Second Edition

Holistic Practice in Healthcare

The Burford NDU Person-centred Model

Edited by
Christopher Johns

Forewords by Jean Watson and Brendan McCormack

WILEY Blackwell

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Christopher Johns RN, PhD, HSGAHN was general manager of Buford hospital, Head of Buford Nursing Development Unit and Lecturer-practitioner with Oxford Brookes University between January 1989 and December 1991. It was an extremely formative period that set the tone and scope for his subsequent academic life. Now retired from Professor of nursing at the University of Bedfordshire, he maintains an active advocate of holistic and reflective practice through writing and consultation. His book *Becoming a Reflective Practitioner* is now in its sixth edition. I developed 'Reflexive narrative as self-inquiry towards self-transformation' as an approach to research published by Sage in 2017. This approach formed the core of a Masters in healthcare leadership leading to the publication of *Mindful Leadership* by Palgrave in 2015. His theories of practice have been inductively and reflexively developed informed by extant theory.

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To Jean Watson, PhD, RN, AHN-BC, FAAN, LL (AAN) is Distinguished Professor and Dean Emerita, University of Colorado Denver, College of Nursing Anschutz Medical Center campus, where she held the nation's first endowed Chair in Caring Science for 16 years. She is founder of the original Center for Human Caring in Colorado and is a Fellow of the American Academy of Nursing; past President of the National League for Nursing; founding member of International Association in Human Caring and International Caritas Consortium. She is Founder and Director of the non-profit foundation, Watson Caring Science Institute (www.watsoncaringscience.org). In 2013 Dr. Watson was inducted as a Living Legend by the American Academy of Nursing, its highest honour.

She is a widely published author and recipient of many national/international awards and honours, including: The Fetzer Institute Norman Cousins Award, in recognition of her

commitment to developing; maintaining and exemplifying relationship-centred care practices; an international Kellogg Fellowship in Australia; a Fulbright Research Award in Sweden; The Hildebrand Center for Compassion in Medicine Award Notre Dame University; Academy Integrative Medicine and Healing Award for pioneering work in Caring Science; Japanese International Society of Caring and Peace Chair. She holds sixteen (16) Honorary Doctoral Degrees, including 13 International Honorary Doctorates (E. G. Sweden, United Kingdom, Spain, British Colombia and Quebec, Canada, Japan, Turkey, Peru and Colombia, S. America, Ireland).

Dr. Watson's caring philosophy and Transpersonal Theory of Human Caring, and Caritas Processes of Caring Science are used to guide transformative models of caring education; and professional caring- healing practices for hospitals, nurses and patients alike, in diverse settings worldwide.

As author /co-author of over 30 books on caring, her latest books range from empirical measurements and international research on caring, mindful caring science practices, to new postmodern philosophies of caring and healing, philosophy and science of caring and caring science as sacred science and global advance in caring literacy. Her books have been AJN books of the year awards and seek to bridge paradigms as well as point towards transformative models for this 21st century.

To Professor Brendan McCormack D.Phil (Oxon.), BSc (Hons.), FRCN, FEANS, FRCSI, PGCEA, RMN, RGN, FAAN, MAE is Head of The Susan Wakil School of Nursing and Midwifery (inc. Sydney Nursing School) and Dean, Faculty of Medicine and Health, The University of Sydney; Extraordinary Professor, Department of Nursing, University of Pretoria, South Africa; Professor of Nursing, Maribor University, Slovenia; Visiting Professor, Ulster University; Adjunct Professor, Zealand University Hospital/University of Southern Denmark; Professor II, Østfold University College, Norway; Professor of Nursing, Queen Margaret University, Edinburgh.

Brendan's research focuses on person-centredness with a particular focus on the development of person-centred cultures, practices and processes. He has engaged in this work at all levels from theory development to implementation science and through to instrument design, testing and evaluation. He is methodologically diverse, but is most at home in participatory/action research. Whilst he has a particular expertise in gerontology and dementia practices, his work has spanned all specialities and is multi-professional. He also has a particular focus on the use of arts and creativity in healthcare research and development. Brendan has more than 600 published outputs, including 240 peer-reviewed publications in international journals and 12 books. Brendan is a Fellow of The European Academy of Nursing Science, Fellow of the Royal College of Nursing, Fellow of the Royal College of Surgeons in Ireland and Fellow of the American Academy of Nursing. In 2014 he was awarded the 'International Nurse Researcher Hall of Fame' by Sigma Theta Tau International. Most recently, Brendan was featured in the Wiley Publishers 'Inspiring Minds' short films series https://www.youtube.com/watch?v=13c5C-tbcT4. In 2022 Brendan was selected as a member of The Academia Europaea.

Foreword by Jean Watson

Jean Watson, PhD, RN, AHN-BC, FAAN, LL (AAN)

From decade to decade, from one century to another, hospitals and healthcare systems have grappled with Nursing and Nurses. Now, each are faced with even greater upheavals with Post-COVID survival, as our industrialized healthcare institutions are turning upside down, and inside out.

