

Some may beg to differ: individual beliefs and group political claims

Preamble:

In the words of Groucho Marx: “*Before I speak I have something important to say.*” I speak/write as if my thesis is settled. I am in truth less confident. This presentation should be viewed as a work in progress.¹ No doubt the argument outlined below requires further development and, of course, I could simply be wrong. In my defence I think I am edging towards something worth saying. How close I am to that thing I cannot say.

Abstract:

Nurses have much to contribute to political discourse and activity. However, to protect and advance this contribution we should perhaps question some of the assumptions underpinning political claims that attach to nurses. In this presentation the group descriptors ‘nurses’ and ‘nursing’ are problematised insofar as these terms depict *all* nurses. It is suggested that when these descriptors are associated with political claims then forms of group coherence and collective ascription (i.e., the ascription of traits, purposes, values etc., to the group ‘nurses’) are implied which are difficult to sustain. It is proposed that using collective descriptors without adequate explanation/clarity weakens the arguments in which they lodge. Hume’s dismissal of shared value theory is linked with the fallacy of composition and it is suggested that this fallacy is associated with collective ascription error. It is proposed that, while individual nurses and groups of nurses can and do act as intentional political agents we should be wary of claims that insist that nurses collectively do (empiric), should (normative), or must (regulatory) act similarly. If the argument advanced here is accepted then the uPNR (2012) question: “What . . . difference . . . [does] philosophy make to practice?” will in part have been met. Philosophy here serves a negative-critical function. It challenges the legitimacy of demands placed upon nurses by some nursing scholars and nursing organisations insofar as it undermines the idea that nurses and nursing can own or exhibit a ‘general will’ regards political matters.

Introduction:

Social interaction involves relations of power, authority, status etc., and, insofar as these relations can be classed as ‘political’, most if not all forms of human activity is describable in political terms. Given this broad definition all nursing activity, scholarship and governance includes a political component or dimension.

Nurses have, as nurses (rather than simply as citizens), much to contribute to political discourse. Specifically, nurses possess detailed knowledge about important elements of health and social care and this knowledge should secure them ‘a place at the table’ when decisions impacting on health and social care are made.

Aspects of the way in which discussions about political matters are constructed will hereafter be critiqued. However, it is not suggested that nurses ought not to involve themselves in political matters. That would be foolish. It is suggested that the coherence of some political claims may be challenged. For example, the implicit assumption in Salvage’s (1985) statement: “Imagine the power for change if nurses decided to act together, to introduce new ways of giving health care or to oppose a particular policy!” (p.169) is presumably that nurses – *all* nurses – can and possibly should collectively agree upon and act to enable political transformation. It is this presumption – the presumption that all nurses should act similarly – that is questioned.²

¹ The presentation title and abstract submitted to the conference organisers in January 2012 are here tweaked – i.e., this title/abstract differs slightly from that in the programme. Although both are still not ‘quite right’ they now more accurately convey what I want to say. These notes build upon ideas in Lipscomb 2010, 2011 and 2012.

² Collective action of the sort proposed by Salvage (1985) may or may not prove beneficial. The utility of such action is not however the subject of this presentation.

Nursing scholars and organisations assert that nurses do, should or must act in certain ways and when those ‘ways’ are about the form that society, healthcare, or professional behaviour takes then those assertions constitute political claims upon the group ‘nurses’. For example, the Canadian Nurses Association (CNA) requires that nurses governed by its *Code of Ethics for Registered Nurses* (2008) actively work to secure a version of social justice:

There are broad aspects of social justice that are associated with health and well-being and that ethical nursing practice addresses. These aspects relate to the need for change in systems and social structures in order to create greater equity for all. Nurses should endeavour as much as possible, individually and collectively, to advocate for and work toward eliminating social inequalities.

CNA (ibid, p.20)

Although this statement appears in the CNA *Code of Ethics* (ibid) it nonetheless makes a political demand. It asserts that greater equity requires socio-structural change and responsibility for affecting this change is laid upon nurses “individually and collectively”. The claim is overtly political insofar as it requires that nurses take a position on and act to alter the manner in which society is governed or administered.

The claim is also problematic and it is this problematic that is here engaged. Thus, while most people endorse social justice as an ideal abstraction, the concept is variously interpreted and not all interpretations require the elimination or radical diminution of social inequalities.³

Many political positions/parties advocate ‘for’ social justice. However, advocacy takes numerous and often contradictory forms. Mainstream political parties may welcome the lessening of extreme inequality (again variously defined). Yet this lessening need not be a policy priority. The CNA claim exceeds the ambitions of mainstream political parties insofar as these parties do not necessarily seek to eliminate social inequality (‘elimination’ is a particularly strong/unbounded term). Further, it is probably not a position that all Canadian nurses accept.

As noted the aforementioned political claim appears in the *Code of Ethics* where it is positioned as “a statement of the ethical values of nurses” (ibid, p.1). Since nurses here mean all ‘subject’ nurses the possibility of individual dissent/refusal is not countenanced. This document, like many others, makes political claims (broadly defined) that aspire to guide or direct the action of the group nurses (i.e., it levies claims upon *all* nurses *as* nurses). However, claims upon all nurses can and probably often do conflict with the beliefs/interests of individual nurses.⁴

Political claims upon nurses can be variously categorised and an obvious distinction (already referred to) exists between claims that nurses ‘do’ (empiric), ‘should’ (normative) and ‘must’ (regulatory) act to achieve a political objective or goal. These categories differentially apply to group agents with regulatory/governance duties (here loosely interpreted to include, e.g., the CNA) and individual scholars. Both group and individual agents can make similar claims; however, when the CNA says ‘should’ (optional) they may mean ‘must’ (obligatory) and when scholars say ‘must’ they can mean ‘should’. (Referent meanings are, in measure, context specific.)

This presentation explores the coherence and/or tolerability of group claims for individuals. It is proposed that political claims on all nurses can be in tension with individual member beliefs/interests.⁵ This tension might undercut the argumentative legitimacy

³ Social justice and social equality are here elided. The CNA *Code of Ethics* (2008) appears to sanction this. However, the conflation is not unproblematic.

⁴ The relationship between beliefs/interests and actions assumed here is complex and contested topic. For example, radical externalists (i.e., behaviourists) deny the “existence as well as the causal efficacy of mental states” (Satz and Ferejohn, 1994, pp.74-5). It is not necessary to accept this position to recognise the potency of the challenge to a realism of psychological states – that is, of intentionally derived behaviour grounded on underlying psychological mechanisms (internalism).

⁵ This observation is not new. See Rafferty (1996) for a discussion of divergent individual-group interests in the historical process of UK nurse (1919) and midwife (1902) registration. Specifically, Rafferty (ibid) notes that “in

(acceptability) of group claims. The ‘fallacy of composition’ argument (Hardin, 2007) and ‘collective ascription error’ (Jones, 2005) are introduced to challenge aspects of these claims. It is asserted that greater clarity in argument is needed. This modest suggestion is uncontroversial in principle. However, it may prove difficult to achieve in practice.

