Every person matters: enabling spirituality education for nurses

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Aims and objectives. This paper aims to identify how the statutory requirements relating to spirituality in nurse education can be supported in preservice and in-service education, in the context of inter-professional working implied by every child matters (Department for Education and Skills (DfES) *Every Child Matters: Change for Children*. DfES, Nottingham DfES 2004a; *Every Child Matters: Change for Children in Health Services*. Department of Health, London 2004).

Background. The basis for this paper is an exploration of the current requirements relating to spirituality in nursing and the consequent requirements for training and education clarified in part through a consideration of parallel policies on spirituality in school education. Inter-professional work, for example, across health, social care and education professions, has a long history in nursing and the changes brought about by the every child matters policy initiative have given such inter-professional work a considerable boost. That policy change has encouraged consideration, in this article, of some common issues arising in nursing and school education professions.

Method. This paper consists of a critical review of current and in-coming statutory requirements related to spirituality, nursing and nurse education, and a synthetic review of definitions of and approaches to meeting spiritual needs.

Conclusion. The emergent relational framework for considering spirituality in nurse education acknowledges the ambiguity of spirituality and treats that ambiguity as in some ways enabling rather than constraining.

Relevance to clinical practice. It is not simply that nurse practice will be likely to change with respect to children. Every person will, in the terminology of the policy, 'matter': there is significant urgency to consideration of effective education and training provision.

Key words: ambiguity, every child matters, nurse education, relationships, school education, spirituality

Introduction

Spirituality is embedded in nursing practice. A good understanding of the rôle of the registered nurse may be obtained through the Nursing and Midwifery Council (NMC) Standards of Proficiency for Preregistration Nursing Education (NMC 2004b). Based on a revision of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting's (UKCC) 2001 requirements for registration and some aspects of statutory instruments and council policy (NMC 2004b), the documentation is explicit in the requirements for registration, stating that preregistration nurses should assess

and have skills to meet the 'spiritual needs' of patients and should take account of and provide a rationale for taking account of 'spiritual … influences' (NMC 2004b, p. 5, 25, 28, 30). Whilst the NMC's code of professional conduct does not stipulate *per se* the importance of spiritual care, Standard 2·2 alludes to spiritual care as an aspect of an individualized patient – and client-centred approach, stating that the nurse is '…personally accountable for ensuring that [he or she] promote[s] and protect[s] the interests and dignity of patients and clients, irrespective of gender, age, race, ability, sexuality, economic status, lifestyle, culture and religious or political beliefs' (NMC 2004a, p. 5). Also relevant to spiritual care in nursing is Standard 3·2 which states that nurses and midwives '…must respect patients' and clients 'autonomy – their right to decide whether or not to undergo any healthcare intervention – … unless a court of law orders to the contrary' (NMC 2004a, p. 5).

This raises issues about the rights of patients and clients to access knowledge and understanding regarding the way they are cared for. On understanding that an 'holistic' nursing care approach is being used, in which the spiritual needs of a patient or client are assessed, a patient thus may wish to identify whether or not spiritual care is given – regardless of the nurse's own assessment of the patient's spiritual care needs. Such complex issues are that much more challenging when considering nursing practice with children and families, yet the very challenges set by revisions in children's services help generate a model of spirituality and professional education and training that can apply across nursing.

The NMC's commitment to assessment informing patient- and client-centred spiritual care is unmistakable and thus serves to inform preregistration nurse education institutions. However, McSherry (2000a)) suggests that many nurses feel insufficiently prepared to meet the spiritual needs of their patients and that this, despite the seemingly genuine desire by nurses to extend their knowledge of and capacity to deliver, spiritual care seems to stem from a '…mismatch between the expectations of education and the reality of practice' (McSherry 2000a, p. 40). Furthermore, recent research by Lehair (2005) identifies a disparity between the desire of most practitioners to care holistically and the feelings of inadequacy felt by many as a consequence of the perceived difficulties in providing spiritual care. Also evident from the nursing literature is the notion that the complexity of spiritual care relates not so much to professional conduct issues, but rather to the ambiguity associated with spirituality and spiritual care (Harrison & Burnard 1993, Cobb & Robshaw 1998, McSherry 2000a,b, Narayanasamy 2001, Orchard 2001, McSherry *et al.* 2004). Indeed, recent evidence suggests that the NMC's stress on spiritual care in

recent years may have created an even bigger gap between nurses and patients, through their contrasting definitions of spirituality, with nursing staff often following a more 'universalistic' definition that 'goes beyond religious affiliation' (perhaps drawing on the official guidance), whilst patients commonly see spirituality as 'synonymous with religion' (McSherry *et al.* 2004, 937–938). It is important that nurse education, therefore, avoids any risk of making nursing less, rather than more, sensitive to patients' own understandings of their situations.