Outdated industrial, economically dominated healthcare mindsets are now having to face loss of core values, meaning, and purpose; resulting in loss of nurses, dispirited nurses, shortage of nurses, turnover of nurses, retention of nurses, unhappy nurses, 'less resilient' nurses and on it goes. In their own way, each are grasping at short-term straws for any superficial 'fix it' tactic to solve this looming, but longstanding institutional human care, nursing quandary.

There is open critique from the public, worldwide, that continues from one decade, one century to another, that the so-called modern, healthcare industry is really a sick-care, body-physical, techno cure system – a system built upon an industrial, product model which differentiated diagnosis, technical treatments from patient/family personal meaning. A system that separated human from their humanity, their culture, spirituality, beliefs, and inner life world of subjectivity, in relation to outcomes. This dominant medicalized, institutional method of control over humanity has reigned over nurses and patients alike. It has been void of self-control, self-knowledge, self-care, self-choices for health and self-healing.

The result: Nursing being restricted from practicing its own profession. Nursing being restricted from its core values, philosophical moral, ethical covenant with humanity and human caring/healing/health for all. Such an industrial model, dominates, to this day, even while knowing other options. Without attention to the evolved, spirit-filled paradigm of health and human caring/healing that integrates nursing's foundational disciplinary philosophy and core values, the inevitable conclusion is that Nurses and hospitals, can no longer endure outdated, detached, medicalized, clinicalized, 'doing' models.

In mainstream organizations, there ironically remains, a proclivity for a dominant practice pattern, disconnecting one's theory and disciplinary grounding about the nature of nursing and nature of human experiences. Thus, there is reluctance to give voice, language, and informed reflection and critique to guide one's actions. Nurses at bedside often left with inability to articulate Nursing to self/system and the public.

To this day, the discourse from within nursing itself, including the American Academy of Nursing, and American Association of Colleges of Nursing continue to debate in despair how to address the 'nursing workforce shortage', the critical need for nurses (al la bodies) to serve a dysfunctional sick-care system of hospitals, in contrast to maturing professional nursing. Beyond hospital nursing culture and patterns. (Author, AAN program, 2022).

In spite of knowing better, mainstream nursing education and practices continue to have an affinity, almost a bias, towards focus on functional, concrete tasks institutional technical skills. This focused mentality is geared towards satisfying the technical accountability demands of a dysfunctional medical, institutional bureaucracy. In turn, restricting and

limiting new patterns of professional practice to improve outdated systems, promoting hospital nurses to be directly accountable to the public for caring, healing, health. As such, nursing's caring ethos has been eclipsed from its natural prominence and place in the conventional medical-care system.

Moreover, the overriding culture of the patriarchal system, in spite of new societal awakenings for equity, diversity, and inclusivity, continues to further restrict nursing from its full development as a distinct discipline, within both practice and academic settings.

Ironically, in midst of these perennial institutional, historic and contemporary Nursing impasses, a timeless global model from the mid-eighties existed within our sight, but oddly overlooked, passed by, and out of sight. Christopher John's revised edition of the UK Burford Nursing Development, Professional Practice model, uncovers solutions to status quo institutional thinking.

It offers up a powerful mature Professional Nursing model of human caring/healing and health; grounded and informed by and from Nursing's own disciplinary solutions, overturning solidified institutional cultures. In this pre/postmodern world of medical science despair, and disorder of our human-environment healthcare/body physical, materialistic, technological 'sick care' system, there is overwhelming agreement that nursing education and healthcare are in a state of post-COVID disequilibrium. As a result, the institutional, scientific, and technological orientation of today's medical and nursing care systems cannot be sustained. Continuous inter/national studies and commissions, reports and research around the world indicate a growing consensus between and among the public and the nursing, medical and health community, search for dire measures to disrupt, repattern the prevailing institutionalized models. The first edition of John's book, in the eighties, demonstrated how Burford Nursing transcended the industrial depersonalized model. Even then during the eighties, the techno cure, bureaucratic hospital model was predicted as doomed, and deemed increasingly archaic and dysfunctional. The public continues to suffer the consequences. The Burford Model, in the eighties demonstrated how Nursing can offer professional caring/healing and health beyond medical/cure foci.

The original Burford model incorporated all the contemporary mandates for change; e.g. multi-disciplinary teams, broad based, integrated caring-healing practices, knowledge and skills; models that attend to praxis activities that seek to both integrate and transform the nurse's personal and professional values, beliefs, and reflective acts with clinical decision making in the concrete world of persons and individualize practices.

As John's clinical scholarship points out, 'all models of nursing are implicitly and explicitly underwritten by the assumptions of their authors concerning the nature of nursing'. It can be likewise acknowledged that all nursing practice is implicitly and explicitly influenced by the practising nurses' views and values concerning the nature of Nursing. And what it means to be human. In that nursing faces all the vicissitudes of humanity; nurses carry all the wounds of society – the joy, pain, celebrations, suffering, harms, hurts, loss, grief, death, dying, and before/beyond death/life – mystery, miracles, and unknowns. Nursing deals with paradox and ambiguity of human-universe existence.