Group and individual agency:

Describing existent relations between individuals, groups, social structures and society is the mainstay of political and social science. Comprehending these relations is central to any thorough or careful understanding of nursing and ‘the political’. These relations can be variously described and a wide spectrum of theoretical positions purport to explain their nature. Since the adoption of ‘a’ theoretical position influences both the sorts of question that are asked and, thereafter, steers the type of analysis offered, full engagement with this subject demands (a deliberately strong term) that the diversity and implications of explanatory theories/models be acknowledged. However, this presentation simply and superficially reflects upon relations between individual nurses and the group ‘nurses’.

It will be presumed that individuals have agency (free will).⁶ This is of course contested (see, for example, Honderich, 1988). However, it is an assumption that is widely made. More problematically, the veracity and reality of group agency is hotly disputed.⁷

If we grant group agency (i.e., if we allow that bodies such as the CNA are or can be group agents) then those agents may sensibly take or advance ‘positions’ (such as that cited above) which differ from those of at least some and potentially a majority of group members. On the other hand if group agency is denied then, if only individual persons can be agents, claims emanating from groups such as the CNA lack vital aspects of legitimacy.⁸

List and Pettit (2011), who argue *for* group agency, acknowledge that consensus on this issue is absent. Developed arguments exist that both support and rebuff the concept. They nonetheless propose a theory of agency based upon supervenience rather than emergence (the main alternative to supervening theory)⁹ and they dispute methodological individualism,¹⁰ eliminativism and singularism (distinct but overlapping theories that deny group agency).

Noting that most ‘talk’ regarding group agency is either misplaced or metaphorical, List and Pettit (ibid) claim we need to be clear about what constitutes group agency if we are to speak coherently. For List and Pettit (ibid), groups must both make judgements based upon beliefs and form preferences based upon desires if they are to be accorded agency and, if groups are to have beliefs and desires, they need to achieve or hold intentional states. More precisely, they must display representational and motivational states akin to those evidenced by individual persons¹¹

many ways the private nurse was analogous to the mid-nineteenth-century general practitioner” (p.183) and, as such, for this group registration was not an unalloyed blessing. Alternatively, intra-group nursing tensions are chronicled in Jones (1999).

⁶ Agency is not simply synonymous with free will. However, more elaborate discussion is not here necessary.

⁷ Or rather group agency is hotly disputed outside of nursing. The issue appears to be ignored within the nursing literature and, yet, without a developed and defensible concept of group agency, nurse scholars who assume this thing run the risk of generating compromised arguments.

⁸ It might be argued that groups lacking agency can still make claims upon group members through, for example, forms of majoritarian attitude aggregation (e.g., voting). Logical problems with this aggregation function are recognised later in this presentation.

⁹ See Satz and Ferejohn (1994), Le Boutillier (2001), Sawyer (2002) or Demeter (2003) for a fuller explanation and critique of supervenience.

¹⁰ Although a variety of methodologically individualist positions are recognised, Georg Simmel might stand as a representative for individualism. Simmel (1898) noted that society seems to have “a structure of independent reality” (p.665), so structures appear to have agency; however, “in the last analysis only individuals exist” (p.665) and individuals here refer to persons only. Various individualist sociological, political, ethical and economic theories were and remain popular. Satz and Ferejohn (1994) believe these theories are reductionist.

¹¹ This interpretation of personhood is ‘performative’ rather than ‘intrinsicist’. It is contentious and may be resisted by some nurses because it appears to sanction the exclusion of people with reduced/impaired levels of consciousness (i.e., those incapable of demonstrating performative skills) from the category ‘person’ (for an

and, vitally, expressions of these states do not rely upon the brute aggregation of member views. Only in these circumstances do groups possess agency. Only then are they not mere groupings.

This presentation follows List and Pettit (ibid) in accepting the ontological reality of group agency. It is thus assumed, it is not argued, that bodies such as the CNA and, in certain circumstances, assemblages of nurse scholars and other groups¹² can meet the aforementioned criteria for group agency. These agents may therefore sensibly make political claims of their members (individual nurses and/or the collectively of nurses in specific jurisdictions).

Regulatory/governance claims have particular significance. However, claims with a political dimension levied upon nurses can be challenged regardless of their source or status (i.e., regardless of whether they are made by group agents with regulatory/governance powers, by group agents lacking regulatory/governance powers or by scholars).

The indeterminate nature of normative claims:

Political claims can be considered the outcome or conclusion of political discourse. Political discourse describes activity ranging from weighty philosophic broodings through to bar room chatter. It encompasses socio-cultural, economic, psychological and ethical factors and, of course, facts and values are closely partnered in all of these ‘dialogs’. However, even when agreed, facts are rarely sufficient to arbitrate or settle political disagreement and, while facts are integral to and important in political debate, it is here asserted that political discourse is predominantly or ‘at root’ normative in character.¹³

What then does it mean to say that philosophy might or can inform our (nurses) understanding of ‘things political’? If the term ‘philosopher’ applies to anyone who thinks carefully and critically,¹⁴ then many philosophers have engaged enthusiastically with socio-political questions. For example, John Rawls (1971) and Robert Nozick (1974) are noted for their differing views on social justice (Schaefer, 2007).

Using Rawls and Nozick as an example of a dichotomy in political outlook, while agents might favour the arguments of Rawls or Nozick on social justice and despite both positions being subject to formidable critique, the internal coherence and plausibility of both viewpoints must, regardless of preference, be acknowledged. Incompatible or contrasting theories may thus be supported by equally valid but different arguments.

extended debate on consciousness and moral status see Levi, 2005). Alternatively, O’Brien (2007) presents an account of individual self knowing agency that is difficult to square with List and Pettit’s (2011) theory of group agency. List and Pettit (ibid) might also be accused of underplaying the temporal component in group functioning (see Archer, 1995) and this may have ontological implications for their theory.

¹² Individuals belong to many groups (family, work, friendship, etc.) and not all of these groups have agency. Groups may also, presumably, evidence agency intermittently. Sociological models tend to assume that agency is a stable attribute. They also “represent interpersonal linkages in binary, or on/off terms” (Freeman, 1992, p.153). Thus you either are or are not a member of a group and that group either does or does not have agency. However, amongst much else, binary models of this sort have been accused of failing to “capture the variation in people’s tendencies to get involved with the group” (ibid, p.153). Allowing that ‘scaled’ degrees or forms of participation occur and change through time may have greater explanatory power in modelling individual-group relations. Thus, for example, let us suppose that a student or neophyte nurse may not be as involved or committed to the group ‘nursing’ as trained/licensed professionals (the converse might also apply). This is important since the “process through which social groups influence political thinking varies significantly depending upon whether an individual identifies with the group in question” (Conover, 1988, p.51). This implies that simply belonging to a group (e.g., the group ‘nurses’) need not mean that individuals necessarily identify with some or all of the aims-ambitions of that group (assuming group agency). In considering the individual’s relationship with the groups to which they belong we ought perhaps to note that affect (i.e., sympathy or empathy) ‘matters’ and – counterpointing reason against affect/emotion – willingness to identify with and promote political causes is not based solely on reason/interest. Issues thrown up by multiple group membership resurface in the section of this presentation headed ‘Some may beg to differ’.

