EDUCATING FOR LIFE, EDUCATING FOR DEATH: DEATH LITERACY AND THE SPIRITUAL DIMENSION IN EDUCATIONAL AND HEALTHCARE TRAINING PATHWAYS

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ABSTRACT
Educating for life inevitably entails educating for death. This theoretical essay explores how health and educational training can integrate death education, death literacy, and spiritual competence to sustain professionals in facing the ultimate human limit. Narrative medicine and educational care are presented as key frameworks for transforming end-of-life encounters into spaces of meaning, responsibility, and relational depth.

KEYWORDS
Death literacy; Spiritual competence; Narrative medicine; Educational care; Professional formation.

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Introduction - The Limit as the Key to Care: Life, Illness, and Death

"The surest way of knowing a town is to see how people work there, how they love, and how they die". (Camus, 2001).

Dying is the boundary that measures life: a radical experience because it is inevitable, quotidian because it is socially diffused, and public because it traverses institutions, professions, and collective languages.
In healthcare, acknowledging its significance means recognizing that technical competence, though indispensable, is not sufficient: it is necessary to integrate knowledge and practices that enable professionals to give form and meaning to extreme transitions, both their own and those of others. The patient-centered turn — which has placed biographical and experiential centrality alongside evidence-based approaches (Kleinman, 1988; Zannini, 2008) — has challenged the traditional doctor–patient dyad, reframing the clinical encounter as an interweaving of life stories (Zaner, 1988), where cultural meanings and interpretive frameworks (Good, 1994) contribute to shaping the outcome of care.
Within this horizon lie narrative medicine (Charon, 2006) and death education (Testoni, 2015): not optional "add-ons," but structural components of a training that integrates biomedical and human sciences in order to sustain a holistic care of transitions, capable of addressing the search for meaning that illness anticipates and death consummates.
The notion of limit—corporeal, temporal, relational—becomes here the interpretive key: illness makes it visible, death brings it to completion.
In a secular and plural perspective, this limit holds a clear spiritual significance: not as doctrine, but as an exercise of meaning through which the person (both patient and professional) seeks to hold together their own story when the order of the everyday is fractured.
The pedagogical goal, therefore, is not simply to "humanize" clinical practice, but to form reflective professionals able to cross the boundary without being overwhelmed by it, transforming the encounter with another's finitude—while simultaneously confronting their own, evoked in that encounter—into an occasion for meaning-making and testimony of one's professional self (Boffo, 2006).
This calls into play postures, languages, practices, and formative environments that legitimize the narrative and spiritual elaboration of experience, so that the care relationship may intentionally become an educational relationship as well.

1. Educational Care and Death: Attending to the Other, to Transitions, and to the Professional Self

To think and practice a pedagogical-educational form of care in professional contexts where death is encountered means situating it within a pedagogy that acknowledges the end as an integral part of life's course. A "pedagogy of vital death" (*pedagogia della morte vitale*) (Malavasi, 1985, p. 98) aims to deconstruct the idea of death as the definitive rupture of biography, proposing instead—despite the paradoxical nature of such a perception—to view it as a coordinate within which one can design both the process of self-formation and one's action in the world.

This perspective extends beyond educational interventions following the transition, such as those directed at supporting the dying, their families, or significant others during bereavement, whose effectiveness is well recognized (Testoni, 2015). Rather, it shifts attention to the primary level, reaffirming the importance of a lifelong education to death and to life, as well as the formation of professionals called to operate in threshold contexts. This task concerns healthcare practitioners, but also educators, as experts of relational processes and active participants in environments such as hospital schools (Boffo, 2022) or pediatric hospices. Death, however, does not manifest only in settings prepared for its tragic unfolding: it may erupt dramatically in any educational service, from early childhood to old age, from schools to contexts of marginality, marking the entire biographical arc.

