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Can professional nursing value claims be refused? Might nursing values be accepted provisionally and tentatively?

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Abstract

Value–act relationships are less secure than is commonly supposed and this insecurity is leveraged to address two questions. First, can nurses refuse professional value claims (e.g., claims regarding care and compassion)? Second, even when value claims are accepted, might values be held provisionally and tentatively? These questions may seem absurd. Nurses deliver care and nursing is, we are told, a profession the members of which hold and share values. However, focusing attention on the problematic nature of professional value claims *qua* claims permits a more conciliatory and realistic stance to be taken towards nurses holding alternative values and value interpretations. This could prove beneficial.

KEYWORDS

ethical values, nursing values, professional identity, professional values, professional value claims, professionalism, values

1 | INTRODUCTION

Regulatory prescription and scholarly exhortation serve multiple purposes and take contrasting forms. However, in asserting professional value claims, claimants (regulators and scholars) make two assumptions both of which can be challenged. First, failing to recognise heterogeneity, claimants presume claims unproblematically apply to nursing as a collectivity or homogenous group. Second, claimants suppose that desired and desirable actions accompany values acceptance. Claimants thus believe values and behaviours are related, and from this vantage values such as care and compassion present promissory notes on or for public action. A person who, for example, values care is expected to perform caring acts because of the values they hold even though what 'acting caringly' means (includes/excludes) often remains frustratingly elusive.

Idealised value–act relationships are realised. Values do initiate value-fulfilling acts (Foot, 2001). Yet, awkwardly, not only are value–act associations obscure, values and acts come apart. Thus, I value moderation and temperance but ravenously scoff cream cakes. What I value and how I act may but need not be coterminous (akrasia), and kindred contradictions and dichotomies exist in the professional arena. Further, ethical principles articulated as values can signally fail to inform actions (resolve moral dilemmas) in the manner commonly anticipated (see, e.g., Baggini, 2002; Sartre, 2007 [1947]), and for any number of reasons nursing actions do not always reflect or instantiate purportedly held values. (Nursing values and professional values are here treated as synonyms.)

That a value is unfulfilled in action says nothing about the worth or goodness of that value. Nonetheless, in this paper, following a critique of non-negotiability and universalism, value–act divergence is explored. This offers a way into understanding aspects of the value claims attached to nursing. And thereafter we provocatively ask: so long as nurses act appropriately—that is, so long as nurses maintain behaviour consistent with common decency, local social norms, and relevant regulatory injunctions where these apply to actions—first, can 'appropriately acting' nurses deliberately and knowingly refuse

professional value claims? Second, when professional value claims are accepted, might 'appropriately acting' nurses deliberately and knowingly hold values provisionally and tentatively (i.e., weakly)? Or is it supposed that values must/should be held trenchantly and resolutely?

The answer to both questions is a qualified 'Yes'. Nurses have recourse to arguments legitimating the refusal of value claims laid upon them in virtue of their being members of the group nurses, and even when nurses assent to professional value claims, that assent might be provisional and tentative in character. Regulators may not sanction affirmation. Having recourse to reasons does not mean those reasons must hold sway/be agreed. Private and publicly proclaimed values (nursing values) need not be identical, and none of what are proposed sanctions bad or uncivil behaviour. Crucially, while we want nurses to act in ways that are colloquially described using positively charged evaluative terms (e.g., care and compassion), this does not necessitate that these terms be labelled professional values.

Insofar as 'Yes' conclusions are permitted, group value claims are problematised, and this should prompt us to critically assess and possibly reconstrue features of the claims enveloping nursing (i.e., features of professionalism/professional identity). Additionally, in addressing these questions we might, on reflection, come to acknowledge if not agree with those who do not share our values or value interpretations. This could be significant.

2 | NAÏVE OPACITY

To cite just one example, UK nursing practice is regulated through the Nursing and Midwifery Council (NMC), this body stipulates expectations in a text known as the Code, and this document states that: 'The values and principles set out in the Code… are not negotiable or discretionary' (Nursing and Midwifery Council, 2018, p.3).

The stridency of this pronouncement is interesting. Despite the assurity with which value claims are made, the NMC–like others—list but do not clarify what the values they extol rest on or concretely imply. Opacity undercuts what is asserted, and the lack of specificity in regulatory documentation is therefore curious.

Anscombe (2000 [1957/1963]) long ago exposed difficulties in describing actions incorporating normative or ethical values, and an actor's (i.e., nurse's) evaluative intentions cannot be straightforwardly read off from or into behaviour. Introductory educational primers such as Trusted (1987) further differentiate between ethical or evaluative (value) claims according to whether they are emotivist, prescriptionist, consequentialist or intuitionist. And Trusted (ibid) also outlines the metaphysical associations which allegedly attach to different axes of discrimination. Yet when practitioners turn to official documents such as the Code (Nursing and Midwifery Council, 2018), subtlety of the sort demonstrated by Anscombe (2000) and Trusted (1987) is lost, and it is unclear what professional value claims signify or entail.

On the face of it this is regrettable. However, conceptual woolliness in regulatory texts is perhaps unavoidable. It might even be desirable. Wainwright and Pattison (2004) note the clarity practitioners hope to find in regulation is 'not there' (p.111). And if the principal function of professional value claims is performative, if these pronouncements reference the joining of a group, if they are intended to engender a sense of coherence or uniformity, and if for these reasons they are not meant to carry concrete meanings (since close attention to meaning might spark disagreement), ambivalence is deliberate.

Different regulators adopt different positions. Nonetheless, professions and groups aspiring to professional status construct themselves as other regarding ethical entities (Koehn, 1994), and this ambition is evidenced in nursing when implicit and explicit value claims appear in statements made by bodies tasked with creating and enforcing ethical and conduct (practice) codes and guidance. These claims possess varying degrees of legal and quasi-legal clout. They are instantiated in institutional policies/practices (e.g., recruitment strategies or disciplinary procedures), and at least some regulators make value demands that must on pain of deregistration/delicensing (terminating employment eligibility) be accepted. This leaves open what 'acceptance' means. Use of the word in this context is plainly question-begging, and we need to be wary of reading value claims too literally. Nevertheless, values for the NMC (sticking with our example) are neither negotiable nor discretionary.

Value claims also thread through the outputs of nursing scholars. These may or may not be prefaced by 'must'. However, absent legal/institutional supports, while scholarly assertions can be bold and persuasive, they are unenforceable and regardless of phrasing scholars ultimately advance 'should' or 'ought' (exhortatory) claims. That is, scholars merely assert/argue that nurses should or ought to embrace particular values/value sets.

