

Please, justify your answer briefly_____

III. THE STATEMENTS OF NURSES' CODES OF ETHICS

Nurses' codes of ethics are regarded as a part of nurses' ethical knowledge base. In teaching nurses' codes of ethics the statements of the codes can be emphasized in different degrees. In the following there is a list of essential statements in the Ethical Guidelines of Nursing (The Finnish Nurses' Association 1996). Please, assess to what extent you have taught the following statements to your students. Regarding every statement circle the alternative (only one) which best corresponds with your teaching.

I have taught:

1. Not at all
2. Fairly little
3. To some extent
4. Fairly much
5. Very much

I. The mission of nurses

18. The mission of the nurse is to promote health	**1**	**2**	**3**	**4**	**5**
19. The mission of the nurse is to prevent illness	**1**	**2**	**3**	**4**	**5**
20. The mission of the nurse is to alleviate suffering	**1**	**2**	**3**	**4**	**5**
21. The mission of the nurse is to support those under her/his care	**1**	**2**	**3**	**4**	**5**
22. The mission of the nurses concerns the whole population	**1**	**2**	**3**	**4**	**5**

II. Nurses and patients

23. The nurse is responsible for her/his actions, first of all, to her patients	**1**	**2**	**3**	**4**	**5**
24. The nurse respects the human dignity of those under her/his care	**1**	**2**	**3**	**4**	**5**
25. The nurse respects the autonomy of those under her/his care	**1**	**2**	**3**	**4**	**5**
26. The nurse is bound to confidentiality	**1**	**2**	**3**	**4**	**5**
27. The nurse exercises justice in nursing actions	**1**	**2**	**3**	**4**	**5**

III. The work and professional competence of nurses

28. The nurse is personally responsible for her/his work	**1**	**2**	**3**	**4**	**5**
29. The nurse evaluates her/his own and others' competence in receiving her/his assignments or when giving assignments to others	**1**	**2**	**3**	**4**	**5**
30. The nurse has an obligation to develop her/his competence	**1**	**2**	**3**	**4**	**5**
31. The nurse is responsible for the quality of the nursing care	**1**	**2**	**3**	**4**	**5**
32. The improvement of the quality of nursing care is the responsibility of the nurse	**1**	**2**	**3**	**4**	**5**

IV. Nurses and their colleagues

33. The nurse supports her/his colleagues in decision-making concerning nursing	**1**	**2**	**3**	**4**	**5**
34. The nurse supports the work capacity of her/his colleagues	**1**	**2**	**3**	**4**	**5**
35. The nurse supports the professional development of her/his colleagues	**1**	**2**	**3**	**4**	**5**
36. The nurse respects the expertise of her/his colleagues as well as her/his own	**1**	**2**	**3**	**4**	**5**
37. The nurse sees to it that no nurses and other health care professionals act unethically	**1**	**2**	**3**	**4**	**5**

V. Nurses and society

38. The nurse participates in discussion concerning health at national and international levels	**1**	**2**	**3**	**4**	**5**
39. The nurse participates in decision-making concerning health at national and international levels	**1**	**2**	**3**	**4**	**5**
40. The nurse collaborates with the significant others of those in her/his care	**1**	**2**	**3**	**4**	**5**
41. The nurse collaborates with different organizations	**1**	**2**	**3**	**4**	**5**
42. The nurse bears global responsibility for the development of living conditions concerning health of human beings	**1**	**2**	**3**	**4**	**5**

VI. Nurses and the nursing profession

43. The nurse sees to it that the members of the nursing profession accomplish their mission in a dignified manner	**1**	**2**	**3**	**4**	**5**
44. The nursing profession supports the ethical development of its members	**1**	**2**	**3**	**4**	**5**
45. The nursing profession controls that the humane nature of nursing is preserved	**1**	**2**	**3**	**4**	**5**
46. The professional organization of nurses functions actively to secure just social and economic working conditions for its members	**1**	**2**	**3**	**4**	**5**
47. The nursing profession is responsible for the expertise of the profession	**1**	**2**	**3**	**4**	**5**

IV. THE ETHICAL CONCEPTS OF NURSES' CODES OF ETHICS

Nurses' codes of ethics include several ethical concepts that guide nursing care. Please, assess to what extent you have taught the following concepts to your students explaining their meaning also in the nurses' ethical codes of conduct. In each concept, please, circle the alternative (only one) which best corresponds with your teaching.