Spirituality and nurse education

McSherry identifies five key issues in nurse education relating to the teaching of spirituality:
(1) What is spirituality?
(2) Why is it necessary to address the spiritual dimensions in nurse education?
(3) How is it taught?
(4) When and where is it taught?
(5) Who should teach spirituality? (McSherry 2000a, p. 40).

As in school education, a consequence of the requirement to deliver spiritual care (or in schools, to develop children spiritually) is an apparent need for spirituality to be placed in its policy context and to be properly defined. In school education, the statutory requirement to develop children spiritually has been in place since the 1944 UK Education Act 'duty to contribute towards the spiritual, moral, mental and physical development of the community' (Bell 2004, p. 5). As a significant piece of social welfare legislation, the philosophy behind the 1944 Act was both whole child and community centred. The later 1988 Education Reform Act (DES 1988) was even more aspiring, stating that the school curriculum should promote not only spiritual, moral, mental and physical development, but cultural development also (Bigger & Brown 1999) and the current statutory requirement in England is for schools to 'promote pupils' spiritual, moral, social and cultural (SMSC) development…' (DfEE/QCA 1999, p. 11). In contrast to nursing, however, an almost reverse scenario is evident with regard to spiritual development in education: whilst the statutory requirement to develop children spiritually is firmly in place, the associated requirements for initial teacher education are at best inferential, with none of the Standards for qualified teacher status (QTS) referring directly to spiritual development, but only references to being 'aware of and work[ing] within, the statutory frameworks relating to teachers' responsibilities' (TTA 2004, p. 13).

Defining spirituality in nursing and schooling alike requires an account of the three most common themes or theories in

the professional and philosophical literatures. Nurses and nurse educators should be engaging with these theories, rather than simply opting in to a single approach (even the approach of the current authors), as colleagues and patients, as well as policy-makers, can in that way be better understood. The term 'spirituality' is well described by Swinton as a 'slippery concept', at least 'within Western culture' (Swinton 2001, p. 12). Along with the need for clarity in this account, therefore, is the need to avoid over-simplifying what are deeply held and fully lived philosophies and ways of life. As Wittgenstein says, slipping along may seem an ideal way to travel, but sometimes, when we want to walk, we need to get 'back to the rough ground' (Wittgenstein 1958, p. 46e, quoted in the context of professional education and 'technique' by Dunne 1997, title and xi). The three themes described here are dualism, materialism (associated also with positivism) and those who go 'beyond' dualism (perhaps described as 'holistic' and/or 'relational' theories). All are linked to various religious traditions, notably in the European and North American literature to various Judeo-Christian traditions (Cobb & Robshaw 1998). As with many definition quests, dictionary consultations reveal a Latin root to the term, with *spirit* translated as 'breath, wind and even life principle' (Robinson *et al.* 2003, p. 21), but it is the complexity of the interpretation, rather than the definition, of spirit that seems to dominate the literature.

The first two sets of theories to be considered, that influence the interpretation of spirituality and spiritual care or development, are dualism and materialism. René Descartes (1596–1650) viewed thought as entirely separate from physical substance, leading to the emergence of mind-body dualism (Macrone 2002) which, for Descartes himself and many since, has been referred to as body-spirit or body-soul dualism (as described, critically, by Macmurray 1991). A dualist analysis might also explain the association by many of spirituality with religion, especially given the strength and significance of the Christian traditions of a separate soul that continues its existence independent of (i.e. after the death of) the body. Pointon's research suggests that such a dualist approach, in the context of a lessening in the commitment to religious dualism (within as well as beyond Christianity), is the reason why student nurses in his study considered spirituality in their education programme to be close to the 'irrelevant threshold' (Pointon 1999, p. 7). In contrast, a wholly materialist approach to spirituality reflects a scientific rational view that everything can be explained in material, substantive terms – or at least has the potential to be explained in this way even if science has not yet yielded tangible evidence to support its theories. Materialists thus view 'spirit' as composed of matter just as the physical body

is and the term spirit may be regarded as a cultural and linguistic synonym for emotion and other higher functioning aspects of the mind (as described in Mason 2000).