One of the breakdowns in nursing practice is, and has been, the separation of the theories, philosophies, values, and worldview of the discipline of Nursing, from institutional professional nursing practice. The separation of one's calling, from reflective, critiquing of status quo, however, without reflective inquiry nurses has the tendency to conform and often complain, rather giving voice and informed moral action to sustain and actualize human caring-healing practices.

Without disciplinary grounding and informed reflection, critique and actions, nurses are left with inability to publicly and professionally ask new questions or constructively critique institutional care, towards generating new solutions. Solutions that overturn status quo

assumptions about what matters? What counts as knowledge? Without informed disciplinary reflection nursing practice perpetuates separation of self from system; knowledge from voice; reflection from action. This non-reflective pattern tends to act without asking; tendency to conform and leap in, without stepping back, pausing, reflecting, questioning.

However, the good news is during the past four to five decades, nursing scholars and clinicians at multiple levels, behind-the-scene of conventional systems, have been questioning and revising nursing's very foundations for education, practice, and research. Such efforts have resulted in the critique of the dominant ideology of the patriarchal system; have led to the generation of multiple nursing theories, clinical nursing research, and theory-based practice models; have led to a revisiting of nursing ethics, basic philosophic beliefs, and ultimately to a re-examining of what is intended and needed for truly professional nursing practice.

For example, during the 1980s, with rise of doctoral nursing education, further important discourses emerged across developed countries about the nature of nursing science. These discourses critiqued nursing's 'modern' epistemological emphasis on empiricism, and critiqued the lack of ontological-philosophical-moral-ethical clarity and congruence among, and between ontology of 'being'; the nature of personhood, caring, health, illness and environment; and about the nature of nursing itself. This discourse brought new voice to nursing's place in healthcare; and has led to new perspectives about the nature of nursing's paradigm and the role of caring values and knowledge in theory and in practice.

Part of nursing's self-critique and revision of the profession is related to nursing coming of age, growing up as both a discipline and profession; is related to nursing gaining philosophical, moral, ontological, epistemological, and pragmatic clarity about its subject matter and its phenomena of interest, in both theory and practice.

Such critique, reflection, and study of foundational issues about nursing are related to the fact that nursing is becoming increasingly critical about its own practice. This 'becoming critical' is related to a recommitment to values and perspectives about human caring, about human-environment-caring therapeutic connections and nursing sensitive patient outcomes; is related to how basic foundational beliefs about such concepts, directly or indirectly, influence one's very acts. One's instrumental and expressive, moral and pragmatic actions in practice.

The current American Nurses Association revision of Nursing attests to new awakening, in that the profession is now catching up with the discipline. The latest (2022) ANA definition is as follows, reflecting a mature disciplinary specific paradigm for nursing's future.

> *Nursing integrates the art and science of caring and focuses on the protection, promotion, and optimization of health and human functioning; prevention of illness and injury; facilitation of healing; and alleviation of suffering through compassionate presence. Nursing is the diagnosis and treatment of human responses and advocacy in the care of individuals, families, groups, communities, and populations in recognition of the connection of all humanity. (American Nurses Association Definition of Nursing. 2022)*

Nursing's re-connection with its roots and basic values is now, at the disciplinary professional level, beginning to have an impact on the health and healing of individuals, families, and communities. At the disciplinary level, this re-connection and re-vision is allowing for a more actualized health and human caring profession to emerge for a new future, in the best tradition of Florence Nightingale. Such maturity positions nursing to truly come of age and awaken to its power to publicly and scholastically address the health challenges of these post-COVID times.

Johns' revised book on the Burford Nursing Development Unit provides a model of scholarly professional caring – healing practices, contributing to the further development of

both the discipline and profession of nursing through a return to its philosophical basis for reflective caring practice and knowledge generation.

Further, the Burford model invites new innovative scholarship. It helps to explicate the details of a professional practice model that can serve as a guide and paradigm – case for transforming clinical nursing care; this revision comes as nursing seeks to respond to the public's cry for healthcare as basic human right.

Finally, as the year 2023 and beyond speeds towards us, the original Burford model is a living reminder and beacon for others who wish to challenge the critics. It offers a hopeful vision, a window of possibility for those leaders and institutions, who linger in the dominant system, but long for deep change. It brings courage and new promises for leaders and systems. It offers trust in a future for those who are fearful of the power of a mature nursing voice, which disrupt the comfort of conformity.

The Buford Community Hospital Nursing Development Model revised edition, not only reminds us of nursing's potential as a distinct health and human caring profession, but also reminds us of our social mandate to improve our reflective practice and coming of age. Calling and inviting us as humans and society to sustain Nursing's global covenant to the public now, and into our timeless, delicate, unknown human-universe future.