The professional ethical dimension therefore implies the ability to take a stance toward such issues, shaping the educator's professional function as that of one who facilitates existential passages. To care for the "final transition," as for every other "transition" that symbolically anticipates it, means to attend to the existential dimensions of the person and to their primary bonds. In this sense, the educational relationship confirms itself as a central locus, capable of integrating both etymological roots of the term education: *educare* and *educere*, that is, preparing conditions and instruments so that the care receiver may activate their own resources and participate freely in constructing their future—even when close to its epilogue (Bertagna, 2010; Boffo, 2011).

Alongside this stands the intrapersonal dimension of care, which begins with the *cura sui* (Foucault, 1984), the foundation of the formative process (Cambi, 2010). Cultivating a dialogue with one's own interiority becomes a premise for caring for others, orienting both personal and professional design. In this horizon, autobiography represents a privileged instrument: narrating oneself allows one to

re-elaborate events and losses, transforming fractures into opportunities for meaning-making and formation (Cambi, 2002; Biagioli, 2015).
Autobiographical processes thus assume an essential role in professional construction: reflecting on the roots and motivations that have guided the choice to care for others means attributing meaning to one's action and assuming ethical responsibility (Boffo, 2020). In contexts where death is a "living presence," autobiography further becomes a tool for elaborating the impact of others' suffering and for avoiding dysfunctional reverberations that could compromise the relationship. Studies conducted with physicians working with terminal patients show that writing and sharing experiences of death foster not only a reflective posture, but also a reduction in personal anxieties: a genuine path of death education mediated by narrative medicine (Roscoe, 2012).
The narrative dimension, particularly at the end of life, thus offers clear educational and formative benefits: it helps the dying to attribute meaning to their experience and enables professionals to integrate stories of illness into training pathways, developing approaches to care that take account of the existential complexity of transition (Zannini, 2008; Stanley & Hurst, 2011; Lanocha, 2021). In this perspective, narration becomes a fundamental reference point for designing training pathways for health and education professionals, who thereby find themselves both recipients and promoters of a new culture of death as an integral part of life.

2. Death Literacy Pathways for Accompanying Life

If death represents the most radical threshold of existence, death literacy can be understood as the educational attempt to render it speakable and addressable. It is not merely a matter of acquiring notions or protocols, but of constructing a symbolic and practical repertoire that enables individuals to accompany, with awareness, life's transitions towards their completion. In this perspective, Noonan and colleagues (2016) define death literacy as "a set of knowledge and skills that make it possible to gain access to, understand, and act upon end-of-life and death care options" (p. 2). Death literacy is therefore closely linked not only to clinical practices, but also to the role of caregivers and communities, who are called to share responsibility in accompanying the final transition.
The research project conducted by Noonan and collaborators (2016) in Australia, based on the testimonies of people who had accompanied their loved ones in dying, demonstrated how the educational processes embedded in such experiences can generate significant formative outcomes. They identified four key dimensions: knowledge of available resources, the development of practical and relational

competences, experiential learning arising from direct contact with death, and finally, the capacity to transform lived experience into social action, giving back to the community what has been learned.

From this six-year study, the "Death Literacy Index" was developed (Leonard et al., 2020), later validated in different international contexts (Graham-Wisener et al., 2022) and refined into a shorter version (Noonan et al., 2024). The tool allows for the measurement of death literacy both at the individual and collective level, assessing knowledge, relational competences, the ability to navigate within the "death system" (Kastenbaum, 1977), and the use of community resources.

The Death Literacy Index could also be adopted within the training of healthcare and educational professionals, offering valuable insights into their preparedness to address death in professional practice. Moreover, it could guide the design of death education programs aimed at raising levels of literacy and fostering self-reflective processes, helping proximity figures to develop a critical and conscious stance. In this view, death and mourning are not conceived as alien elements to be removed, but as biographical fractures to be elaborated and transformed into formative resources across the lifespan.