Finally, values are folded into socio-cultural-historical norms. These norms ("how we do things around here") play a vital role in determining what and how acts are performed, omitted, discussed and ignored. Norms can be contradictory and inconsistent (MacIntrye, 1999). Yet despite considerable practical influence social norms are often overlooked in values discourse.

Whatever their source and heedless of vaguity, value claims impose or attempt to impose obligations and devoirs onto nurses. They are sometimes critically explored in journals such as this. However, by and large, values are declaimed rather than argued. They are articulated in ways that presume acceptance and enactment (through value–act linkages), yet protestations of non-negotiability are problematic. Conflict inevitably surrounds what is valued and how what is valued is interpreted (Anscombe, 1958, 2000; Pattison, 2004). Argument and revision cannot be foreclosed. And while non-negotiation may in limited instances be laudable (since the immorality of particular forms of human behaviour might be beyond debate), non-negotiability suggests evaluator overconfidence (hubris), and/or non-negotiability characterises a technology for fabricating/entrenching group allegiance.

Linked with or to non-negotiability, value claims are often thought of as applying universally, and as such they have been coupled with, among much else, principlism. Yet just as non-

negotiable assertions invite challenge, universalism is, as even its staunchest supporters acknowledge, robustly critiqued (Mounk, 2018, 2023a). These critiques take many forms, and for example, universalism sits uncomfortably (as does non-negotiability) alongside the commonplace observation that values are not consistently recognised and accepted across time and geography. Thus, although local temporal consensus may be achieved, in their 'take up' values and value sets are mutable. Gilligan (2003 [1982]) famously gave voice to an alternative non-universalising feminist care perspective or ethic (see also Kuhse, 1999); non-universalist ethical discourse secures significant interest and traction across a variety of disciplinary fields (see, e.g., Msoroka & Amundsen, 2018; Tangwa, 2004; Winkler, 2022) and non-universalism has deep historical roots (see, e.g., Reinhard, 2005—arguably also Smith, 2000). However, many nursing publications continue to discuss values in ways that outwardly suppose universalism, and while this statement is not defended, those familiar with nursing's literature will grant what is proposed.

Articulating and presenting value claims in ways that assume without supporting argumentation that they are non-negotiable and universal could (should?) be thought naïve even by those favouring these positions. Yet to complicate matters, the notion that holding or accepting a value is or can be tied unproblematically to forms of practice (acts/behaviours) is contestable, and this demands acknowledgement.

3 | A SPACE BETWEEN VALUES AND ACTS

Distinguishing intentional from non-intentional actions presents difficulties (Schwenkler, 2019). Nonetheless, intended as opposed to accidental or unintended acts are morally risky insofar as, absent prescience, we do not in advance know (epistemic deficit) what benefits and harms accompany even everyday actions (Foot, 2001; Lee-Stronach, 2021). However, regardless of intent, including values-informed intent, value–act relations often dissolve upon inspection, *but*, more so even than non-negotiability and universalism, this aspect of values discussion is underexplored in the nursing literature.

While supposed or anticipated value–act relationships are, as granted, instantiated, multiple and occasionally incommensurable acts follow on from or can be tied to accepting a value (valuing), and contrariwise, any one act is associable with multiple and occasionally incommensurable values. Attempts to articulate value–act relationships are therefore complicated. Holding a value does not mean that value will be enacted, and acting in a particular manner does not mean identifiable values 'back' what is enacted. Further, if we allow a distinction between what we think we believe and what we actually believe, we may think we hold values we do not, and/or we possibly hold values we are unaware of. Value–act linkages must therefore be interpreted and argued for. They cannot simply be gleaned from observation or evidenced by assertion.

Once assumptions about value–act linkages are bracketed disquieting possibilities hove into view. For example, acts that reasonable others would interpret as being kind occur unscaffolded by buttressing values. Or ostensibly acceptable/good acts are performed by actors absent desired/desirable values. This is not hair-splitting. A nurse might act in a manner that suggests she holds a particular value (value set) without necessarily holding that value (value set). Concretely, a nurse could treat and interact with all patients appropriately (e.g., she could act non-prejudicially) while maintaining unvoiced and potentially unrealised values that she and/or others would, if articulated, describe as prejudiced/prejudicial towards patients who are members of othered or minority groups. However, so long as appropriate acts are performed (i.e., non-discriminatory behaviour consistent with common decency, local social norms and relevant regulatory requirements pertaining to acts is maintained), perhaps the private (here nasty) values of practitioners are irrelevant? Perhaps not?

It might be objected that it is not possible for a nurse with prejudicial (e.g., racist) views/values to act appropriately (as outlined), and discrimination will therefore be evidenced in action/behaviour. But is this correct? Nurses inevitably interact with people they dislike. Yet hopefully they learn to recognise negative emotions/dispositions and compensate accordingly. It is therefore plausible that a nurse who holds prejudicial views and values could treat those she interacts with and distains equally or equally enough. She merely needs to act in ways that offset or discount her bigotry. This might, as suggested, involve cognitive insight (recognition, self-awareness), or it could involve acting in line with the behaviour of others (following or copying local norms) when those behaviours facilitate non-discriminatory interactions.[1] Alternatively, acts may be inappropriate/bad whilst those who perform them believe they possess appropriate/good values. Actions interpreted as racist are, for example, performed by people who recoil at the suggestion they are racist/hold racist views/values.

Numerous reasons can be advanced to explain disjunctions between asserted values and acts, and it is not immediately obvious how these reasons should be ordered. However, within the caldron of potential explanations, problems of definition and belief (broadly defined) provide suitable entry points for discussion. Thus, speaking personally, if I consciously believe I value something (e.g., kindness) but consistently act in ways that run counter to that value it is sensible to question whether I truly hold that value. Perhaps I am fooling myself? Perhaps I am deluded (values incontinence or illusions of thought)? Perhaps I am unclear about what kindness means/involves? When someone believes they value kindness but repeatedly acts unkindly, does belief express a wish? The wish to be the sort of person who is kind. Or where belief is declaimed ("I am kind"), absent actualisation are we witnessing misdirecting signalling? It is probably foolish to require that some quantity of kind acts be performed before beliefs/declarations of kindness can legitimately be established as held values. Yet at a professional or macro level, if nurses repeatedly act in ways that contradict expressed and believed (consciously held) values, maybe they do not hold those values.