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Foreword by Brendan McCormack

Being Present – the 'Big Work' of Nursing Practice
Brendan McCormack

In 1994 when the Burford Nursing Development Unit (BNDU) Model of Nursing was first published I was very much at the beginning of a career in nursing that had yet to be realised. From 1991 I was employed in a unique role at the Oxford City Community Hospital that combined being a Lecturer/Practitioner with that of Clinical Lecturer in Nursing with responsibility for nursing leadership, preregistration nursing education, practice development and research. Such a role was indeed the combined vision of great nursing leaders at that time, who were passionate about the practice of nursing and ensuring that there was a synergistic relationship between the practice of nursing and the advancement of nursing knowledge. Having recently graduated with my own degree in nursing and embarking on doctoral studies, the role provided every opportunity to shape how we practised as nurses, how students experienced practice learning and how patients experienced care. No stone was left unturned in the pursuit of what I now call person-centred care and the cultures that needed to be in place to support such practices.

At the same time, Chris Johns was advancing a similar pursuit at the Burford Community Hospital in rural Oxfordshire, where one of the first nursing development units in the UK had been established by Alan Pearson. Burford was synonymous with being a testbed for nursing innovations and demonstrating the effectiveness of nursing interventions and care. It was internationally known for its work in this field and so it was 'natural' for me to connect with Chris and become part of a larger community that was concerned with nursing effectiveness, person-centredness and demonstrating the impact of nursing on the lives of people. Chris developed different models of reflective supervision that many of us who became contributors to the first edition of *The BNDU Model of Nursing* were participants in. Whilst reflection was not new to nurse education, its explicit and deliberate use as an integrated practice tool for explicating the essence of nursing, its quality and impact was new and seemed quite revolutionary at the time. At the Oxford City Community Hospital, the BNDU Model of Nursing provided us with a framework for shaping practice development and moving from a task-orientated, routinised practice model, to one that placed persons and their unique needs at the core of our focus. Bringing about such change was not easy of course and whilst most of the nursing leaders who engaged in this work bear the scars we acquired along the way, what we celebrate more often is the joy of the experience as nurse leaders, educators, researchers, and clinicians. Each of the chapters of this book reflect that joy and stand as testament to an approach to nursing that sadly feels like it was a 'unique' experience.

So twenty-eight years later, it is a humbling experience to re-read those same chapters, reflect on those practice experiences and yes, mourn what we have lost in nursing since then. In the 1994 edition of this book, Jean Watson's foreword highlighted the challenges and dilemmas for nursing at that time, as it established its evidence base, built a body of contemporary knowledge and figured out 'what matters' in practice. Watson postulated that

> *... this revision of nursing is related to a reconnecting, a remembering of its values, traditions and beliefs during a modern century dominated by technology, cure and economic-bureaucratic metaphors which have distorted and silenced nursing's values and practice.*

Given the realities of nursing in the 21st Century, this challenge is more real than ever. Revisiting the BNDU Model of Nursing in contemporary 21st Century nursing and healthcare is an important thing to do, as we increasingly slide into a world of rationalism, pragmatism and genericism! But what we do know more than anything else is that human connection matters and the formation of meaningful connection is core to our being and the foundation upon which excellence in nursing is established.

In recognising the need for an ecological approach to changing systems, Sharmer (2018) proposed 'Theory U' as an awareness-based methodology for changing systems, emphasising the importance of being attentive to our internal world so we can engage wholeheartedly with the external world. The theory is informed by transformative principles of 'being before doing'. Theory U contends that to act effectively we need to know the source/drivers from which we operate when we act, communicate, interpret or think. It is easy to see what we do (results) and how we do it (process), but we are often not aware of the inner drivers for our 'doing' (our practice). These inner drivers can be understood in many ways – values, beliefs, energies, reflectivity, cognition and socialisation to name but a few. Scharmer challenges us to engage in the 'big work' of self-transformation, where we move from a fixed and immutable understanding of practice (i.e. successfully and effectively completing the tasks and interventions of nursing) to one in which we see our practice as the source for maximising individual potential of becoming and evolving into a greater being, i.e. the nurse as a facilitator of human flourishing. In this mode, being and doing are interconnected and guided towards the newly clarified purpose of facilitating flourishing of all persons. With its core question of 'who is this person', the BNDU Model of Nursing acts as an important vehicle for transforming practice from being immutable to person-centred.

The values and principles of the BNDU Model of Nursing are synergistic with principles of person-centredness and the underpinning values of personhood of the Person-centred Practice Framework (PCPF) of McCance and McCormack (2021). We define person-centredness as:

> *an approach to practice established through the formation and fostering of healthful relationships between all care providers, service users and others significant to them in their lives. It is underpinned by values of respect for persons (personhood), individual right to self-determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development.*

Person-centred practice requires us to connect with our inner-selves as human beings with feelings, emotions, thoughts and desires that guide us as persons. It is the sum of these feelings, emotions, values and desires that guide us towards 'that which really matters' and a connection with our unique humanness as persons – our embodied knowing. The concept of personhood is core to all our being. It is what distinguishes humans from other species. Personhood in its simplest form means being able to reflect on my being in the world – being with my values (what I stand for), being in time (why I respond like I do), being in place (where I am most at ease), being in the social world (how the context influences my behaviour) and being in relation (people I am most authentic with) (Dewing & McCormack 2015). Reflexively understanding my being in the world helps me to know myself as a person and in the context of nursing practice, helps me understand how I can provide person-centred care. Reflective

models like the BNDU Model of Nursing bring personhood to life in everyday practice and enable it to be the holistic vehicle for the practice of person-centred nursing.