Accepting Cartesian dualism when applied to nurse education, Benner (1994) suggests that the spiritual aspect of a person is what distinguishes people from other animals and relates also to the non-material aspect of a person, capable of scientific study. Referring to the hermeneutic tradition, she further states that '[t]o stress that human beings are spiritual beings means stressing that they are beings with a language' (Benner 1994, p. 10). Citing Kuhn's approach to scientific rationalism she argues, therefore, that it is necessary to view patients as subjects, not objects; as either acting rationally, or irrationally due to 'causes'. Thus, for Benner, '[a] science of nursing has to solve the problems of Cartesian dualism' (Benner 1994, p. 12). For some feminist theologians, moreover, healthcare provision itself is dualist, characterized by female provision of material, bodily care; and male provision of care for the 'higher functions' of mind, spirit or transcendence (Grosvenor 2000, p. 28).

An alternative way of dealing with Cartesian dualism would be to follow the structuralism developed within anthropology. A structuralist approach might pose the materialist view of spirit as a binary opposition to the belief held by others that spirit is a (Cartesian) non-material yet real substance. Tension between the two oppositional entities, reflecting the ambiguity in the concepts of spirituality and spiritual development, would be regarded within structuralism as *taboo* (like the incest taboo), which in turn would be regarded as *functional* (Lévi-Strauss 1963).

Challenging both dualism and materialism is a third set of theories that are variously described as 'holistic' and (especially in the current account) 'relational'. Watson's Transpersonal Caring-Healing Model (Watson 1999) offers what she describes as a postmodern approach to nursing, which accepts that 'no one meaning is possible' (p. 289). Rejecting, or at least setting aside, dualist and systematic models, Watson's model is based partly on an ontological approach in which 'being human in relation with and seeking harmony with all else in the universe' is central (Watson 1999, p. 289). For Watson, the 'transpersonal caring moment' is the point at which nursing – including spiritual care – is effected, where '[t]ranspersonal refers to an intersubjective, human-to-human relationship, which encompasses two individuals in a given moment, but simultaneously transcends the two, connecting to other dimensions of being and a deeper/higher consciousness that accesses the universal field and planes of inner wisdom: the human spirit realm' (Watson 1999, p. 115). Sharing some similarity with Watson's transpersonal model, Sawatzky and Pesut (2005) propose a model which, although

emerging from the three key influences of religion, science and existentialism, recognizes '[s]piritual nursing care as an intuitive, interpersonal, altruistic and integrative expression that rests on the nurse's awareness of the transcendent dimension yet reflects the patient's reality' (p. 30).

Another example of a more relational approach has come from Macmurray (1891–1976), a philosopher to whom nurse educators owe a particular debt. Macmurray was the Dean of Faculty of Arts at Edinburgh university responsible for the founding of the first university-based nurse education in the UK (see Costello 2002, p. 347 and the article Nurses in an Expanded Health Service in Macmurray 1968). For Macmurray, the need was to go beyond Cartesian dualism, as that is both flawed and leads inevitably to a materialist atheism (see especially Macmurray 1991, pp. 18–23 and 74–81 and see also Stern 2001). Macmurray's concern with a spirituality made of personal relationships and with how they form communities, is a philosophical approach with much in common with more recent 'care ethics' theorists such as Noddings (see Noddings 1984, Edwards 2001, pp. 114–119, Brenda Almond's account in Fergusson & Dower 2002, p. 160, Noddings 2003, especially chapter 8 on 'character and spirituality'). Macmurray's approach to spirituality also related to that of Martin Buber (1878–1965), who said of himself and Macmurray 'I see no difference between us. It is simply that you are the metaphysician and I am the poet' (quoted in Costello 2002, p. 322). Buber's philosophy of spirituality is also centred on relationships and, for him, the dialogue by which relationships are made (see Buber 1958, passim, Friedman 1999, Friedman's introduction to Buber 2002). Buber considered the problem of treating people as 'it', an approach that might, here, be illustrated by the stereotype of medico-nursing practice as referring to a person as 'the appendix in bed two'. This problem, for Buber, was matched by an equally problematic approach to a private life of feelings. Both positions need to be overcome. In modern society, he said, all too often:

Institutions are 'outside,' where all sorts of aims are pursued, where a man works, negotiates, bears influence, undertakes, concurs, organizes, conducts business, officiates and preaches. They are the tolerably well-ordered and to some extent harmonious structure, in which, with the manifold help of men's brains and hands, the process of affairs is fulfilled.