[1]Hampshire (1982 [1959]) proposed that copying right action is synonymous with acting rightly. However, Murdoch (1970) queries this.

Failing to hold a value says nothing about whether that value should be held. However, before jumping to assert 'must' or 'ought', we need to be clear about what is proposed, and vis-à-vis values, this requirement is infrequently met. For example, my view on what constitutes kindness has and probably will again alter, and you might designate as kind acts I would not (or vice-versa). This destabilises both the object of consideration (kindness) and claims regarding that object, and assuming kindness should be valued within professional contexts is problematised (Contandriopoulos et al., 2023; McCartney, 2023). What then is kindness? What does it mean/involve? And if something as beige as kindness presents challenges, more viscerally, more ominously, what are we to make of justice and equity? Values associated with these terms/concepts are even more complex and contestable.

Societal ideas about what is acceptable and unacceptable have altered over recent decades, and change will presumably continue. Revision is neither continuous, uniform or linear (there may be no telos), and this complicates the difficulty of clarifying and operationalising (agreeing on) basic terms in evaluative discussion. Yet regardless of definition and belief, context rather than intension or studied logic/thought may play the bigger role in designating and influencing what is permissible/likely.

Behavioural psychological studies indicate that environmental cues play a huge role in steering the actions of people who are unaware of those cues (Sunstein, 2015; Thaler & Sunstein, 2009), and thus, irrespective of the values we consciously or unconsciously hold, what occurs (how we act) is swayed by circumstance. This is obvious in extreme situations and, for example, when the cost of action is deemed excessive most people (excepting saints) will not enact behaviour commensurate with their values. In tyrannous dictatorships individuals may thus be unable to effect in social action values they passionately hold in private. However, outside limit situations, 'soft' socio-cultural norms and contextual influences can prove decisive in guiding action—*but*—where the cost of action is low or negligible, when the price of action is minimal (i.e., in non-dramatic everyday situations), does it make sense to say someone holds a value when that value is not fulfilled in action because trivial environmental prompts (enablements or constraints) nudge behaviour otherwise? Behavioural psychology challenges an overemphasis within the values literature on belief and logic (abstract rationality) as well as presumptions around value–act linkages.

What we *believe*, *value* and *do* need not cohere, and henceforth it is presumed that values and actions can come apart. However, value–act linkages have been argued over for millennia. There are no agreed conclusions to these debates, and instead we encounter complexity. Complexity regulators and those making value claims in the nursing literature mostly ignore.

4 | REFUSING VALUES

Before outlining the grounds on which nursing value claims might be refused, four asides require consideration.

First, distinguishing values from acts clears a space in which the case for professional value claims refusal can be made. However, the following argument for refusal (and thereafter provisionality/tentativeness) is not intended to persuade or alter anyone's viewpoint. More thorough and detailed arguments would be required before that became a plausible goal. Instead, allowing the possibility of refusal (which differs from accepting/agreeing with that possibility) deflates professional value claims, and this lays the groundwork for questioning whether nurses holding alternative values or no values are overlooked in current discourse.

Second, declining to accept a value claim does not mean the refuser necessarily wants or intends to act in ways that oppose whatever actions allegedly accompany that claim. Thus, someone might reject claim 'x' because they do not think it is always wrong to perform action 'y' (a supposed behavioural correlate of 'x') while having no plan or inclination to ever do 'y'. A nurse might then refuse a value claim without anticipating behaving in ways that run counter to that value instantiated in action even if she has no objection to that action. At a personal level, while others value life because, for them, it is in some sense sacred or sacrosanct, sacredness is not a concept/value I recognise, and I therefore have no 'in principle' objection to terminating life because of its sacredness. At the same time, I do not currently intend to deliberately end my or anyone else's life (e.g., by performing suicide or participating in forms of assisted dying). Or value 'z' might be rejected for reasons unconnected with contrasting behavioural correlates of 'z' (the rejector might simply dislike claim 'z'), and the person rejecting 'z' may still not undertake actions commensurate with those correlates. Liberalism and liberal values including the elevation (consecration) of autonomy/individualism might therefore be rejected without the rejector supporting, agreeing with, or intending to perform acts associated with authoritarianism or illiberalism (Guess, 2022).

The point here is that refusing to accept, for example, value claims associated with care, compassion or the blandishments of liberal democracy/individualism does not mean the person refusing will in their actions necessarily be uncaring, uncompassionate or illiberal. Nurses who refuse professional value claims need not act differently from those who accept them, and refusal does not sanction bad behaviour (here behaviour contrary to common decency or civility). However, unproblematic assumptions pertaining to value–act linkages have been severed, and we cannot therefore tie acts or act-omissions to values in any straightforwardly non-critical fashion.

Third, since speech is an act. If a nurse declared she accepted a value claim she knowingly refused that person would be lying (act). If codes of conduct or ethics (i.e., regulatory frameworks) stipulate that nurses cannot lie, lying puts liars in breach of regulation, and depending on a regulator's powers of enforcement (policing), that person could have their ability to practice terminated. The UK NMC Code does not address this issue specifically. Yet as noted, the NMC (2018) declares that 'The values and principles set out in the Code… are not negotiable or discretionary' (p. 3). This mandates values

acceptance, and the question: 'Can a nurse *publicly* refuse the value claims that are laid upon her?' appears from a UK regulatory standpoint to be 'No.'

On the other hand, because the NMC do not adequately define their terms, since practitioners lack clarity on what values are or what acceptance entails, ambiguity exists. Further, we do not know what others think. We only know with variable degrees of confidence what people tell us they think and/or what we infer, and so long as refusal is not voiced; if a refusenik nurse does not court trouble by drawing attention to herself, if she complies with whatever the regulatory framework she operates within says about acts, refusal could pass unrecognised. In these circumstances, 'Yes' a nurse who declines professional value claims can continue to practice. But of course, matters are more interesting than this. We are not concerned with whether or how someone would get caught/get away with refusalist views. We are instead interested in understanding facets of the claims attaching to nursing.