¹³ See Humphreys (2012) on the relationship between scientific ‘facts’ and normatively grounded political policy.

¹⁴ This qualification is inserted since some theorists and commentators may not consider themselves philosophers even though they engage in what others term philosophic endeavours.

Individual and group agents can form and hold political beliefs and desires. Beliefs and desires may be associated with or tied to philosophic argument (e.g., the arguments of Rawls and Nozick). Beliefs and desires might even have their genesis in philosophic consideration. However, if conclusions with which we disagree (conclusions associated with alternative/contrasting beliefs/desires) can be derived from arguments that are as intellectually robust, sensible and reasoned as those we favour then those conclusions cannot be gainsaid on logical grounds and philosophy cannot close discussion, it is not final and, when normative (political) questions are being disputed, philosophy undetermines argument.

Thus when the Athenian Sceptic Carneades addressed a Roman crowd in 155 BCE, he argued that justice was a good thing and, as such, it was always in an individual’s interest to act justly. The following day Carneades returned to the public space and, with equal verve, argued against the idea that justice is a natural good. He claimed it was not always in an agent’s interest to be just. These performances have been variously interpreted (Wilkerson, 1988; Halsall, 1998). However, it is here proposed that, by acting in this way, Carneades highlighted two important facets of philosophic inquiry. First, he illustrated that oftentimes ones opponents in debate have good points to make and we should therefore be wary of reaching hasty conclusions. Second and this is a stronger, a more contestable claim, Carneades allowed that philosophy not only opens up debate, it also forecloses upon the possibility of conclusion.

To emphasise and develop this point, several approaches exist that, as previously noted, differentially describe social justice. Michael Sandel (2011 – but see also 2010) suggests that these approaches can be categorised using three umbrella headings, namely: Benthamite Utilitarianism, Kantian Deontology and Aristotelian Virtue ethics (this last option is his preferred choice).

We can thus define social justice as a concept and each of Sandel’s three descriptions of the concept as conceptions. By extension each conception covers a range of possible further subdivisions in understanding (so each conception is capable of further subdivision) and, importantly, whilst similar ‘policy’ options can be derived from two or more conceptions, it is also the case that each conception can be associated with distinct policy options. Put crudely, looking at social justice through a Benthamite lens; looking for policy options that maximise aggregate utility (the greatest good of the greatest number) can produce different options from those that emerge if a Kantian deontological rights based approach is assumed.

This prompts us to confront indeterminacy. A range of politically implicative philosophic choices are available. Some approaches are more appealing than others (to agents) and each approach is rational. Yet in the absence of a metric or method external to logic and reasoning, while agents cannot but have favoured arguments, we have no means of arbitrating on which approach is ‘best’.¹⁵

In addition, when thinking about what philosophy can bring to our understanding of ‘the political’, we might note that (contra Rawls and Nozick) philosophers have, in approaching politics and political questions, explicitly subordinated politics, decision making and government to ‘higher goals’ and, for example, Plato’s (2007 [375 BCE]) philosopher Guardians were, in *The Republic*, required to value reflection above power. They were obliged to be reluctant leaders and decision makers.

More forcefully, major branches of philosophy reject traditional forms of political activity. For example, Epicureanism belittles political engagement and an Epicurean was (in)famously absent from the three man Athenian philosopher debt relief embassy to Rome that

¹⁵ Two linked points might be made here. First, the arbitration being denied here only applies to the idea that widespread or general consensus is possible/plausible. It is not suggested that individuals should not form and argue for particular positions. Second, indeterminacy can be circumvented by taking a closed or sectarian approach to politics and philosophy. We can therefore choose only to engage with a limited range of ideas, ideas that support our prejudices. However, if political beliefs can be both sustained and undercut by equally plausible philosophic insights then, while we cannot but have favoured options, it might be proposed that we are nudged towards academic scepticism in normative matters where ‘rules governing others’ (but not ourselves) are contemplated.

included Carneades. Further, naturalistic, deterministic, materialist Stoics, having placed supreme value in virtue and wisdom were relatively indifferent (following the indifference principle) to political aspiration.¹⁶

These examples illustrate that major and influential philosophic perspectives challenge unreflective assumptions concerning the supposed self-evident utility of ‘traditional’ political engagement. Scepticism (Pyrrhonian skeptikos), Stoicism and Epicureanism problematise, downplay and reject political activity. And even Plato (2007) ends *The Republic* with what appears to be a denial of the practical worth of politics (592a & b).

Indeed, while Plato situated belief midway between knowledge and ignorance, Greek sceptics identified belief with doxa which for them meant common or mere opinion. For sceptics such as Pyrrho, doxa as mere opinion is a poor guide to decision making since opinions of this sort favour truth claims in the absence of knowledge and, in the absence of knowledge, we simply guess.

This is a strong assault on the possibility of justified political belief (where belief is grounded on more than guesswork). It may or may not be sensible to maintain strict boundary definitions around, for example, knowledge and ignorance or, in relation to belief; we might want to employ a graded schema that allows degrees of truth (Van Deemter, 2010). However, the indeterminate nature of normative-political claims is hereafter assumed.

Some may beg to differ:

Mindful of recent US debates and challenges to President Obama’s Health Care Reform Act let us grant that, in the US, many nurses support the Republicans. Further, some Republican nurses doubtless sympathise with Tea Party objectives. Political theory and ideology is not the same as party politics. Political groups do not simply ‘give voice’ to theoretical or ideological nostrums in any straightforward sense (Deakin, 1994). Nonetheless, accepting these caveats and the oversimplification involved, let us suppose that Republican and Tea Party supporters need not reject neo-liberal ideas. Thus members of these groups and neo-liberals favour low taxation, small government and market ‘freedom’. Neo-liberal nurses will be against ‘the bill’.¹⁷

What then will neo-liberal nurses (to use an inelegant phrase) make of comments in the nursing literature regards neo-liberalism? It is difficult to find any favourable reference to neo-liberalism in the nursing literature¹⁸ and, instead, the following two quotations are crudely representative of what is on offer. If nothing else these quotations capture something of the tone of writing on this subject.