However, I am also conscious of the burden of responsibility that this places on nurses. Whilst thoughtless practice can never be condoned (such as the personal experience outlined by Chris in Chapter 15) we also know that context matters! Fundamentally, nurses want patients, colleagues and organisations to respect their personhood! As registered nurses providing care, if we are to do so from a person-centred perspective, then we need to work in workplaces and organisations where our personhood is equally valued to that of the patient. To suggest otherwise is to devalue the humanity of registered nurses and compromise their personhood. The importance of person-centred care can never be under-estimated, and we should never take for granted its focus in providing holistic nursing practice. There is ample evidence demonstrating the importance of the existence of a person-centred culture if we are to espouse person-centred care for patients. The person-centred practice framework of McCance and McCormack (2021) has been globally accepted as one theoretical framework that sets out the criteria and qualities that need to be in place for person-centred care to exist and is consistent with the BNDU Model conceptual map set out by Chris in Chapter 15 (page 187). In this framework we articulate the strategic and policy contextual characteristics that governments and other agencies need to put in place to enable organisations to realise a person-centred culture. The framework also highlights the qualities of practitioners that are necessary to be in place to practice person-centredness. However, the framework is also clear that no matter how well developed these qualities, if the practice context is not conducive to this way of practicing, then person-centred care cannot be sustained. We also identify the person-centred processes that healthcare workers need to engage in (irrespective of context or specialty) to facilitate patients experiencing person-centredness and have their personhood respected and nurtured. In the busy, unrelenting, demanding and complex world of everyday practice these demands may seem like idealism, but we know that striving for these ways of being, doing and becoming are core to our personhood and make the difference between us as registered nurses 'doing practice' and being 'engaged with practice'. We also know that the outcome from the implementation of these organisational and practice constructs is that of a 'Healthful Culture' - one in which decision-making is shared, staff relationships are collaborative, leadership is facilitative, innovative practices are supported and it is the ultimate outcome for teams working to develop a workplace that is person-centred. Ultimately a healthful culture leads to the flourishing of all persons.

The BNDU Model of Nursing is being re-published at a critical juncture in the evolution of nursing. This is a time for all nursing leaders to engage in meaningful dialogue about 'what matters' in nursing. Whilst ensuring we achieve the best outcomes for patients, families and communities, we also need to be assertive about the nursing ontological and epistemological foundations upon which such outcomes are achieved. Adopting a holistic and person-centred focus enables us to consider the well-being of all persons and ensure that we are proactively developing workplace cultures that are respectful of all persons and have a central goal of therapeutic effectiveness. Adopting the BNDU model's deeply reflective approach to our practice could be a vehicle for significant transformation in nursing. As Pema Chödrön (2020: 9) asserts:

"When things are shaky and nothing is working, we might realize that we are on the verge of something. We might realize that this is a very vulnerable and tender place, and that tenderness can go either way. We can shut down and feel resentful or we can touch in on that throbbing quality."

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Preface

Last year I was invited to become an honorary scholar of the Global Academy of Holistic Nursing in recognition of my work developing holistic practice. At the 2022 online induction ceremony I was invited to give the end-note address. I chose to tell the Burford story. I realised it remains relevant, perhaps even more so, to inform and influence healthcare practice.

The Burford NDU Model: Caring in Practice was published by Blackwell Science in 1994. The model is grounded in Burford practitioners' collective holistic vision and ensuing systems to enable the vision to be realised in everyday practice. This revised edition is not a prescription of how to *do* holistic practice. It is an invitation for readers to dialogue with the text to inform your practice, whether you are a practitioner, teacher or organizer, towards realising holistic practice as a lived reality.

The term 'holistic practice' was used throughout the original text. Since then I preferred the term *person-centred practice* as it seemed to be more direct for practitioners to understand. Holism may seem too abstract, especially within a British nursing culture focused more on what I do rather than what I believe. But I return to the word *holism*. Being person-centred is integral to being holistic. A word holds meaning and I sense holism is a powerful word. It is about perceiving the bigger picture.

Scanning Amazon there are numerous references to person-centred practice published in the UK over the past few years that indicate the significance of this approach to current healthcare practice, not least by McCormack (2021), McCormack and McCance (2016). The emergence of the International Community of Practice spanning different countries is committed to developing person-centred practice.[1] However, there is considerably less reference to holistic practice in the UK, although commonly referenced in the USA. Hence the distinction between the two concepts appears to be largely cultural.