Fourth, requesting that agents provide grounds or reasons for the values they hold/refuse assumes reasons ought to be given, and this need not be the case in all or every situation. For example, some acts (e.g., genocide, paederasty, slavery) may be considered so heinous that, arguably, even entering into discussion about their wrongness is wrong where or if discussion assumes alternative viewpoints will be dispassionately weighed/debated. Or if autonomy is a cherished value, why should valuers or value refusers meet demands that they supply reasons for and justify their views? Acquiescing to such demands, let alone demands requiring that reasons be acceptable to others, compromises key features of autonomy (Dworkin, 1988). Or it may simply be that my reason for holding a value is that I 'like' that value (see, e.g., Haworth, 1986). There may be no more to it than that and this could be sufficient. Arguably ethics and morality ultimately reference aesthetic preferences, and aesthetic judgement dissolves in part at least to socialisation and psychology/emotion.[2]

However, if we are to give reasons for the values we hold/refuse, those reasons do not need to be widely agreed. We do not determine the correctness of a value by voting on it. That such and such a percentage of people hold or refuse a value says nothing more than that that value is popular/unpopular, and popularity and correctness can be very different things. Correctness is, of course, a strange word to link with values. Nonetheless, contra Rachels (1993), should a nurse refuse some or all of the value claims associated with nursing, her reasons for doing so do not need to be definitive/conclusive, prevalent or persuasive. Instead, they only need to be 'good enough' where good enough suggests reasons are logically coherent and defensible at some level. And coherence and defensibility are relative descriptors. For example, coherence and defensibility are established when reasons for refusal are comparatively or roughly as robust as those they oppose, and when this is the case, if another person's values/lack of values differ from ours but both value sets are held respectively on grounds that are broadly or equally supportable (or equally unsupportable/indefensible), what else can be said other than that people disagree?

Problematically we lack generally agreed criteria for establishing that those who value differently to us are wrong. We might not like them or their values/lack of values. However, we are now dealing with psychology rather than reason/rationality, and in this circumstance a nurse who refuses nursing values simply holds other or no values. Should we want to insist that she holds 'our' values (e.g., nursing values or 'our' interpretation of these), we ought to be courageous enough to acknowledge that any ability we have to impose and enforce 'our' will rests on power/coercion and not superior logic/reason (i.e., demonstrably superior values). Not everyone is comfortable with this.

By retort it might be objected that metrics do exist. Theists, for example, cite God's will and this, for them, provides a measure for measures. Non-theist naturalistic humanists, by contrast, appeal to what pragmatically works or what is agreed upon by right-thinking people, and informed consensus generates their metric. Theists and non-theist humanists both claim against different criteria that 'something' underpins values/value claims. (Reference could also be made to two worlds vs. one world philosophers, or rephrased/reimagined, the mythos of Jerusalem vs. Athenian logos.) This something makes it possible to determine better from worse values, and since better values should be held, these can legitimately be promoted and (perhaps?) imposed.

The problem here is that unless we are already team players, unless we have bought into a side, we have no way of determining which vantage is correct. Non-theists cannot accept God's will as foundational. Theists baulk at the suggestion we know what works or that what is agreed implies anything of substance outside an understanding of God's will. Disputing an opponent's premises allows their conclusions to be scorned. However, since this strategy is available to both sides in argument, we need an external metric for choosing between metrics (here God vs. Man), and there isn't one.

Caveats aside, what then (finally!) might 'good enough' reasons be for refusing professional value claims if not valuing? With reference to the absence of agreed metrics, confronted by the complexities of choice (Andreou, 2023), and equally plausible but incommensurable value systems (e.g., theistically framed deontology and Benthamite consequentialism), Pyrrhonic sceptics suspend or cease judgement (epoché or epokhē) by declining to pick sides (Pritchard, 2019). Alternatively, relativists refuse the idea that truths about values exist and/or can be known, and from this vantage values and value systems emerge from or articulate socio-cultural and historical forces/contexts rather than absolute principles, powers or anything else. Theoretically, it might be that truths about ethics/morality and indeed values can be sifted out by or from history. However, relativists note this has not and may not ever be

[2]Rachels (1993) provides a contrasting perspective on values and aesthetic judgement. Edgar (2004), however, is more supportive of the suggestion made here. Eiser et al. (1988) discuss attitudes from a psychological perspective (stressing their social dimension/construction) in a manner that, possibly, might be tied to a version of aesthetic judgement and the significance of aesthetic judgement vis-à-vis values. We should also note Anscombe (1958) and Murdoch (1970). Crucially, a range of perspectives exist on this matter and no candidate solution has obvious primacy.

demonstrated, and they reject the notion that values have a foundational base beyond fallible and contingent desire/assertion (Moser & Carson, 2000; Recanati, 2007).

Scepticism and relativism are not the only grounds on or against which professional values might be refused. Snelling (2018) notes that if an emotional response is involved in experiencing, for example, compassion, regulators (and we might add scholars) cannot sensibly require that individual nurses have compassionate feelings since feelings are not the sort of thing that can be commanded. Experiencing compassion and valuing compassion are not synonymous. However, distinguishing a psychological affect from value claims that name and presuppose possession of affects is useful, and should claimants assume nurses experience specific psychological states before values associated with those states are held or evidenced in action, too much is demanded, and claims incorporating these assumptions can be declined.

Alternatively, scientific and philosophic determinism trouble key presumptions made by those espousing value claims (Honderich, 1990, 2015; Klein, 1990), and kindred worries await anyone who lifts the lid on values internalism-externalism (see, e.g., Dimova-Cookson, 2005; Olson, 2012). Marxism conjoins values with ideological class position to destabilise the idea that values can be considered dispassionately or neutrally. And psychoanalytic thought and psychological research findings question the ability of selves to engage meaningfully/rationally in the sorts of moral reasoning professional values adoption arguably necessitates. Further, materialist neurophilosophy suggests physical and evolutionary processes (e.g., hormonal/chemical production) account for most of what humans phenomenologically constitute as values/evaluation (see Churchland, 2011, 2019). And among others, Eilan and Roessler (2003) trespass into the territory between a problematised agency/self-awareness and brain mechanisms. Individually and collectively these decentring arguments/viewpoints can be marshalled to refuse nursing value claims. Or, perhaps counterintuitively, professional values could be rejected when, from the valuer's perspective, they do not go far enough.

Thus, in my role as an educator I recall a committed or fundamentalist religious nursing student whose value set led her to query nursing values because, for her, they were incomplete, inadequate, and in interpretation, misconstrued (imagine Maritain, 2020 [1939] in her place!). Or consider Rand's (1964) philosophy of uncompromising individualism (heroic selfishness as virtue), or Fanon (2001 [1965]) or Rothbard (2015 [1974]) on liberalism/liberal values. Like the student, these thinkers' perspectives are out of kilter with contemporary nursing value claims. Yet without an agreed method of valuing values, on what basis bar fiat (power/coercion) are they to be dismissed? Henceforth, rather than wandering the labyrinth of these and other potential refusalist positions, to carry the point that rejection is credible, we stick with scepticism and relativism (*simplex sigillum veri*). These perspectives arguably subsume or sum up several problems generated by the alternatives listed here. However, to repeat, alternatives exist.