Feelings are 'within,' where life is lived and man recovers from institutions. Here the spectrum of the emotions dances before the interested glance. Here a man's liking and hate and pleasure are indulged and his pain if it is not too severe. Here he is at home and stretches himself out in his rocking-chair. … But the separated *It* of institutions is an animated clod without soul and the separated *I* of feelings a uneasily-fluttering soul-bird. Neither of them knows man: institutions know only the specimen, feelings only the 'object'; neither knows the person, or mutual life (Buber 1958, pp. 62–63).

Buber and Macmurray both describe relations as at the heart of spirituality: we only know people through particular kinds of relationships and we only *are* people in and through our relationships. Knowing the person is an *action*, not a 'state of mind' but a kind of 'imaginative leap' to the reality of the other person. The action of knowing is, therefore, an act of 'inclusion': 'It is inclusion – imagining the real – that banishes the illusion that we are confined to our skins or our own private experiences, as so many people think' (Friedman 1999, p. 410).

The reason for preferring to group together the third set of theories as 'relational' rather than 'holistic', despite the latter term being widely used in the nursing literature, is that holism may in some forms itself be materialist. Notions of the holistic self, meaning mind–body–spirit, is often taken from the Taoist tradition (Kaptchuk 1983, Po-Tuan 1986). Ironically, although Taoism is regarded as a highly 'spiritual' belief system, its premise that everything in the universe is composed of *Qi* ('energy') – likened by some to sub-atomic particles and notions of matter and anti-matter – is thus open to interpretation as essentially materialist in nature. Nevertheless, there are approaches to holism, such as that of Robinson, that are helpful additions to this account of theories going beyond dualism and materialism. Robinson *et al.* refer to their approach to spirituality having:

a strong sense of holism – involving the integration of affective, cognitive and physical elements and making it impossible to isolate the spiritual from the physical. The spirit is a dynamic reality that expresses itself in the body. This can apply also to groups (Robinson *et al.* 2003, p. 21)

Robinson's view 'contrasts sharply with the more dualistic view of the spirit as quite separate from the body' (Robinson *et al.* 2003, p. 21) and is 'relational' as '[e]ssentially, … spirituality is relation and action centred and about making connections with these different aspects of life' (Robinson *et al.* 2003, p. 23). Reference is made to empirical evidence for such a view of spirituality and the authors conclude with a working definition of spirituality:

(1) Developing awareness and appreciation of the other (including the self, the other person, the group, the environment and, where applicable, deity).
(2) Developing the capacity to respond to the other. This involves putting spirituality into practice, embodying spirituality and thus the continued relationship with the other.

(3) Developing ultimate life meaning based upon all aspects of awareness and appreciation of and response to the other (Robinson *et al.* 2003, p. 23).

Empirical research on children's spirituality has been undertaken by David Hay (Hay 1998, Hay & Nye 1998) and he similarly describes spirituality in terms of relational consciousness, a position supported by government guidance for work on spiritual development in schools which refers to:

Relationships – Recognizing and valuing the worth of each individual; developing a sense of community; the ability to build up relationships with others… [S]teps to spiritual development might include: recognizing the existence of others as independent from oneself (SCAA 1995, 3–4).

Hay's relational approach is complemented by three dimensions, these being awareness-sensing, mystery-sensing and value-sensing. Combining the relational approach with such dimensions can provide a framework in which spiritual issues may be exemplified. Based on the work of Robinson *et al.* and that of Hay, along with their philosophical predecessors, a framework is generated which describes a person's relationship with the self, with 'the other', with others, with groups (communities and institutions) and with the world (or 'the

whole') and sets it alongside the 'sensing' dimensions (as in Table 1). Nurses and nurse educators can use that framework both as a guide to the broadly relational philosophies, as they apply to nursing, or – especially if they themselves follow a more dualist or materialist approach to spirituality – as a way of analysing aspects of nursing practice.