I have taught:

1. Not at all
2. Fairly/quite little
3. To some extent
4. Fairly/quite much
5. Very much

48. Patients' rights are both legal and moral rights. They include the right to good care, to access to care, to knowledge, and to self-determination, the right to complain about malpractice, and the right to confidentiality.	**1**	**2**	**3**	**4**	**5**
49. Privacy is the right to physical safety based on respect of human self-determination, and the duty to confidentiality of patient information.	**1**	**2**	**3**	**4**	**5**
50. Truth-telling is a duty to honesty based on the respect of a human being and his/her self-determination, and the respect of confidentiality of the care relationship	**1**	**2**	**3**	**4**	**5**
51. Justice is a duty to treat people as equal without discriminating them on morally untenable justifications (e.g. age, sex) and a duty to aim at distributing existing resources equally.	**1**	**2**	**3**	**4**	**5**
52. Self-determination is a duty to respect a human being's right and ability to freely determine about matters concerning her/himself based on her/his wishes and values.	**1**	**2**	**3**	**4**	**5**

53. Confidentiality is a duty not to disclose information concerning another human being without his/her consent to such parties that this information does not concern.	**1**	**2**	**3**	**4**	**5**
54. Duty is action regarded as right, which can be demanded from an individual based either on legal or moral justifications.	**1**	**2**	**3**	**4**	**5**
55. Sanctity of life is a duty to sustain human life based on the idea that destruction of human life is morally wrong.	**1**	**2**	**3**	**4**	**5**
56. Responsibility/Accountability is a human being's responsibility for his/her own actions, including the responsibility for a deed and the responsibility to a person who was the object of the deed, so called human responsibility and task responsibility.	**1**	**2**	**3**	**4**	**5**

V. THE FUNCTIONS OF NURSES' CODES OF ETHICS

Nurses' codes of ethics have several functions. Please, assess to what extent you have taught the following functions of the codes to your students. Regarding each function, please, circle the alternative (only one) which best corresponds with your teaching.

I have taught:

1. Not at all
2. Fairly little
3. To some extent
4. Fairly much
5. Very much

I. The professional function					
57. To describe and promote the nurse's professional position in the society	**1**	**2**	**3**	**4**	**5**
58. To describe the principles of the nurse's professional conduct	**1**	**2**	**3**	**4**	**5**
59. To describe nursing's professional values and ideals	**1**	**2**	**3**	**4**	**5**
60. To develop the nurse's professional thinking	**1**	**2**	**3**	**4**	**5**
61. To support the nurse in her/his work	**1**	**2**	**3**	**4**	**5**
62. To unite the nursing profession	**1**	**2**	**3**	**4**	**5**
II. The social function					
63. To state the nurse's basic mission in the society	**1**	**2**	**3**	**4**	**5**
64. To state the nurse's responsibilities and duties to the society	**1**	**2**	**3**	**4**	**5**
65. To state the nursing profession's social standing	**1**	**2**	**3**	**4**	**5**
66. To protect the nurse and the patient by declaring publicly what is expected of the nurse	**1**	**2**	**3**	**4**	**5**
67. To act as an agreement between the nursing profession and the society ensuring compliance with the regulations governing the profession	**1**	**2**	**3**	**4**	**5**
III. The practical function					
68. To guide the nurse in ethical decision-making	**1**	**2**	**3**	**4**	**5**
69. To give the nurse moral guidance and principles for nursing care	**1**	**2**	**3**	**4**	**5**
70. To state the nurse's basic function in the society	**1**	**2**	**3**	**4**	**5**
71. To act as the standard of quality of nursing care	**1**	**2**	**3**	**4**	**5**

IV. The ethical function					
72. To describe the values of nursing	**1**	**2**	**3**	**4**	**5**
73. To describe the ethical nature of the goals of nursing	**1**	**2**	**3**	**4**	**5**
74. To describe the ethical responsibilities of the nurse	**1**	**2**	**3**	**4**	**5**
75. To act as the standard of the nurse's ethical practice	**1**	**2**	**3**	**4**	**5**
76. To describe the ethical standards of nursing	**1**	**2**	**3**	**4**	**5**
V. The legal function					
77. To state the legal responsibilities of the nurse	**1**	**2**	**3**	**4**	**5**
78. To act as the instrument of the nursing profession's self-regulation	**1**	**2**	**3**	**4**	**5**
79. To act as the justification to the nursing profession to carry out nursing care	**1**	**2**	**3**	**4**	**5**
80. To act as the criteria to assess professional misconduct	**1**	**2**	**3**	**4**	**5**
81. To protect nurses' from the legal responsibilities when assessing malpractice and misconduct	**1**	**2**	**3**	**4**	**5**
VI. The duty function					
82. To describe the moral duties related to the nurse's work	**1**	**2**	**3**	**4**	**5**
83. To describe other duties related to the nurse's work	**1**	**2**	**3**	**4**	**5**
VII. The educational function					
84. To guide the content of curricula by describing the criteria of ethically high quality care	**1**	**2**	**3**	**4**	**5**
85. To support nurse educators and clinical instructors in their teaching work by describing the criteria of ethically high quality care	**1**	**2**	**3**	**4**	**5**
86. To support nursing students to evaluate their know-how by describing the criteria of ethically high quality care	**1**	**2**	**3**	**4**	**5**
87. To develop nursing students' critical thinking	**1**	**2**	**3**	**4**	**5**
88. To teach nursing students to recognize moral and practical duties related to nursing care	**1**	**2**	**3**	**4**	**5**