First, Teghtsoonian (2009) from the University of Victoria linked mental health depression with neo-liberalism and determined that neo-liberal policies produced: “negative effects . . . on diverse groups of women and other marginalized communities” (p.30). So that neo-liberal policies: “contributed to its [depression’s] widespread prevalence” (ibid, p.30). Second, Salmon (2011), from Vancouver, in a paper on aboriginal mothering, fetal alcohol spectrum disorder (FASD) and neo-liberalism argued that: “FASD prevention . . . [feeds] into neo-liberal

¹⁶ See Blecher (2006) and/or Fiala (2003) for a fuller explanation of the Stoic position. See Wilson (2008) regards Epicureanism.

¹⁷ Not all Republican or Tea Party supporters are neo-liberals. A fuller exploration would want at this point to distinguish between neo-liberal and neo-conservative ideas. Moreover, opposition to the Health Care Reform came from a variety of sources. Some Democrats in the House of Representatives opposed the bill and we might therefore assume that some Democrat supporting nurses (i.e., nurses who are neither neo-liberals nor neo-conservatives) also reject this measure.

¹⁸ An unlimited CINAHL search performed in early April 2012 produced 154 hits for the keyword ‘neoliberal’ and 114 hits for ‘neo-liberal’. A reasonably large review of located papers (n>40) identified none that were favourable to neo-liberalism/neoliberalism and only one that was ‘neutral’ (i.e., Ayo, 2012). Negative commentaries are not only confined to the nursing literature. Non-nursing publications such as the *International Journal of Health Services* also carry hostile pieces. See, for example, Collins and McCartney (2011) who argue that “the west of Scotland became a particular target for [neo-liberal] political attack planned by the UK Conservative Party” (p.501).

policy agendas in ways that can compromise social justice concerns of Aboriginal peoples, women and people with disabilities” (p.172).

No opinion is offered regarding the soundness or otherwise of these descriptive claims.¹⁹ However, neo-liberal policies have been enacted by democratically elected governments and, presumably, some nurses voted for these administrations. Following this, scholars who are antipathetic to neo-liberalism cannot, in their writings, claim that they represent or mirror the spectrum of views that exist in the wider public or professional community. It is acceptable to hold and present ‘an’ opinion. (It may be a virtue.) Yet however sincerely or strongly opinions are held, readers of nursing literature need to be cognisant of the partiality of views being expressed. Claims that imply or state that nurses do, should or must act in some way or claims that disparage or support political positions are not always accompanied by the phrase *from this perspective*. Neo-liberal views are discounted in many nursing texts and scholars infrequently acknowledge the indeterminate and partisan nature of their arguments.

The literature also contains statements that promote or require political activism. For example, the CNA *Code of Ethics* (2008) states that:

nursing ethics is concerned with how broad societal issues affect health and well-being. This means that *nurses endeavour to maintain awareness of aspects of social justice that affect health and well-being and advocate for change*. Although these endeavours are not part of nurses’ core ethical responsibilities, they are part of ethical practice and serve as a helpful motivational and educational tool for *all* nurses.

CNA (2008, p.2 – italicisation added)

And, similarly, the preface to the American Nurses Association *Code of Ethics* (ANA, 2001) says that:

Nursing has a distinguished history of concern for the welfare of the sick, injured, and vulnerable and for social justice . . . *Nurses act to change those aspects of social structures that detract from health and well-being*. Individuals who become nurses are expected not only to adhere to the ideals and moral norms of the profession but also to embrace them as a part of what it means to be a nurse. The ethical tradition of nursing is self-reflective, enduring and distinctive. A code of ethics makes explicit the primary goals, values and obligations of the profession.

ANA (2001, Preface – italicization added)

A lot might be said about the status of these statements. However, here it is simply noted that, for the CNA “nurses endeavour to maintain awareness of aspects of social justice that affect health and well-being and advocate for change” (2008, p.2) and, while this is not a ‘core ethical responsibility’, it unconditionally applies to ‘all nurses’ who are subject to the CNA. Likewise, the ANA require that “Nurses act to change those aspects of social structures that detract from

¹⁹ This is not a hostile comment. It is nonetheless worth noting that, in general, papers decrying neo-liberalism often define the object of their censure in subtly different ways (so it is not always clear that they are discussing the same object). Further, despite this subjectivity in definition, the nursing literature does not appear to acknowledge that varieties of neo-liberalism exist. It is rather assumed that only one form of economics and only one form of politics describes this perspective. Theorists associated with neo-liberalism (e.g., Von Mises, Hayek, Friedman, etc), theorists who might or might not reject the epithet, have however been willing to accept, for example, differing levels of and rationales for government intervention in the market (e.g., Hayek was more amenable to government activity and redistributive taxation than Von Mises – Caldwell, 2005). Though the following two claims cannot be quantified; (i) nurse scholars do not or rarely cite primary sources when discussing neo-liberalism (e.g., I can locate no citation for Von Mises in the nursing literature). (ii) They also seem to make generalisations that gloss important variants in these positions. For the sake of brevity neo-liberalism is henceforth described *as if* it were one thing. However, weaknesses in this approach are readably acknowledged.

health and well-being” (2001, preface) and, in this instance, individuals who become nurses are explicitly required to accept this norm. In both instances political claims (claims requiring nurses to act to affect societal change) are incorporated in (conflated with) ethical claims.

These statements oblige nurses to interest themselves in political activity. Where claims languish as abstractions little is at stake. However, should these statements attach to specific policies (e.g., policies favouring an enhanced role for government, increased state intervention in ‘the market’, or more expenditure on health – perhaps to enhance well-being?) then many nurses, and not just neo-liberal nurses, might object. It is therefore of interest that the ANA have been active supporters of President Obama’s Health Care Reform Act²⁰ and, yet, some Democrat nurses, many and possibly a majority of Republican nurses and probably almost all nurses who support the Tea Party will, we might assume, hold personal views at odds with the ANA’s position.

The key point here is that, whatever the merits of a particular piece of legislation, individuals belong to many different groups and nurses are not merely members of a profession. They can also hold political views and have political affiliations that conflict with those espoused by their profession. Values associated with professional and political groups need not be harmonious, they can conflict, and when this happens individual nurses may find themselves ‘at odds’ with scholars and bodies speaking (ostensively) on their behalf or, rather, on behalf of the group of which they are members.²¹

Moreover, as was noted, major philosophic traditions problematise political engagement. Ancient traditions were used to make this point, though modern ones could also suffice; however, whether ancient or modern, nurses can be attracted to logically valid philosophic positions that do not tally with the assumption that political engagement is a ‘good’ and, for example, a nurse who accepts Epicurean precepts must, one assumes, meet the aforementioned CNA claim with ennui or apathy. There thus exists a potential tension between philosophy and the world, or, at least, Epicurean Canadian nurses and the CNA.