Every child matters

The statutory policy framework that currently dominates health, social care and education for children and young people, is that of every child matters (Department for Education and Skills (DfES) 2004a, e), which identifies five outcomes all of which are to be supported by each service: health (Department of Health (DH) 2004), social care (DfES 2004b), justice (DfES 2004d) and schools (DfES 2004c). These five outcomes are for children to be healthy, stay safe, enjoy and achieve, make a positive contribution and achieve economic well-being. Being healthy refers to physical, mental, emotional and sexual health, along with healthy lifestyles, choosing not to take illegal drugs and parents carers and families promoting healthy choices. Staying safe involves avoiding maltreatment, neglect, violence and sexual exploi-

Table 1 Framework for spirituality in nursing and nurse education, in the light of every child matters, with numbers representing each of the five outcomes listed earlier in the article

	Awareness-sensing (here-and-now, tuning, flow and focusing)	Mystery-sensing (wonder and awe, imagination)	Value-sensing (delight and despair, ultimate goodness and meaning)
Relationship with self	Self-awareness, self-control, ability to lose self, sense of well-being (1)	Imaginative links with younger and older selves, selves in different contexts and conditions (1, 3)	Pleasure in understanding, in creating. Realizing despair. Distinguishing pain from suffering (1, 5)
Relationship with 'other'	Realizing the not-self, existential humility (i.e. limits to the self), perspective, awareness of the significance of own death (2)	Imagining 'position' in universe (4, 5)	Sense of different meanings to different people. Fear of death (2, 4)
Relationships with others	Team-work (including sport, play, music, conversation), physical engagement (sensitivity of touch), aural/oral engagement (sensitivity of listening and talking), visual engagement (sensitivity of look and visual presentation of self) (2, 3)	Sensing of unconditional trust and love, e.g. in family relationships. Imagining the real (1, 2)	Friendship and love and the loss of friendship and love (2)
Relationships with groups: communities and institutions	Social skills, job and career. Adapting the self, without losing the self, in a community/institution (3, 5)	Sociological, geographical and historical imagination. Sense of creativity in making a family, group or community (3, 4)	Memberships and their meanings (4, 5)
Relationship with (or 'oneness with') the world, or the whole	Sense of the infinite and eternal (1)	Imagining god, gods, or nature. Wonder at eternal life (3, 4)	Meaning of life, in context of whole. Beyond a fear of death (1)

tation, accidental injury and death, bullying and discrimination; being free from crime and anti-social behaviour in and out of school, having security, stability and being cared for and having parents, carers and families providing safe homes and stability. To enjoy and achieve, children should be ready for school, attend and enjoy school; they should achieve stretching national educational standards at primary school, achieve personal and social development and enjoy recreation, achieve stretching national educational standards at secondary school; parents, carers and families should support learning. By making a positive contribution, children would be engaging in decision-making and supporting the community and environment, engaging in law-abiding and positive behaviour in and out of school, developing positive relationships and choosing not to bully and discriminate, developing self-confidence and successfully dealing with significant life changes and challenges and developing enterprizing behaviour; parents, carers and families would be promoting positive behaviour. Finally, to achieve economic well-being, children and young people would engage in further education, employment or training on leaving school; they would be ready for employment, live in decent homes and sustainable communities, have access to transport and material goods and live in households free from low income; parents, carers and families would be supported to be economically active.

These five outcomes, in the context of the whole every child matters policy initiative, encourage the consideration of issues common to nursing and nurse education alongside those of other professions. A further incentive for action is the requirement that all work with children and their families be covered by an inter-professional common assessment framework (CAF) (DfES 2004a, p. 18), which will 'help to achieve both the NSF standards and the five every child matters outcomes by providing a 'whole child' assessment' (DH, 2004, p. 11) and 'aims to provide an easy-to-use assessment of all the child's individual, family and community needs, which can be built up over time and, with consent, shared between practitioners' (DfES 2004a, p. 19). The CAF will:

(1) Improve the quality of referrals between agencies by making them more evidence-based;

(2) Help embed a common language about the needs of children and young people;

(3) Promote the appropriate sharing of information;

(4) Reduce the number and duration of different assessment processes, which children and young people need to undergo (DfES 2004a, p. 19)

It is not that the five outcomes and the CAF should be accepted uncritically, as there is potential for controversy in each element – such as the risk-averseness of the policy implied by 'stay safe' and the requirement for intervention not only 'where families are facing difficulties' but also where 'children might experience risk' (DfES 2004e, p. 27). It is, rather, that in this policy framework, opportunities for engagement with spirituality are enhanced and the need is therefore increased for further support for nursing. It is also likely that there will be an impact on the nature of nursing as a profession and on the other professions brought together by every child matters. Some of these opportunities and impact are considered in the following section.