Without doubt, a holistic vision is compelling. Most nursing and other health care practitioners aspire to realising it. Why would anyone choose nursing as a profession if they didn't want to practice holistic care? However, we might commence nurse training motivated with a notion of caring, yet through training and organizational conditioning, this caring can fade in light of reality. Thus both the way nurses are trained and organizational practices need to shift to meaningfully and practically cultivate holistic practice. Although this is obvious, in reality it is challenging due to deeply entrenched tradition. The basic question remains as valid today as in 1994 – that if we value and aspire to holistic practice, how can it be *truly* realised within everyday practice? I italicise *truly* because no doubt many practitioners across health care professions believe their practice is holistic. Of course this question challenges that practitioners have a sense of what holistic practice looks like and experienced.

ROOTS

Burford Community hospital was nestled in the rural Cotswold Hills of Oxfordshire. It became well known as a centre of innovative practice from 1983 through the work of Alan Pearson (1983) who established its status as a nursing development unit. Pearson (1988) had

researched the development of nursing beds with nursing as a primary therapy based on the vision of the Loeb Center in New York (Hall 1964). He introduced primary nursing at Burford that shifted the culture of the hospital from its previous task approach to practice. Pearson departed in 1986 to establish a companion nursing development unit at the Radcliffe Infirmary in Oxford. Investment in nursing development in Oxford during this time was a significant factor fuelled by wider developments in nursing with the advent of nursing models, nursing diagnosis, the nursing process and primary nursing. These ideas all focused on the development of nursing as a profession.

Arriving at Burford in 1989, I commenced a process of reflection on the nature and delivery of clinical practice at Burford. The recognition of being a nursing development unit with its achievement through Pearson's work created the expectation that the Burford NDU would pursue an active developmental role.

POSING THE QUESTION

Consider - 'What do you, the reader, aspire to achieve when you pull on your uniform?' 'What are your beliefs about the nature of your practice?' 'Are your beliefs realised in everyday practice?' 'What needs to change to realise your beliefs?'

Clearly the rhetoric of holistic practice is a powerful influence. Yet aspiration needs articulating. Then it needs realising.

There is much media reports that healthcare and nursing practice is far from satisfactory. Just last week, Panorama[2] revealed their undercover exposure of care at Edenfield hospital in the UK. It was shocking. How can nurses practice like that? How does the practice environment become so toxic? The fact is that practice easily becomes routine where people, both staff and patients, are reduced to objects. Caring becomes non-caring, adding to suffering for both patients and practitioners. Morale plummets. Sickness rates rise. Practitioners go through the motions.

I know this from my own experience and my retort that 'people are not numbers to crunch' (Johns and Rose 2022) where we had become objects in an illness fixing machine and where nurses were blind. On sharing this narrative as a performance, a member of the audience poignantly noted (p. 141):

> *I'm a nurse matron of acute medicine. What you portray is most uncomfortable. It has really made me think. What makes nurses blind in my view, is the way care has become so routinised and so unreflective because of the need to get through the work and poor leadership. It has become a pervasive and perverted culture. Also our systems are inadequate if they don't guide the nurse to consider how the person is feeling like 'nurse fantastic' in the performance. Not that a nurse should need guiding. It should be a built in as a natural way to approach the person. I feel so very sorry for Otter and yourself for experiencing that.*

Clearly there is a massive problem within organizations to allow this 'perverse and pervasive' practice to exist and persist. Every person who requires health care deserves holistic practice. There are no excuses even when practice is under pressure. Yet I sense that nothing much has changed over the past thirty years. Many nurses are not blind although they may turn a blind eye. I meet many nurses who want to give holistic care and yet they practice in situations that constrain this. As Jonathan, an advanced nurse practitioner admitting me for an appendicectomy recently responded after I had informed him that he was the first nurse to introduce

himself (three previous nurses had failed to this) "I know, it's not good enough, all the good ones leave." It's as if nurses fit-in to whatever system exists, without any power to shift this. Without doubt, health care practice has become increasingly corporate with emphasis on outcomes or targets with finite resources and staff shortages that makes practice reactive rather than proactive, task driven rather than creative, managerially driven rather than leadership, risk adverse rather than therapeutic; factors all contributing to caring being a lottery rather than committed intent.

It requires organizations to wake up to the challenge and invest in people towards realising holistic practice, to realise their own vision statements that espouse holistic or person-centred practice. It requires a holistic type of leadership to work with practitioners through creating a vision of holistic practice and to develop systems to facilitate its realization. This leadership should be at every level of the organization to create a dynamic learning organization.

It requires teachers to re-vision the curriculum around reflection and holistic values to prepare practitioners to become holistic practitioners with close links to clinical practice working with organisations to ensure students learn in holistic environments.