Turning from group (CNA) to individual (scholarly) agents, Chaffee *et al* (2012), in Mason *et al*’s (2012) book *Policy and Politics* list the who, what, where and why of what is claimed to be ‘nursing’s policy influence’ and, under the caption ‘why do nurses act to influence policy’, it is asserted that nurses act to improve access to care as well as removing “disparities in care” (p.8).

As with CNA and ANA claims cited above, insofar as individual nurses who disagree with these statements can overlook them, then no one need object. However, in the context of this text, Chaffee *et al* (ibid) use the descriptor ‘nurses’ in a manner that implies *all* nurses. This usage is critiqued shortly. For now it is simply suggested that if Chaffee *et al*’s (ibid) claim applies to all nurses then it is problematic.

From a neo-liberal perspective both claims are suspect. It could be argued that access to care would, on aggregate, be improved if markets functioned unimpeded by government-regulatory intervention or, contrariwise, government-regulatory intervention might be necessary to meet this same objective. As phrased Chaffee *et al*’s (ibid) statement is open to alternative interpretations and it therefore lacks precision. However, within the context of the text the latter rather than the former interpretation appears to be being promoted and the idea that disparities in care should be removed cannot easily be reconciled with the notion of unimpeded market operations. Thus, in both instances, neo-liberal nurses cannot accept Chaffee *et al*’s (ibid)

²⁰ Commenting on political matters in an unfamiliar country is notoriously risky. However, support for this claim comes from documents at: http://www.rnaction.org/site/PageServer?pagename=nstat_HCRT_Resources&ct=1 – accessed 24.04.12. See also Chaffe *et al* (2012, pp.1-3) on the role of the ANA regards the Patient Protection and Affordable Care Act.

²¹ This distinction is important and more work needs to be done to develop and explore this issue. When speaking on behalf of the group ‘nurses’ the CNA and/or ANA can but need not play a representative role.

prescription and, since the claim is phrased in a manner that suggests it applies to all nurses and since not all nurses can accept the claim, its ‘legitimacy’ may be queried.²²

In response, the authors of this and kindred texts might argue that this presentation misreads or misinterprets their position. More specifically it could be claimed that, insofar as the above analysis ‘infers’ meaning, this was not what was ‘implied’ by the authors.²³ If it held this would be a significant rejoinder. And, yet, if Chaffee *et al* (ibid) only intended to mean that their claims applied to nurses of a particular political persuasion then this is not what they say, they do not make this clear.

Does this matter? Does it matter if individual nurses do not support the political claims that are made on their behalf, claims made by individual and group agents in the name of the group they are members of? I think it might. We must assume that nurses vary in their political views. They therefore have different ideas about how society should be organised and health and social care delivered. If those who speak on behalf of the group ‘nurses’ are to maintain the support and allegiance of the members of that group (if their claims are to ‘make sense’) then this problematic must be acknowledged. To explore tensions between individual and group views in more detail the fallacy of composition and, thereafter, the concept of collective ascription error is introduced.

Hume and the fallacy of composition:²⁴

Scottish enlightenment philosopher David Hume wrote on many subjects including political philosophy. Hume is an accessible author and his work has been variously interpreted. Whilst alternative readings are possible the understanding presented here is guided by renowned Hume scholar Russell Hardin.

Following Hardin (2007), Hume was interested, as were many in his day, in political theory and the nature of social order. Hume proposed that three broad categories of theory describe how social order is created and maintained. These theories are labelled arguments from force, arguments from shared value and, his own contribution, the argument of coordination. This presentation does not go into detail about force or coordination theories;²⁵ instead the focus is upon shared value theory and its dismissal by Hume.

Shared value theorists assume that states or bodies/groups coalesce around a shared value or values and religious or religious-like beliefs have been associated with this role. Thus religiously inspired philosophers and, in the modern age, communitarians and sociologists such as Talcot Parsons and August Comte have been linked with shared value theories (Hardin, ibid).

²² This example might give the false impression that only neo-liberals encounter difficulty with political claims made on their behalf. However, in a paper by Buettner-Schmidt and Lobo (2011) the following assertions appear: (i) “The term *social justice* is used in documents guiding practice for nurses” (p.8, italicisation in original) and (ii) “Attributes of social justice include . . . equity in the distribution of power, resources, and processes that affect the sufficiency of the social determinants of health” (p.8). Most nurses with centre-right political affiliations and many centrists could object to demands for unlimited/unbounded equity in the distribution of power and resources. (Indeed, only a minority of radical socialists would support the statement as framed.) Further, it is not at all clear what “equity in the . . . processes that affect the sufficiency of the social determinants of health” (ibid, p.8) actually means/implies (i.e., it is unclear what policy options follow on from acceptance of this claim). Alternatively, Trossman (2011) says in *The American Nurse* (official publication of the ANA) that the ANA is supporting “All along the way” (p.1) lobbying activities aimed at assisting and supporting specific pieces of health legislation – legislation that, as noted, some ANA members may have voted against (insofar as they voted for candidates who represent parties/positions that reject this legislation). From a left-wing perspective most political claims probably do not go far enough.

²³ Insight suggested by P C Snelling (personal communication, 2012).

²⁴ The term ‘fallacy of composition’ is not here used in a cosmological/religious sense (e.g., see Reichenbach, 2008).

²⁵ That said, Thomas Hobbs, whose ideas were formed during a time of violent upheaval and unrest might stand as an apologist for arguments from force (Hardin, 2007). From this perspective legitimate sovereign rulers in non-failing states should use violence or its threat to maintain social order for the greater good. Subjects know this and willingly or otherwise they recognise this as necessary. Humean coordination theory might be described or summarised as a precursor of rational choice or modern game theory.

Hume proposed however that the plausibility of the idea that society is glued together by shared values collapses as soon as we think about it critically.²⁶ To paraphrase Hume’s position, outside of exceptional circumstances (unless the barbarians are at the door), it is unlikely that modern, dynamic, successful, liberal, democratic and diverse societies hold together because their members share common values. Hume wrote in the 18th century. He saw the society of his day as being riven or split along numerous fracture lines (e.g., property/wealth, religion etc.) and one might suppose that today’s multicultural and globalised communities are even more diffuse, even more fragmented.

For Hardin (*ibid*), in this argument, Hume identifies a version of the fallacy of composition. This fallacy describes a situation in which individuals attribute personal beliefs/opinions/values to the group or collective that they are members of.²⁷ Shared value theorists commit the fallacy of composition when they erroneously assume that the nation or collectivity is bound or held together by shared values because they hold those values.