VI. THE CODES OF ETHICS OF OTHER HEALTH CARE PROFESSIONS

Many health care professions have their own codes of ethics. In addition, there exists the common value base, common goals and principles (code of ethics) for all health care professionals (ETENE 2000). Please, assess to what extent you have taught the codes of ethics of other heath care professions and the common code of ethics to your students. Regarding every code, please, circle the alternative (only one) which best corresponds with your teaching.

I have taught:

1. Not at all
2. Fairly
3. To some extent
4. Fairly much
5. Very much

89. The International Council of Nurses' Code of Ethics (ICN 2000)	**1**	**2**	**3**	**4**	**5**
90. International Code of Ethics for Midwives (1998)	**1**	**2**	**3**	**4**	**5**

91. Code of Ethics for Nursing Leaders (2003)	**1**	**2**	**3**	**4**	**5**
92. Code of Ethics for Practical Nurses (2000)	**1**	**2**	**3**	**4**	**5**
93. The Ethical Principles of Child Care (1993)	**1**	**2**	**3**	**4**	**5**
94. Code of Medical Ethics (2000)	**1**	**2**	**3**	**4**	**5**
95. Shared Values in Health Care, Common Goals and Principles (National Advisory Board on Health Care Ethics, ETENE 2000)	**1**	**2**	**3**	**4**	**5**
96. Other, which_____	**1**	**2**	**3**	**4**	**5**

VII. THE ESSENTIAL LAWS AND AGREEMENTS RELATED TO NURSES' CODES OF ETHICS

The health care legislation includes several laws, and agreements, which are important from the viewpoint of the nurses' codes of ethics. Please, assess to what extent you have taught the following laws and agreements to your students explaining their significance from the viewpoint of nurses' codes of ethics. Regarding every law and agreement, please, circle the alternative (only one) which best corresponds with your teaching.

I have taught:

1. Not at all
2. Fairly little
3. To some extent
4. Fairly much
5. Very much

97. United Nations' Universal Declaration of Human Rights 10.12.1948	**1**	**2**	**3**	**4**	**5**
98. European Convention of Human Rights 439/1990	**1**	**2**	**3**	**4**	**5**
99. Convention on the Rights of the Child 1989	**1**	**2**	**3**	**4**	**5**
100. The Constitution of Finland 731/1999	**1**	**2**	**3**	**4**	**5**
101. Primary Health Care Act 66/1972					
102. Act of Specialized Medical Care 1062/1989	**1**	**2**	**3**	**4**	**5**
103. Act on the Status and Rights of the Patients 785/1992	**1**	**2**	**3**	**4**	**5**
104. Patient Injury Act 585/1985	**1**	**2**	**3**	**4**	**5**
105. Act of National Authority for Medico Legal Affairs 1074/1992	**1**	**2**	**3**	**4**	**5**
106. Act of Health Care Professions 559/1994	**1**	**2**	**3**	**4**	**5**
107. Act of Nursing Profession (554/1962)	**1**	**2**	**3**	**4**	**5**
108. Decree on the National Advisory Board on Health Care Ethics 1347/1991	**1**	**2**	**3**	**4**	**5**
109. Medical Research Act 785/1999	**1**	**2**	**3**	**4**	**5**
110. Mental Health Act 1116/1990	**1**	**2**	**3**	**4**	**5**
111. Act on the Protection of Privacy in Electronic Communications 516/2004					
112. Other, which_____	**1**	**2**	**3**	**4**	**5**

VIII. TEACHING METHODS OF NURSES' CODES OF ETHICS

The following questions concern the methods used in teaching the codes of ethics. From the following alternatives, please, circle three teaching methods that you use the most.

113. Teaching method

a) Lecture
b) Discussion (small group, dialogue)
c) Argument (e.g. argumentative debate)
d) Writing (essay, portfolio, diary)

e) Games, role games, simulations (e.g. "Moot Court")
f) Computer-based teaching (e.g. internet, intranet)
g) Problem Based Learning
h) Seminar/Presentation
i) Educational visit
j) Other, which_____

IX. THE EVALUATION OF THE OUTCOMES OF THE TEACHING OF NURSES' CODES OF ETHICS

The following questions concern the evaluation of outcomes used in teaching the codes of ethics. From the following alternatives, please, circle three evaluation methods that you use the most. (Questions 114-116).