HOLISTIC KNOWING

Eduardo Chillida (2019:48) jotted:

> *The artist (and we can say the practitioner is an artist) knows what he's doing, but for it to be worthwhile, he must take the leap and do what he doesn't know how to do. In that moment, he is beyond knowledge.*

So every day make the leap with the intention to be holistic. Your performance as a practitioner is art in motion. Holism is a way of being in the world that is often ineffable, beyond words, informed by knowledge yet transcending knowledge – knowing something directly through experiencing it [knowing how] more than knowing something indirectly through information [knowing that]. Knowing something through experience can be made more explicit through reflection whereby the practitioner's knowing becomes a self-inquiry to gain insight to inform future practice. Such knowing is largely intuitive within the moment. We may have ideas about what holistic practice is but that's not the same as living it. Obviously ideas inform but we can only know something through doing it. Hence the significance of reflection as feedback – "How do I know if I am realising holistic practice?' You can read books about it, you might gain some ideas about it but they won't tell you what it is like to be a holistic practitioner.

As Yoko Beck notes (1989:123)

> *Suppose we want to realise how a marathon runner feels; if we run two blocks, or two miles or five miles, we will know something about running those distances, but we won't know anything about running a marathon. We can recite theories about marathons; we can describe tables about the physiology of marathon runners; we can pile up endless information about marathon-running; but that doesn't mean we know what it is. We can only know when we are the one doing it. We only know our lives when we experience them directly, instead of dreaming about how they might be if we did this, or had that. This we can call running in place, being present to we are, right here and right now.*

THE BURFORD NDU MODEL: AN OVERVIEW

The core of the Burford NDU model is a collective holistic vision of practice reflecting the beliefs of Burford practitioners to give meaning and direction to their practice. Practitioners are guided to live the vision through five systems set within the dynamic learning culture and holistic leadership.

However, practice is not rationale but steeped deeply in issues of power, tradition and embodiment that must be understood and shifted as necessary to accommodate holistic practice (Fay 1987). As the book unfolds the reader will grasp the necessary shift in culture to effectively accommodate holistic practice.

However, the Burford NDU model is simply a structure. It can be adapted to 'fit' other practice settings who aspire to holistic practice. Some practice settings may simply 'take it of the shelf' and apply in a functional way as they might any other idea although the model's impact on enabling holistic practice may be limited.

STRUCTURE OF THE BOOK

The whole book is a reflective and holistic text. It explores the pattern of systems within the whole, patterns that are essentially tentative and moveable, always reflected on and developed to support holistic practice.

Jean Watson writes one foreword to this new edition just as she wrote the original preface bridging the time span between texts. Brendan McCormack writes a second foreword alongside his original engagement with the Buford NDU model again spanning time between texts. Both are world leaders and activists in developing holistic practice globally. Their words are inspirational and set the scene for the book's unfolding.

In Chapter 1, I set out a holistic vision of practice and how this was constructed at Burford hospital to become the foundation of the Burford NDU holistic model for practice. I argue that a vision needs to be valid, addressing the nature of caring, the internal environment of practice and its social viability. I also argue that a vision needs to be 'collective', owned by practitioners.

In Chapter 2, I set out the Burford NDU model evolving from Burford hospital's vision for practice as the structure to enable practitioners to realise their holistic vision as a lived reality. The model comprises five systems set within a culture of a dynamic learning culture driven by 'holistic' leadership reflecting a synchronicity between process (organising holistic practice) and outcome (realising holistic practice). Yet realising holistic practice is not a rational process. It requires a significant culture shift moving from a prevailing dominant task focused functional culture to delivering clinical practice. As such, the holistic leader is a dynamic change agent. As such, the whole book is a template for guiding practitioners and organizations through change. It is reflective rather than prescriptive, opening possibilities.

In Chapters 3–7, I set out the five systems designed to enable the Burford hospital vision to be realised in everyday practice.

Chapter 3 sets out the pattern appreciation or assessment strategy to tune practitioners into the holistic vision and guide practitioners to gather necessary information to nurse the person as an ongoing dynamic process throughout the person's journey in hospital and beyond. It is this aspect of the Burford model that most likely will attract potential users due to its profound simplicity and meaningful practicality.

Chapter 4 sets out a system for reflexive communication. Reflexivity is looking back in the present moment whilst anticipating moving forward. Dialogue is the mode of communication both verbal and written as an unfolding narrative that tells the story of working with the person.

In Chapter 5, I advocate primary nursing as the most appropriate system to deliver holistic practice because it best facilitates the relationship between the practitioner and the person in contrast with other approaches. However, primary nursing needs to be supported by the therapeutic team. However, this is not without its challenges, notably the emergence of 'ownership' whereby associate nurses can feel 'pushed out' and 'unacknowledged' for their contribution, and the 'harmonious team' with its consequence of practitioners not being available to each other, dealing effectively with situations of conflict, and giving and receiving feedback.

Chapter 6 sets out guided reflection as the system to enable practitioners to realise the Burford NDU model supported by three scenarios recorded from guided reflection sessions. It makes absolute sense that a practice discipline such as nursing ground learning in its practice. This account of guided reflection is brief. The reader is referred to my book *Becoming a Reflective Practitioner* (Johns 2022) for an in-depth exploration of learning through reflection from both educational and clinical settings.