But how do we know such assumptions are erroneous? Hume the sceptic, the empiricist, would want claims about shared values to be supported by evidence and it must be questioned whether substantive evidence in favour of shared communal values, values strong enough to counter disunity, values capable of playing the role allotted to them, could readily be sourced. This is not to say that groups cannot or do not share values and, for example, in times of peril, fear, of war, the uniting focus of shared values might have utility. However, if external threats are necessary for internal coherence then, we can ask, what happens when external threat recedes?²⁸

As Hardin (*ibid*) notes, it can be difficult to argue against shared values.²⁹ It is difficult because, first, the arguments in which shared values sit often assume rather than explicitly state that values play this ‘binding’ role. And, second, value claims lodged at an abstract level rarely excite offense. In practice shared value claims are frequently expressed in a vague and ambiguous manner.³⁰

For example, Chaffee *et al* (2012) state that: “After decades marked by nurses’ fighting to make their perspectives on care count, the nation is realizing that they are key to making this shift a reality” (p.1). The ‘shift’ referred to here is a multifaceted thing that includes resource re-distribution and re-focusing care towards health promotion. However, what, we might ask, do the descriptors ‘nurses’ and ‘the nation’ mean here? Are Chaffee *et al* (2012) suggesting that all nurses fought for this recognition? Presumably not. Further, Chaffee *et al* (*ibid*) cannot mean the whole nation because their own text recognises opposition to reforms supported by the ANA (and by implication nurses) a few paragraphs later and, in addition, a 2010 Gallup poll is cited that found “only 14%” (p.3) of non-nursing opinion leaders thought nurses capable of influencing healthcare reform.

²⁶ Criticisms of shared value assumptions come from a variety of sources and, for example, Archer (1996) similarly recognises that, in sociological theory, ‘culture’ has been assumed, implausibly, to be a repository of shared universal understandings and ways of behaviour. Alternatively Anderson’s (1993) *Imagined Communities* perhaps raises similar issues albeit differently framed.

²⁷ Hummel (1990) takes a similar position to that of Hardin (2006, 2007). However, whereas for Hardin (2006): “A common move in social explanation is to attribute to collectivities the motivations or capacities of individuals . . . [and] We commit this fallacy whenever we suppose the characteristics of a group or set are the characteristics of the members of the group or set *or visa versa*” (p.5 – italicisation added), contra Hardin (2006), Vermeuele (2009) distinguishes between fallacies of composition and fallacies of division. Thus in the fallacy of composition “the assumption that what is true of the members must also be true of the aggregate. In the . . . [fallacy of division] the assumption that what is true of the aggregate must be true of the members” (*ibid*, p.4).

²⁸ As an aside, revisionist historians suggest that the British wartime ‘blitz spirit’ (‘pulling together’ in the face of death) was in large part a deliberately manufactured propaganda myth (e.g., see, Jones *et al*, 2004). This suggests that even in times of peril we should look for evidence of shared values before accepting their existence.

²⁹ Moody and White (2003) likewise note that “social cohesion . . . [is] vague and difficult to operationalize” (p.105). Jones (2005) and, from a different perspective, some modern game theorists (e.g., Olson, 1971); explore how disputable propositions are allowed to go unchallenged.

³⁰ Vagueness and ambiguity are not the same thing (Van Deemter, 2010).

This sort of ‘overegging’ might come about because scholars assume that nurses share values *and* this sharing allows/promotes collective action (in this particular instance something similar may also be happening vis-à-vis ‘the nation’). However, without evidence we should not assume that any group is bound together/acts primarily or substantively because its members share values. If we make this assumption without empiric support we may commit the fallacy of composition. Likewise, without convincing evidence we cannot assume that ‘nurses’ or ‘nursing’ – i.e., the sum of all individual nurses or a majority of nurses – are united by shared values in any meaningful sense (though many or all nurses might share trivial ‘understandings’).³¹

Collective Ascription Error:

Todd Jones (2005) has authored an excellent and very readable paper titled: *How many New Yorkers must like bagels before you can say New Yorkers like bagels* and, helpfully, the argument presented in that paper is in some measure captured by the title. The title alone highlights the problem or issue being identified.

Jones (ibid) explores the way in which language ascribes or appears to give coherence to group descriptors (termed collective ascription). He argues that while language collectively ascribes group coherence the real world legitimacy of this ascription must often be refused. For example, we might say that New Yorkers like bagels. However, not all New Yorkers like bagels and, where we to perform a survey then we might find that a majority of New Yorkers do not like bagels. Yet since New York is renowned for, amongst other things, bagel consumption, ordinary language use appears to sanction this sort of discourse.

Recalling the CNA (2008) claim that: “nurses endeavour to maintain awareness of aspects of social justice” (p.2), we might presume that in this statement collective ascription error occurs since, although some nurses may act in this way, others probably do not. However, saying ‘nurses’ without inserting a qualifier, indeed without a quantified determiner (e.g., 48% of nurses act in this way), the statement appears to erroneously presuppose that all nurses do this thing. It is thus assumed that ‘nurses’ refers to or is indexical of a global generalised quantifier and, as such, set theory takes it that “the most general meaning of determiners” (Glanzberg, 2006, p.51) is being described – i.e., in this instance the total set of all nurses rather than merely some nurses is assumed.

The point being made by Jones (2005) and, indeed, others (e.g., Van Deemter, 2010), is that we must not mistake or confound ordinary language use claims with the reality of the thing being described. Language use often involves collective ascription; however, collective ascription *error* occurs when language leads us to falsely attribute unwarranted common features to groups. And when statements with a political component lay claims upon all nurses, and when those claims do not or cannot apply to all nurses then logical and other problems are generated. In speaking and often in writing it would be cumbersome not to say nurses or nursing when describing our profession. Yet when we say ‘nurses’ and imply ‘all nurses’ this assumption can be unwarranted. Collective ascription is (tautologically) erroneous when it is inaccurate.

Three classes of overt or implied propositional statements (‘empiric’, ‘normative’ and ‘regulatory’) appear in the politically orientated writing of some nurse scholars and nursing organisations and, in each instance, greater clarity is required since either the fallacy of composition and/or ascription error may be present. When these errors occur poor or weak arguments are presented. Since we care about the strength of our arguments, because we want to persuade others, this is important.

³¹ It is also worth noting that if group agents (e.g., the CNA or ANA) form and hold representations and motivations towards, for example, the notion that a particular healthcare reform be accepted/promoted, then those intentional states cannot simply result from the aggregation of majoritarian attitude preferences (i.e., voting). This would collapse agency to individualism and, following List and Pettit (2011), this move may produce a variety of paradoxical outcomes (e.g., the paradox of majoritarian attitude aggregation).

Empiric claims:

The CNA (2008) statement: “nurses endeavour to maintain awareness of aspects of social justice” (p.2) is, as noted, an example of an empiric statement that in all probability commits collective ascription error for, if not all nurses act in this way, then the proposition is false.