Implications for education and training: every person matters

There are various approaches to spirituality, to be considered in the context of every child matters. All involve relationships of some kind. Those who would see spirituality in terms of a separate 'substance' are in the Cartesian tradition, concerned with the relationship between 'spirit' and 'matter'. Those who would see spirituality in terms of a materialist view would seek a (materially) holistic view of spirituality in the context of all matter. Those looking at spirituality as experienced through transpersonal moments, through actions of care, community and/or dialogue, are also concerned with relationships. The relational view of spirituality specifically based on the philosophies of Macmurray and Buber, therefore, provides a remarkably helpful framework. It is a framework likely to be acceptable to those from other philosophical and religious traditions, whilst also having its own distinct philosophical roots. In that way, the framework for considering spirituality can be described as *ambiguous*, with ambiguity itself being a positive quality. Ambiguity is seen in the long literary tradition (e.g. Empson 1961) as representing a surfeit of meaning, dividing and joining, forcing interpretation, rather than merely a presence of confusion or uncertainty. Within nursing, ambiguity can, therefore, save us from oversimplification and a simplistic rejection of sincerely held beliefs and strongly embedded practices. It is a source of riches in nurse education, just as it is a source of riches in life: a world without ambiguity would be bland and problematically 'literal'.

The development of the nursing profession is seen by some as treading a path between two extreme models of nursing:

In response to these claims [of professional 'service' and 'calling'], different identities have been formed of the nurse and her profession. At one extreme is the image of the angel, the de-sexed, ultimate carer … At the other extreme is the image of technician, whose task is to save lives. The first is all care, the second is all competence. Neither is human and neither reflects the complex and rich spirituality of the

nurse who has to hold together both care and competence, something reflected in the concepts of covenant and contract (Robinson *et al.* 2003, p. 229).

That contrast and the need for its resolution, is clearly related to the approach of Buber, described above, who criticized the contrast between the 'soulless' and the 'feeling' approaches to people and institutions. Buber's and Robinson's need to 'know the person', not in a romanticized and essentially private way, but as part of a holistic and public relationship, supports the need for a framework that can be used across professions. Knowing the person is how professionals can demonstrate that every child matters, or rather that every *person* matters, as also in Oppenheimer's view that 'people matter; mattering matters; and mattering is more given than chosen' (referred to by Tschudin in Marks-Maran & Rose 1999, p. 77). Table 1 is, therefore, an attempt to describe how nurse educators, along with school teacher educators and other professional educators, might identify and encourage spirituality in professional practice, starting from an initial CAF and working through all clinical practice.

This framework might simply be left, without further comment, for consideration by readers. However, there is clearly a value in nurses trying to find examples of each of these 'boxes' from their own clinical experience. Examples might be sought of patients with and able to express, an attitude towards their own death, social skills, love or self-awareness. Equally, examples might be sought of the absence of such evidence. The presence of examples in clinical practice suggests evidence of the expression of spiritual needs, allowing nurses to help meet those needs. The absence of examples suggests either a need for developing nursing practice (to allow for the communication of such evidence) or the absence of spiritual engagement. In Swinton's poignant phrase, referring to people with depression, some people may be 'living with meaninglessness' (Swinton 2001). Nurse education can help prepare nurses for the assessment of and appropriate responses to, evidence of meaning and meaninglessness. The engagement of nurses with a range of philosophical and religious traditions feeding in to this spirituality framework and with the five outcomes of every child matters, will enable such assessment also to be recognizable by those in other professions and across professional-client boundaries. Every person will be more likely to matter, to every profession and every client.

Contributions

Study design: SJ, LJS; data collection and analysis: SJ, LJS; manuscript preparation: SJ, LJS.

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