Scepticism and relativism take many forms and abridged descriptions of the sort offered above can be challenged (as indeed can sweeping statements about theists and non-theists). Nevertheless, these perspectives might be recruited to decline value claims associated with nursing, and regardless of an individual's disposition towards scepticism or relativism, both standpoints are irrefutable in any final sense. Scepticism and relativism are, as arguments (intellectual positions), as robust and warranted as the viewpoints they oppose. Scepticism and relativism articulate and provide reasoned and reasonable arguments for those who accept their premises (Stern, 2000; Williamson, 2015—see also Blackburn & Simmons, 1999), and to restate, it is plausible to refuse nursing value claims using these arguments.

By response it might be supposed that few if any nurses are strong sceptics or relativists, and invoking these positions represents 'overkill' insofar as we are here dealing with uncontentious professional value claims regarding, for example, care and compassion. Is this all then baloney?

First, Mounk (2023b) proposes, in synopsis, that Foucault was a strong amoral values-relativist (see also MacIntrye, 1999, p. 102, regards Foucault's acceptance of the inevitability of exploitation), and while this proposition is no doubt contestable nursing scholars who use and lord Foucauldian insights in their work presumably know of these sorts of claim. Potentially, if Mounk (2023b) is correct, it might be that amoral values-relativism is acceptable to Foucaultian nursing scholars. (Ditto Nietzsche and Nietzschean-informed nurse scholars.)

Second, although full-throated relativism and scepticism produce logical anomalies, and it is unlikely that value claims expounding care and compassion will generate negative reactions/excitement commensurate with red-blooded relativism/scepticism, there is no agreed corpus of nursing values, and this cannot but tickle relativist/sceptical sensibilities. Thus, different jurisdictions emphasise alternative value sets and it is not clear which values (if any) are vital as opposed to optional. For example, if there is a graduated scale of nursing values, might care and compassion be more vital than justice and equity? Or is every addition to the palette of claimed professional values equal in some respect? Ambiguity invites scepticism. Further, agreed actions do not, as noted, accompany values acceptance, and contrasting interpretations of permissible/appropriate value-informed actions generate contention. Thus nurse 'A' might insist that care and compassion sanction and indeed demand universal socialised/nationalised healthcare, while nurse 'B' cites the same values to validate voluntary or private non-universal provision. Scepticism and relativism gain traction when, in healthcare, contested implications of values acceptance are acknowledged.

We can never be certain whether acts instantiate values lacking settled value–act meanings and given this, regardless of whether a nurse values care and compassion; absent agreed associated operationalised acts it is quite reasonable to refuse value *claims* about care and compassion when those claims rest on vacuous rather than fixed expressions of what acceptance implies. This does not entail non-cognitivism. Ethical pronouncements/value claims might in principle (though this is improbable) be capable of articulation in ways that permit them to be factually true or false (van Roojen, 2018). However, it is justifiable to decline claims when we are unsure about

what acceptance means in practice, and although professional value claims undoubtedly gesture towards nice or good things, what is included/excluded from the pantheon of nice things remains indeterminate.

5 | PROVISIONALITY AND TENTATIVENESS

Socio-cultural and historical forces/contexts shape thinking and understanding including thinking/understanding about values, and we are all to some extent products of the zeitgeist of our age. Moreover, recognising that what is desirable varies across time and geography (recognition that is itself part of our zeitgeist) problematises any uncritical leap of faith into the arms of particular values/value sets. In consequence, putting aside strong versions of scepticism and relativism, that is, distinct from outright refusal/indifference; might nurses who appreciate the contingent, complex, and contested nature of values and value claims choose to hold values provisionally and tentatively?

If we ignore earlier complexifying comments regards belief and consciousness we could hold that values are, as a binary opposition, held or not held. That is, it might be supposed that one either does or does not, for example, value care or compassion. However, noting the crushing simplicity of this supposition, positioning possession in this way underplays temporality or change through time, as well as fluctuation in the strength of values possession. Thus, at both individual and group levels, values held yesterday or last year might not be identical with those held today or tomorrow, and when held, values may be possessed more or less vigorously. This suggests, in principle at least, that value possession can be measured along or across scales of temporality and strength.

By riposte it might be argued that, empirically, values are not the sorts of thing that, whatever they are, are held and dropped wantonly. Hence, although value understandings may and do alter across lifespans, for most people this evolution is a slow and (ideally) considered process. Further, although different values might be possessed with varying levels of resoluteness, it is nonetheless the case that even provisionally held values are owned with a modicum of vigour.

Rejoinders to in principle suggestions are interesting. They may even be correct. Nonetheless, allowing that different values are held across time, and permitting that held values are possessed with wavering degrees of steadfastness means—mindful of normal distribution curves—that some nurses clasp values provisionally and tentatively. This suggestion counters the outputs of regulatory bodies and scholars who appear to expect nurses to wholeheartedly buy into and accept value claims associated with nursing. (The UK's NMC (2018) states that the values presented in its Code are not 'discretionary', p. 3.) And from the perspective of those asserting that values must or should be accepted, provisionality and tentativeness may be unacceptable. A nurse who in one way or another says professional values are 'okay for now', or a nurse who accepts values 'if you want', holds those values (if they do) in ways that, possibly, differ markedly from the assumptions and aspirations of regulators and scholars.

Few nurses are thoroughgoing sceptics or relativists. However, some acquiesce lightly in the value claims which wrap around nursing, and I place myself in this provisional/tentative camp. Thus, I have nothing against most of the claims I encounter. They are innocuous enough, and I am happy to go along with the sentiment expressed. Yet by and large I do not think that sentiment conveys anything of substance, and my support is therefore decidedly lukewarm or tepid. Further, I try to ignore what for me are irksomely foolish claims (regarding, often, ill-considered pontifications on justice and equity), because I cannot be troubled to argue with those pontificating. Maybe I am unusual? I suspect I am not. I have participated in enough conversations over the years to infer that others caveat their commitments; and thus, the level or surety of allegiance to value claims that regulators and scholars presumably want is not something I and probably others are able to supply.