114. The evaluator of learning outcomes

a) Nurse educator
b) Other student/s
c) Student her/himself
d) Clinical instructor
e) No evaluator
f) Somebody else, who_____

115. The evaluation method of the learning outcomes

a) Writing an essay in an examination session
b) Writing an essay as a home assignment
c) Multiple-choice examination
d) Oral exam
e) Evaluation discussion
f) Performance assessment (e.g. video taping)
g) Portfolio
h) Diary
i) No evaluation
j) Other, which_____

116. Form of the outcomes evaluation

a) Numeral grade
b) Written feedback
c) Passed/Failed
d) Oral feedback
e) No feedback
f) Other, which_____

117. Please, evaluate the graduating students' knowledge of nurses' codes of ethics

I regard the students' knowledge as:

1. Very poor
2. Quite poor
3. Average
4. Quite good
5. Very good
0. I can not say

118. Please, evaluate the graduating students' skills to apply nurses' codes of ethics in nursing practice

I regard the students' skills to apply as:

1. Very poor
2. Quite poor
3. Average
4. Quite good
5. Very good
0. I can not say

119. Please, describe briefly, how you would develop the teaching of nurses' ethical codes of conduct_____

120. What else would you like to say about the teaching of nurses' ethical codes of conduct?

_____

Thank you for your valuable answers!

Appendix 9. List of polytechnics curricula 2003

Arcada ammattikorkeakoulu. Opinto-opas 2003-2004.
Diakonia-ammattikorkeakoulu. Opinto-opas 2003-2004. http://www.diak.fi/files/diak/Diaktori/Opinto_opas_2003-2004.pdf (Accessed 25th March 2010)
Etelä-Karjalan ammattikorkeakoulu. Opinto-opas 2003-2004. RT-Print. Pieksämäki. Finland
Hämeen ammattikorkeakoulu. Opetussuunnitelmat 2003-2007 OffsetKolmio. Hämeenlinna. Finland
Jyväskylän ammattikorkeakoulu. Opinto-opas 2003-2004. http://webas.intra.jypoly.fi/pdf_yleisopas03_04/SOTE.pdf (Accessed 10th March 2010)
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Kemi-Tornion ammattikorkeakoulu. Opinto-opas 2003- 2004. http://www.tokem.fi/soster/Filet/terveysalan%20ops%202004-2005.pdf (Accessed 10th March 2010)
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Kymeenlaakson ammattikorkeakoulu. Opinto-opas 2002-2004. http://www2.kyamk.fi/opinto-opas/2002-2004/ (Accessed 10th March 2010)
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Laurea ammattikorkeakoulu. Opinto-opas 2003-2004. Kirjaksa ky. Vantaa. Finland
Mikkelin ammattikorkeakoulu. Opinto-opas 2003
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Pirkanmaan ammattikorkeakoulu. Opinto-opas 2003-2004 http://www.piramk.fi/web/mm.nsf/lupgraphics/Opintoopas0304.pdf/$file/Opintoopas0304.pdf. (Accessed 10th March 2010)
Pohjois-Karjalan ammattikorkeakoulu. Opinto-opas 2002-2003 http://www.ncp.fi/opiskelijapalvelut/opiskelu/oppaat/opas0203/soster.pdf (Accessed 10th March 2010)
Rovaniemen ammattikorkeakoulu. Opinto-opas 2003 http://www.ramk.fi/?deptid=11112. (Accessed 10th March 2010)
Satakunnan ammattikorkeakoulu. Opinto-opas 2003-2004. http://kesy01.cc.spt.fi/intra/tiimit.nsf/daac366605152bd2882571cc007d9d60/43CB60C949FEC36EC22571E6003C948F/ $file/hoitotyö.doc (Accessed 10 March 2010)
Savonia-ammattikorkeakoulu. Opinto-opas 2003. http://portal.savonia.fi/amk/opiskelijalle/opiskelu/opinto-opas/hoitotyo_ops_2009-2012.pdf (Accessed 10 March 2010)
Seinäjoen ammattikorkeakoulu. Opinto-opas 2004-2005. Rt-Print. Pieksämäki. Finland
Stadia ammattikorkeakoulu. Opinto-opas 2003-2004. http://opinto-opas-ops.metropolia.fi/old/ops.php?y=2006&c=128&clang=fi&mod=1062 (Accessed 10 March 2010)
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Vaasan ammattikorkeakoulu. Opinto-opas 2003-2004. http://www.puv.fi/attachment/e865047a81b0a6b2a94c639db22554bb/be84ae95e5056a38cac913a6b450985c/HT.pdf (Accessed 10th March 2010)
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