It might however be objected that this is too strict and perhaps, more pragmatically, we should allow that not everyone has to do whatever is demanded for these types of statement to ‘ring true’. In this vein both Austin and the later Wittgenstein (and others) recognise that when we speak we use words loosely. Indeed, the meanings carried by words in use are often vague and uncertain. We want to be as exact and precise as we can be whilst avoiding stultifying pedantry and, in this quest, as Van Deemter (2010) put it: “It would be foolish to sacrifice utility for precision” (p.69). That seems reasonable. Yet even if we take a looser or more generous approach to propositional clarity, some assertions made by agents such as the CNA are vulnerable to critique since, if anything other than a small minority of Canadian nurses do not endeavour to maintain awareness of social justice (definitional and measurement problems notwithstanding) then the statement remains ‘uncarried’.

Claims that nurses ‘believe’ or ‘act’ are often strictly false. We can only ever sensibly say that a certain number or percentage of nurses believe some thing or act in some way. Unbounded empiric political claims may rest on the assumption that all nurses share similar values and such claims probably involve or commit collective ascription error. Group agents with regulatory/governance powers can assert claims against the views of individual members. However, whether group agents can enforce their will is another matter? Individual agents (e.g., lone scholars) who make empiric political claims are, perhaps, speaking only to a constituency of nurses (i.e., nurses who share their opinion).

Normative claims:

Normative claims differ from factual claims³² and many (possibly most) normative theories seek to make universal claims. Nonetheless, large numbers of politically resonant normative assertions are made by nurses and a great number of normative burdens are placed upon nurses.

For example, Browne and Tarlier (2008) from the University of British Columbia state in a paper on social justice that nursing practitioners “ought to be concerned about . . . the powerful association between neoliberalism and increasing inequalities” (p.88). Browne and Tarlier (*ibid*) are clear and open about their political orientation. However, they nonetheless assert a normative claim on all nursing practitioners to recognise a link between neo-liberalism and inequality and, in the context of their paper; this is seen as a grave ill. Moreover, their claim applies to nursing practitioners because, professionally, they occupy that role. The claim applies irrespective of practitioners’ personal political beliefs, beliefs that might include neo-liberal elements. It is assumed that nursing practitioners can and should share common political values. The claim encompasses a form of collective ascription error.

In this instance the normative status of the claim advanced is overt. However, normative assertions are often implied. For example, the following statement appears in a paper by Van Herk *et al* (2011) who are based at Ottawa.

Although notions of social justice are often touched upon within nursing education, nurses need to take personal initiative to further explore issues of power, privilege, and oppression within their practice and profession.

Van Herk *et al* (*ibid*, p.29)

³² This distinction can be overdone. Hare (1964) noted that: “almost every word in our language is capable of being used on occasion as a value-word (that is, for commending or its opposite): and usually it is only by cross-examining a speaker that we can tell whether he is so using a word” (pp.79-80).

The normative component here is located in the word “need” which is, in this instance, in the context of the paper, synonymous with ‘ought’ or ‘should’. This is a professional moral claim. It is a categorical imperative insofar as, while it does not apply to everyone; it unconditionally applies to ‘all nurses’. It is certainly more than a hypothetical imperative. And it is more than this since the claim is closely tied to the conditional suggestion that failure to engage with this issue “affects who is perceived as a ‘good nurse’” (ibid, p.30). Van Herk *et al* (ibid) do not push this issue; however, we can perhaps ask, if nurses who do not do this thing are not good nurses then what should happen to nurses who refuse this claim, or, what should happen to those who accept the claim but who then do not explore issues of power?

At a minimum, moral reprobation is called for. But since we want nurses to be good nurses then perhaps other stronger strictures might also be appropriate.³³ If we assume that those making normative claims on nurses mean what they say then nurses who refuse or fail to meet these claims are morally at fault and this is no small matter. It is clearly important when we are talking about professional practice.

Regulatory/Governance claims:

It has been noted that ANA and CNA claims seem to demand political engagement and, as agents, these sorts of body are empowered to make demands of members. Regulatory/governance claims must generally be met. However, claims upon action that conflict with individual beliefs may be ignored and when large numbers (significant percentages) of nurses fail to meet such claims then regulatory/governance systems lose credibility. Political claims of the sort referred to in this presentation are vulnerable in this respect.

Further, although claims emanating from regulatory/governance bodies may be phrased using the normative ‘should’, it is difficult to imagine that individual leeway in interpretation is permitted and, for example, the claim: “Nurses should endeavour as much as possible, individually and collectively, to advocate for and work toward eliminating social inequalities” (CNA, 2008, p.20) is, as previously stated, presumably not optional.

This places individuals with alternative political outlooks in an invidious position and, for example, Wilmot (2012), of the University of British Columbia, recently argued that the CNA was, to use his terminology, moving away from ‘liberal civic professionalism’ and towards what he defined as contextualism. If Wilmot is correct, and his paper is persuasive, then we might wonder at the position of liberal Canadian nurses. What will their relationship be with the CNA if that body embraces a version of social justice that is at odds with their individual beliefs? In this instance we must remember that the CNA can enforce its will with more than moral reprobation and, while contextualism is not yet explicitly framed as a regulatory/governance injunction, it might be expected (following Wilmot’s, ibid, argument) that overtly non-liberal claims may soon be framed.³⁴

Concluding comments – John Locke and the need for non-politicised spaces:

When political claims are made of nurses and when ‘nurses’ mean all nurses then we might expect that some individual nurses will object to or refuse those claims. In certain instances ‘some’ nurses may be a majority of nurses. Conflict can therefore exist between individuals and the group (here nursing) to which they belong. Recognising the potential existence of this conflict is important. Recognition can permit overbearing claims to be shunned. It can allow more sustainable or realistic/acceptable claims to be made.

³³ P C Snelling (personal communication, 2012) suggests that many ‘should’ claims of the sort described in this presentation actually reference ‘good’ nurses rather than ‘minimally acceptable’ nurses. The claims are thus aspirational in tone and content. Prefixing these claims with ‘good’ raises its own problems however. Good now means ‘nurses who agree with’ whatever claim is being made and, by implication, those who do not act as prescribed or those who disagree or demure are not ‘good’ nurses solely because disagree with the claim being advanced.

³⁴ This paragraph reproduces material in Lipscomb (2012).

At least two interlinked problems beset some claims levied upon nurses by group agents (e.g., the CNA) and individual scholars. First, unproven and possibly false assumptions regarding shared values may encourage claims that incorporate or make the fallacy of composition (Hardin, 2007, on Hume was introduced to illustrate this ‘problem’).³⁵ Second, following Jones (2005), ordinary language use allows collective ascription even though this ascription is often erroneous. In everyday conversation both errors generally pass unrecognised. However, when political claims seek to direct action in professional nursing practice, and when claims incorporate or are built upon these errors, then discord and imprecision may result. Mistaken assumptions about shared values can prompt collective ascription error.