6 | SUMMARY

Since values and acts can come apart, so long as nurses behave appropriately where 'appropriately' means complying with common decency, local norms and relevant regulatory injunctions concerning acts, nurses can either refuse group value claims, or they can hold/accept values provisionally and tentatively. This does not, it must be stressed, sanction bad or uncivil behaviour. What is proposed does not mean nurses can act in ways that reasonable others would colloquially describe as uncaring, uncompassionate, etc. It does mean nurses can distance themselves from professional value claims 'talk' about care, compassion, etc.

Depending on temperament, this suggestion is either silly or obvious. If refusal is a legitimate position for sceptics and relativists to take, and if there is nothing untoward or incomprehensible about scepticism/relativism, it is obvious. Or, recognising the contingent and plastic nature of value claims across time and geography, it is not unreasonable for practitioners to question and withhold enthusiastic support from those encountered locally. After all, wait long enough and new values and value interpretations will come along. Further, given the difficulties involved in defining values, as well as problems inherent in determining whether this or that act instantiates a named value, provisionality and tentativeness might be considered laudable. However, if nurses 'obviously' need to accept the value claims that are loaded onto them, if that is all there is to it, these suggestions are silly.

7 | OTHERING

Deflating professional value claims allows us to look critically both at the values constituting those claims and the uses to which they are put.

Among others, Nietzsche (Brobjer, 2021; Keaton, 1973; Salamah, 2018) and Anscombe (1958—see also Cremaschi, 2017)—albeit from different vantages—allow that some of the values nurses designate 'professional' are (in synopsis) encrusted with layers of assumptions deriving from, in Europe-America, a Judeo-Christian or Abrahamic faith heritage. These assumptions do not necessarily make sense or command assent in a secular age, and humanists and those who do not share an Abrahamic faith need not feel or be duty-bound to read/comprehend terms such as care or compassion (or indeed 'duty') in the same way that people who accept the aforementioned inheritance might.

Since the values nurses are enjoined to hold lack meaning outside socio-cultural-historical frames, indeed outside a religious frame, universal and non-negotiable interpretations of values can be challenged. Few nursing scholars, however, acknowledge the parochial nature of their assertions, and scholars in North America and Europe mostly write as if the values they hold are or should be held everywhere. Yet, clearly, perfectly able nurses work in countries that do not share what is here described as an Abrahamic heritage, and these nurses—together with many in North America and Europe who repudiate or question this heritage—may hold values North American and European commentators abhor. When universalising and non-negotiable value claims appear in the nursing literature, and when those claims speak to or reference a subset of values and value interpretations, what is happening?

Exceptions notwithstanding, nursing's literature assumes a broadly liberal, socially progressive and secular cum scientific orientation (my position). Yet it is not obvious this orientation represents or captures values held by all or even a majority of nurses. Problematically, and perhaps inevitably, because much of nursing's literature is written by and published in what, for the sake of succinctness, we might term a Western press; and because those writing often share similar views and values (in part a consequence of common class, educational and other positional interests), alternative perspectives are treated as irrelevant or disparaged. Specifically, the viewpoints of socially and politically conservative nurses are ignored, and traditionalist religious expression is similarly underrepresented. Where, for example, are the voices/values of Trump supporting nurses located in our literature? Where do those whose values instantiate orthodox religious interpretation find space?

This is not an argument in favour of tolerance (see McKinnon, 2006, regards this highly problematic concept). Rather, it is merely noted that the personal values of nurses differ, and this difference is ignored in public declarations of group professional value claims (see Bell, 2021). Over the years I have encountered nurses whose views and values I took to be radically conservative, non-liberal, non-progressive, and non-secular.[3] And this is unsurprising. Nursing draws recruits from across the population, and recruits imbibe the full range of opinions and values (nice and nasty, familiar and alien) found within the cultures/groups from whence they come. Yet given this diversity, why is our values literature so homogeneous?

Non-liberals, non-progressives and non-secularists can of course value care, compassion, etc (though if the argument regards scepticism and relativism holds, refusal is an option). Nevertheless, their interpretations of these values may differ from liberal, progressive and secularist interpretations, and when the voices of those holding other interpretations are omitted from consideration scholars perhaps only communicate with and address those with whom they already agree. Those like them. This need not mean anyone's voice is deliberately or conspiratorially ignored. Yet an unknown but possibly significant percentage of nurses might—globally—not share values and/or value interpretations which according to national/regional regulators and many who write in the professional press they are supposed to. Within the confines of a single jurisdiction global opinion/belief could be deemed irrelevant (though transnational recruitment suggests otherwise). Nevertheless, the declamatory nature of value claims in the outputs of national regulators is problematised when we realise how provincial these claims are. And the assertive pronouncements of scholars could be read as suggesting that nurses who do not share liberal, progressive or secular values (nationally or globally) are in some sense bad or misguided (see Ross, 2023, regards allied institutional mismatches). These statements include or rest on admittedly sweeping generalisations, and to be substantiated empiric investigation is required. However, it is not unreasonable to suppose that, if tested, support would be found.

References to values in regulation demand adherence/acquiescence yet fail to clarify what this presumes or requires, and scholarly exhortations can be both wearisomely pious and conceptually uniform. Facile assertion rather than argument is often presented (and I am as guilty here as anyone). However, at a time of cultural and political tension when shrill voices declaim on almost every issue and politeness is in short supply, thinking about how value claims are presented in journals such as this has merit. At present (dare we say?) our literature often neglects to adequately acknowledge the deeply contested and problematic nature of the evaluative concepts it invokes. It too readily assumes value–act linkages that are unsustainable. And in conflating these errors, and by advancing a limited set of perspectives (i.e., liberal, progressive, secular) without adequately engaging what for many are reputable alternatives, our writing contains two associated blunders. First, professional value claims discourse can lack depth/profundity. Second, our outputs risk denigrating perfectly able nurses who happen to hold contrasting values/value interpretations. None of what is said sanctions unacceptable behaviour, it is not proposed that the values of others (those we disagree with) should not be critiqued, and we are perhaps required to argue in favour of the values we uphold. What is petitioned for is simply better and more diverse argument. That is all.

8 | SO WHAT?