Chapter 7 sets out a system for living and ensuring quality whereby quality of care is everyone's business moment by moment facilitated by everyday talk both formal and informal, guided reflection, standards of care and clinical audit. In fact every aspect of practice is concerned with clinical effectiveness and practitioner performance.

Chapters 8–10 are written by Buford practitioners reflecting on working with the Burford model. These chapters are reproduced from the 1994 version accompanied by new footnotes to draw out significance. They offer critical insight into living the Burford NDU model to enable readers to contextually sense the nature of holistic practice and what it means to be a holistic practitioner alongside the practicality of the Burford NDU model to facilitate it. As the reader will appreciate, it is not all plain sailing. The accounts reveal that it can be difficult and painful at times reflecting how old ways of practice are difficult to shift. It is the commitment to holistic practice that enables these practitioners to prevail in hard times – because the joy in practicing holistically far outweighs any difficulty.

Chapters 11–13 are written by practitioners from other practice settings who critically reflect on implementing the Burford NDU model, offering their own insights and adaptations to suit their local practice from different practice settings. One setting is a comparable Community hospital to Burford. Another setting is an acute medical ward within a large general hospital. The third setting is a district nursing practice.

As with Chapters 8–10 I have written footnotes to draw out significance.

Chapter 14 is my reflection on my practice as a holistic therapist in a hospice setting that had implemented the Burford NDU model although without a collective vision. I draw out significant aspects of what it means to be a holistic practitioner working autonomously yet within the multi-disciplinary team. The narrative conveys that the individual practitioner can approach their practice with holistic intent even for brief moments and where holistic beliefs are not collective. However, the narrative also suggests the struggle such individuals face where holistic beliefs are not collective.

In Chapter 15, I coin the mantra 'holistic practice matters'. It explores the consequences of holistic practice from political, organizational and educational perspectives returning to the question – can holistic practice ever be a reality in everyday health care practice or will it always be a compelling pipe dream of the way practice ought to be but ultimately fall upon stony ground? In drawing together the threads of the book I set out a conceptual map and argue that the truth of realising holistic practice lies essentially with practitioner accounts. Finally the chapter is an invitation to dialogue.

So this book, a 30th anniversary review and development of the Burford NDU holistic model, asserts itself as a challenge to all practitioners, organizations and universities to wake

up and heed the call towards enabling practitioners to become holistic practitioners and in doing so, to unleash their therapeutic potential for the benefit of people everywhere and, in doing so, to realise their professional destiny.

In the words of Martin Luther King, Jr.:

> *This is no time for apathy or complacency. This is a time for vigorous and positive action.*[3]

I have tended to use the term 'practitioners' suggesting that holistic practice is not just the concern of nurses but for all healthcare disciplines. Obviously my background is as a nurse and it is nurses that set the environmental tone of practice settings.

I am mindful of the British-centric nature of the text. International readers will be aware of that to reflect on how the text can inform their own cultural practices.

Readers will note that many references are dated to the era of the original text. This gives a flavour of the background to the model's development and its relevance for today's nursing and health care practice. Readers inspired to explore and implement holistic practice can search a more recent literature. A notable example is the text by McCormack et al (2021). The inside flap states 'Fundamentals of Person-Centred Healthcare Practice presents evidence-based perspectives on a broad range of approaches to person-centred practice in healthcare'.

NOTES

1 The International Community of Practice for Person-centred Practice (PcP-ICoP) is an international community of collaborating organisations committed to improving the understanding of person-centredness and its advancement in clinical practice, research, education/learning, facilitation, management, policy and strategy.

McCormack B and Dewing J (2019) International Community of Practice for Person-centred Practice: position statement on person-centredness in health and social care3. International Practice Development Journal 9.1.3. (https://doi.org/10.19043/ipdj.91.003)

2 BBC Panorama Undercover Hospital: Patients at Risk – Thursday 29th September 2022. [https://www.bbc.news.com]

There have been many exposures of poor healthcare. People often complain about care. The report 'A Review of the NHS Hospitals Complaints System; Putting Patients Back in the Picture' [October 2013] states: 'One of the most shocking failures in NHS care was documented on 6th February 2013 when Robert Francis QC published his Public Inquiry into Mid Staffordshire NHS Foundation Trust. He found a story of appalling and unnecessary suffering of hundreds of people.

To quote

> *'They were failed by a system which ignored the warning signs and put corporate self-interest and cost control ahead of patients and their safety. A health service that does not listen to complaints is unlikely to reflect its patients' needs. One that does will be more likely to detect the early warning signs that something requires correction, to address such issues and to protect others from harmful treatment. A complaints system that does not respond flexibly, promptly and effectively to the justifiable concerns of complainants not only allows unacceptable practice to persist, it aggravates the grievance and suffering of the patient and those associated with the complaint, and undermines the public's trust in the service'.*