It is suggested that although individual nurses and groups of nurses can and do act as intentional political agents – as is appropriate – we ought to be wary of claims that insist that all nurses collectively do (empiric), should (normative), or must (regulatory) act similarly. Political claims made by scholars upon nurses ought to recognise the particular political perspective being advanced. Claims emanating from regulatory/governance bodies should be tempered so that unnecessary individual-group dissonance is mitigated or avoided.³⁶

For John Locke, civil society rests in the last instance upon consent and, analogously, in the ‘realm’ of nursing, neither individual scholars nor group agents can dispense with the consent or acquiesce of those petitioned. Locke suggested in *An Essay concerning Toleration* and other writings (2006 [1667-1683]) that, while subjects must obey rulers, rulers cannot sensibly claim obedience in all spheres. Locke was principally concerned with religious freedom. However, parallels between the right to freedom in religious and political belief can and have been made. Further, in *The Second Treatise of Government* (1980 [1690]) Locke states that:

nor can any edict . . . have the force and obligation of a *law*, which has not the *sanction* from the *legislative* which the public has chosen and appointed: for without this the law could not have that, which is absolutely necessary to its being a *law*, *the consent of the society*, over whom no body can have a power to make laws, but by their consent

Locke (ibid, pp.69-70 – italicisation in original)

³⁵ See also Thompson (1992) on essentialism and identity politics. In key respects the critique offered here can be read as challenging the idea that nursing has an essence and/or a universal identity of interests.

³⁶ On the other hand, group-individual conflict is sometimes appropriate and necessary. Thus the proposition: ‘racist acts committed by nurses must result in dismissal’, is one that most people, this author included, accept. Such acts cannot be tolerated by regulatory/governance bodies even if individual political views/values explain such acts *and* these views/values may in other areas of civil society be tolerated. However, it is also the case that this proposition creates potentially awkward problems for regulators. For example, Marine Le Pen of the National Front party secured 17.9% of votes in the first round of April’s 2012 French Presidential elections. Many people believe the National Front is, on the basis of its anti-immigration policy, a racist party (though they deny this). Balle (2012) reports that as many French woman as men voted for Le Pen (24th April – *The Wall Street Journal*) and we might assume that some of the 6.4 million votes garnered by this party’s candidate came from French nurses.

If, for the sake of argument, nurses voting for Le Pen are voting for a racist candidate then this might count as *prima facie* evidence that they also share racist views – that they are racist. It would be odd to suggest that voting or campaigning for a legally constituted party could, in itself, lead any nurse into conflict with their regulatory/governance body (see NMC, 2008, for a UK commentary on this issue) – albeit that prominent participation in a party such as the National Front might conceivably lead to ‘friction’ in the work environment. Nonetheless, putting Le Pen to one side, can nurses who merely think racist thoughts be nurses? Is it acceptable to be a racist so long as one does not act in a racist manner?

The proposition described above refers to acts and not beliefs. However, some people would want racists (those holding racist beliefs) to be excluded from the profession even if they did not act in an overtly racist manner. This clearly raises complex questions. It is not necessarily clear whether regulators/governance bodies should or should not penalise nurses whose beliefs but not actions run counter to accepted norms. (And the status of speech acts requires clarification.) If possession of disallowed beliefs is sufficient to warrant censure then, presumably, regulators/governance bodies would have to determine what is and is not an acceptable belief. This would be difficult since – assuming such a process is in principle possible – with some few exceptions, not only would the specific contents of any prohibited belief list be challenged but, also, sorites type problems would be encountered in determining whether beliefs of this or that strength/level require correction/punishment.

Political claims made by nurse regulatory/governance bodies (claims directing the actions of individual members of the group regulated/governed) which lack the consent of the governed are, extending Locke’s criteria, of doubtful or uncertain legitimacy.

To clarify questions surrounding issues of legitimacy (and using the CNA as a representative group agent); first, we might ask what number/percentage of nurses subject to CNA political claims, sanction that body to make such claims. Second, we might ask what number/percentage of nurses agree/disagree with specific claims made. Third, we might ask whether the wider society (nation/jurisdiction) sanctions the CNA to make such claims. Fourth, even if most nurses agree that the CNA can make political claims, and even if specific claims are approved, and even if the wider society allows this, it could still be argued that to safeguard alternative/minority viewpoints, individual political beliefs and the actions they inform should not be subject to external control, direction or censure. Thus – and this is a controversial suggestion – mindful of the indeterminate nature of normative argument, it may be inappropriate for agents such as the CNA to assert that nurses collectively should or must act to affect political change where such acts conflict with the reasonably held views of individual nurses.

Locke’s *Essay concerning Toleration* (2006) and Chapter XV of the *Second Treatise* (1980) advise political rulers to leave ideas and beliefs most suited to individual reflection and action to individual discretion. It may be that agents such as the CNA (but also scholars) risk failing to allow individual nurses non-politicised ‘spaces’. Group political claims upon individual actions might in some instances be viewed as unreasonable or transgressive.

To conclude, it is proposed that greater clarity is required when agents (individuals or bodies) advance political claims. Specifically, first, claimants should be clear about the status of political claims being advanced (i.e., are they making empiric, normative or regulatory claims?). Second, claimants should indicate what the descriptors ‘nursing’ or ‘nurses’ covers – i.e., do ‘nurses’ refer to (i) *all* nurses, or (ii) are only *some* nurses captured by the descriptor (and if so what number or percentage of nurses are described), or (iii) is the term ‘shorthand’ for a group agent or some other thing? Third, claimants should make clear what penalty (if any) is incurred by nurses (individuals) who refuse political claims or who accept but then fail to meet claims. Fourth, the authority by which claimants assert political claims that direct the actions of some or all group members should be explicitly stated. In principle these suggestions are not onerous and if accepted they might improve political discussion. They might help to protect political arguments from criticism and, if error can be avoided, then that is a good.

Postscript:

To restate, this presentation seeks to better understand one aspect of the way in which nursing agents discuss ‘the political’. It does not question or downplay the value or worth of nurses engaging in political debate. Hopefully it is a self-evident truism that nurses have an enormous amount to contribute to political dialog and the absence of nursing voices from key political contests can only be lamented. The argument presented here is not hostile to political action or political discourse; indeed, I would personally like to see considerably more discussion/activity by nurses in the political arena.

The presentation is moreover, as stated, a work in progress (therefore these notes do not constitute ‘a paper’). No doubt much could be improved and, additionally, concentrating upon how nurses ‘speak to’ nurses may be unduly inward looking when the profession’s focus should perhaps be outward facing. Further and finally, both the fallacy of composition and collective ascription error clearly raise questions about non-political as well as political discourse.

Despite these weaknesses/issues I think I am nudging towards something of interest and I look forward to talking through these issues with others at this year’s uPNR conference.

Martin Lipscomb – presentation notes – May 2012

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