Rightly or wrongly, helpfully or unhelpfully, many of those who speak about and for nurses define nursing as a profession that, at its core, is an ethical enterprise or undertaking (see, e.g., Jolley & Brykczyńska,

[3]Self-evidently liberalism, progressivism, and secularism do not designate a unitary or coherent perspective. Liberals need not be secularists, etc. Further, secularism here references the subtraction of theistic references from public argument/discourse. Secular discourse does not require that discussants be non-theists.

1993). Proposing that nursing values can be refused or held provisionally and tentatively is thus knowingly provocative, and it is not anticipated that readers will agree with what is argued. However, papers such as this aim to stimulate thought and provocation is therefore a spur or inducement to encourage those who disagree to clarify and explain why they disagree. Let us then us then be clear about what is suggested.

Few nurses are thoroughgoing sceptics or relativists. Nonetheless, these perspectives provide legitimate grounds on or against which professional value claims might be refused, and it is assumed that holding these positions does not in itself entail or necessitate exclusion from practice (exclusion from nursing). Further, an unknown but possibly sizeable number of nurses probably hold/accept professional values provisionally and tentatively. These suppositions, if correct, problematise overly declamatory statements regarding nursing value claims. They raise questions about how liberal, progressive, and secularist scholars write about non-liberal, non-progressive, and non-secular values/value holders. And they complicate values discussion on and around equality, diversity and inclusion agendas. That is, discussions concerning critical social justice, critical race theory, decoloniality, queer theory, and gender identity theory are undercut by the arguments presented when these discussions assume correct or agreed positions linked to settled professional values can or have been established.

Nurses hold contrasting values, and they disagree on how values are to be interpreted. Some may refuse value claims entirely.[4] That said, nurses ought to act in ways that (definitional ambiguity notwithstanding) sensible others and most patients deem appropriate. Yet, crucially, this 'ought' statement signifies nothing more than that nurses should be civil (evidence common decency) and competent. Civility and common decency rest on evaluative assumptions presupposing values. However, acknowledging this does not require the invocation of or resort to professional value claims. This additional step is not necessitated.

A longer study would more comprehensively detail what values and value claims entail. Sidestepping complication this paper has not explored connections between values and virtues, values and ethics, values and morals/morality, etc, and moreover, fuller engagement might examine the extent to which privately held values exist apart from social formulations of values such as those articulated in nursing value claims (see, e.g., Murdoch, 1970 [1964]). A great deal therefore remains unspecified, and this study is perforce exploratory. Nonetheless, while what we think about values clearly matters, maybe nursing can, as a profession, dispense with or downplay the idea that care, compassion or any other value is essential where essential implies collective or agreed/shared values nurses must/should hold in virtue of their being nurses. Perhaps such claims are less important and vital than is imagined? Put another way, rather than worrying about professional values 'talk', perhaps nursing and nurses should attend more to action (behaviour)? Patients are interested in what we do. They are presumably less concerned about our intentions or why we do what we do. And so long as nurses act/behave appropriately (civilly, competently), regulation notwithstanding, we might allow that nurses do not have to accept the professional value claims that are laid upon them, or we might admit that values can be held provisionally and tentatively. This would require a new framing for professionalism. Nevertheless, the reframing imagined could allow nurses holding no or other values and value interpretations greater recognition, and that may prove beneficial.

[4]One commentator proposed that nurse education aligns or should align differences in values conceptualisation so that blank refusal becomes impossible. However, more questions are raised than answered if it is supposed that education can 'teach' and thus align values in the same way that teaching conveys objective facts/knowledge.

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REFERENCES

Andreou, C. (2023). *Choosing well: The good, the bad, and the trivial*. Oxford University Press.

Anscombe, G. E. M. (1958). Modern moral philosophy. *Philosophy (London, England)*, *33*(124), 1–19.

Anscombe, G. E. M. (Ed.). (2000). *Intention* (2nd ed.). Harvard University Press.

Baggini, J. (2002). Jean-Paul Sartre: Existentialism and humanism (1947), *Philosophy: Key texts*. Palgrave Macmillan. https://doi.org/10.1007/978-1-4039-1370-8_6

Bell, B. (2021). Towards abandoning the master's tools: The politics of a universal nursing identity. *Nursing Inquiry*, *28*(2), e12395. https://doi.org/10.1111/nin.12395

Blackburn, S., & Simmons, K., (Eds.). (1999). *Truth: Oxford readings in philosophy*. Oxford University Press.

Brobjer, T. H. (2021). *Nietzsche's 'Ecce Homo' and the revaluation of all values: Dionysian versus Christian values*. Bloomsbury.

Churchland, P. S. (2011). *Braintrust: What neuroscience tells us about morality*. Princeton University Press.

Churchland, P. S. (2019). *Conscience: The origins of moral intuition*. WW Norton & Company.

Contandriopoulos, D., Stake-Doucet, N., & Schilling, J. (2023). Fake kindness, caring and symbolic violence. *Nursing Ethics*. Advance online publication. https://doi.org/10.1177/09697330231209290

Cremaschi, S. (2017). Anscombe on the mesmeric force of 'ought' and a spurious kind of moral tealism. *Etica and Politica/Ethics and Politics*, *19*(2), 51–86. https://philarchive.org/archive/CREAOT

Dimova-Cookson, M. (2005). Internalism and externalism in ethics applied to the liberal-communitarian debate. *The British Journal of Politics and International Relations*, *7*(1), 18–28. https://doi.org/10.1111/j.1467-856X.2005.00164.x

Dworkin, G. (1988). *The theory and practice of autonomy*. Cambridge University Press.

Edgar, A. (2004). Professionalisation and aesthetic values. In S. Pattison & R. Pill (Eds.), *Values in professional practice: Lessons for health, social care, and other professions* (pp. 35–45). Radcliffe Medical Press.

Eilan, N., & Roessler, J. (2003). Agency and self-awareness: Mechanisms and epistemology. In N. Roessler & N. Eilan (Eds.), *Agency and self-awareness: Issues in philosophy and psychology* (pp. 1–47). Oxford University Press.

Eiser, J. R., & van der Pligt, J. (1988). *Attitudes and decisions*. Routledge.

Fanon, F. (2001). *The wretched of the earth* (C. Farrington, Trans.). Penguin.

Foot, P. (2001). *Natural goodness*. Oxford University Press.

Gilligan, C. (2003). *In a different voice: Psychological theory and women's development*. Harvard University Press.

Guess, R. (2022). *Not thinking like a liberal*. Harvard University Press.

Hampshire, S. (1982). *Thought and action* (2nd ed.). Chatto and Windus.

Haworth, L. (1986). *Autonomy: An essay in philosophical psychology and ethics*. Yale University Press.

Honderich, T. (1990). *The consequences of determinism* (Vol. 2). Oxford University Press.

Honderich, T. (2015). *Essays on freedom of action*. Routledge.

Jolley, M., & Brykczyńska, G. (1993). *Nursing: It's hidden agendas*. Edward Arnold.

Keaton, A. E. (1973). The force of Nietzsche's criticism of Christianity. *Journal of Thought*, *8*(1), 78–81. https://www.jstor.org/stable/42588342?seq=1

Klein, M. (1990). *Determinism, blameworthiness, and deprivation*. Oxford University Press.

Koehn, D. (1994). *The ground of professional ethics*. Routledge.

Kuhse, H. (1999). *Caring: Nurses, women and ethics*. Blackwell.

Lee-Stronach, C. (2021). Morality, uncertainty. *The Philosophical Quarterly*, *71*(2), 334–358. https://doi.org/10.1093/pq/pqaa030

MacIntrye, A. (1999). *Dependent rational animals: Why human beings need the virtues*. The Paul Carus Lecture Series #20 Open Court—Carus Publishing Company.

Maritain, J. (2020). *The primacy of the spiritual: On the things that are not Caesar's* (J.F. Scanlan, Trans.). Cluny Media.

McCartney, M. (2023). The job of a doctor is not necessarily to be kind. *British Medical Journal*, *382*, 1995. https://doi.org/10.1136/bmj.p1995

McKinnon, C. (2006). *Toleration: A critical introduction*. Taylor and Francis Group.

Moser, P. K., & Carson, T. L. (2000). *Moral relativism: A reader*. Oxford University Press.

Mounk, Y. (2018). *The people vs. democracy: Why our freedom is in danger and how to save it*. Harvard University Press.

Mounk, Y. (2023a). *The identity trap: A story of ideas and power in our time*. Penguin.

Mounk, Y. (2023b). LSE public lectures and events—Introduced by Professor Andrés Velasco. *Podcast—The identity trap: a story of ideas and power in our time* (castbox.fm).

Msoroka, M. S., & Amundsen, D. (2018). One size fits *not quite* all: Universal research ethics with diversity. *Research Ethics*, *14*(3), 1–17. https://doi.org/10.1177/1747016117739939

Murdoch, I. (1970). *The sovereignty of good*. Routledge & Kegan Paul.

Nursing and Midwifery Council. (2018). *The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates*. https://www.nmc.org.uk/standards/code/

Olson, P. R. (2012). Putting knowledge in its place: Virtue, value, and the internalism/externalism debate. *Philosophical Studies*, *159*, 241–261. https://doi.org/10.1007/s11098-011-9700-y

Pattison, S. (2004). Understanding values. In S. Pattison & R. Pill, (Eds.), *Values in professional practice: Lessons for health, social care, and other professions* (pp. 1–12). Radcliffe Medical Press.

Pritchard, D. (2019). *Scepticism: A very short introduction*. Oxford University Press.

Rachels, J. (1993). *The elements of moral philosophy* (2nd ed.). Mc-Graw-Hill Inc.

Rand, A. (1964). *The virtue of selfishness: A new concept of egoism*. Penguin.

Recanati, F. (2007). *Perspectival thought: A plea for (moderate) relativism*. Oxford University Press.

Reinhard, K. (2005). The ethics of the neighbor: Universalism, particularism, and exceptionalism. *Journal of Textual Reasoning*, *4*(1). https://jtr.shanti.virginia.edu/volume-4-number-1/the-ethics-of-the-neighbor-universalism-particularism-exceptionalism/

van Roojen, M. (2018). Moral cognitivism vs. non-cognitivism. In E. N. Zalta (Ed.), *The Stanford encyclopedia of philosophy*. https://plato.stanford.edu/cgi-bin/encyclopedia/archinfo.cgi?entry=moral-cognitivism

Ross, J. (2023, September 1). Fact-checker suspicion 'reflects mistrust' of universities: Action against RMIT service comes as institutions support 'yes' vote in forthcoming Australian referendum. *Times Higher Education*. https://www.timeshighereducation.com/news/fact-checker-suspension-reflects-mistrust-universities

Rothbard, M. N. (2015). *Anatomy of the state*. Ludwig von Mises Institute.

Salamah, O. B. (2018). *Nietzsche's critique of morality and revalidation of values*. University of Iowa. https://iro.uiowa.edu/esploro/outputs/undergraduate/Nietzsches-Critique-of-Morality-and-Revaluation/9984109908502771

Sartre, J.-P. (2007). *Existentialism and humanism*. Methuen Publishing Ltd.

Schwenkler, J. (2019). *Anscombe's intention: A guide*. Oxford University Press.

Smith, D. (2000). Chapter 2: The historical geography of morality and ethics, *Moral geographies: Ethics in a world of difference* (pp. 23–44). Edinburgh University Press. https://doi.org/10.1515/9781474472685-003

Snelling, P. (2018). Why you cannot regulate for virtuous compassion. In E. Carr (Ed.), *Cultivating moral character and virtue in professional practice* (pp. 1–12). Routledge.

Stern, R. (2000). *Transcendental arguments and scepticism: Answering the question of justification*. Oxford University Press.

Sunstein, C. R. (2015). *Choosing not to choose: Understanding the value of choice*. Oxford University Press.

Tangwa, G. B. (2004). Between universalism and relativism: A conceptual exploration of problems in formulating and applying international biomedical ethical guidelines. *Journal of Medical Ethics*, *30*(1), 63–67. https://doi.org/10.1136/jme.2003.003194

Thaler, R. H., & Sunstein, C. R. (2009). *Nudge: Improving decisions about health, wealth and happiness*. Penguin Books.

Trusted, J. (1987). *Moral principles and social values*. Routledge and Kegan Paul.

Wainwright, P., & Pattison, S. (2004). What can we expect of professional codes of conduct, practice and ethics? In S. Pattison & R. Pill (Eds.), *Values in professional practice: Lessons for health, social care, and other professions* (pp. 109–121). Radcliffe Medical.

Williamson, T. (2015). *Tetralogue: I'm right, you're wrong*. Oxford University Press.

Winkler, E. A. (2022). Are universal ethics necessary? And possible? A systematic theory of universal ethics and a code for global moral education. *SN Social Sciences*, *2*, 66. https://doi.org/10.1007/s43545-022-00350-7

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