A significant example in this direction is offered by the Last Aid courses, educational programs that originated in Germany and subsequently spread internationally, designed to provide citizens with basic tools to understand and face palliative care (Bollig & Heller, 2016; Bollig et al., 2021). Structured in brief and accessible modules, these courses deliver both practical and symbolic knowledge to support patients and their families, fostering a vision of death as an integral part of life. The initiative has also been extended to healthcare professionals who are not specialists in palliative care (Bollig et al., 2019), proving useful in broadening their capacity to intervene in extreme situations and in strengthening community bonds around the experience of dying.

In this perspective, death literacy is not simply a technical competence, but an educational device that interweaves knowledge, skills, and reflective practices. Training professionals and citizens in this literacy means promoting what the European Commission (Sala et al., 2020) has termed *LifeComp*: a framework of life competences—self-regulation, flexibility, empathy, collaboration—essential to facing the critical passages of existence. Death, then, is not only a concluding event, but also a pedagogical threshold through which life itself can be rethought, cultivating capacities for care, resilience, and shared responsibility

3. Spiritual Competence, Situatedness, and Secularity in Education and Healthcare Education

If death literacy makes death speakable and shareable, spiritual competence offers it a horizon of meaning. Within this framework, death education and the pedagogical care of transitions—understood as preparation for life's thresholds—open the space for a deeper reflection: both show that, in the face of extreme vulnerability, neither technical knowledge nor communicative skills are sufficient. What is needed instead is recourse to symbolic and narrative resources, imperative for orienting the meaning of experience. It is here that spiritual competence reveals its urgency: as both a continuation and a transcendence of death literacy, in its capacity to shape the "beyond" that illness and death disclose, rescuing them from the opposing and equally paralyzing abysses of technical reductionism and dogmatic confessionalism.

From a factual standpoint, to speak of spirituality in healthcare contexts means clarifying that, in a public, plural, and secular environment, it does not coincide with any single religious perspective. Rather, spirituality manifests itself as the human capacity to make sense of experience, to confront finitude, and to construct existential coherence amid the uncertainties of crisis and vulnerability.

Such capacity, however, cannot be understood—like any other competence in its potential profile—as an innate or immutable gift. It is configured and actualized historically, through practices and narratives that religious traditions, in their multiple forms, have been able to offer.

In pedagogical terms, if one wishes to explore the complex and fascinating morphology of spiritual competence, it is necessary to consider its situated mobilization: it emerges, for example, in moments of existential drama, when knowledge and abilities rooted in the historical forms of its expression are called into play. Such forms become possible only through a process of religious literacy, which can also take the "negative" form of a critical distancing from a religion and its moral practices.

The option of spiritual competence thus proves to be as fascinating as it is complex. On the one hand, its effective mobilization requires passing through practices of religious literacy that, through efforts of signification, symbolization, and ritualization, make the exercise of spirituality possible. On the other hand, in a secular and plural perspective—not laicist nor ideologically secularized—appropriate to the public sphere, it is necessary to avoid imposing the attested forms of any one religion. In this direction, Habermas's theory of the public sphere allows spirituality to be read as a symbolic language that can enter the shared dialogical space, not as a confessional claim but as a critical and communicable contribution (Habermas, 1989). Parallel to this, Martha Nussbaum's *capabilities* approach reinforces the idea that spiritual freedom must be guaranteed as a

fundamental human capability, with respect for cultural and plural differences (Nussbaum, 2000).

For a proper understanding, it is also necessary to clarify beforehand the category of competence, distinguishing it both from the mere materiality of the knowledge and skills that constitute its prerequisite, and from the unrealistic, counterfactual hypothesis of an innate origin.

According to Rey (2009), competence is not a stable portfolio of abilities that a subject "possesses", but the capacity to activate cognitive, affective, metacognitive, and operative resources in response to complex, unpredictable, and situated problems. In other words, competence emerges only when it is "tested" in real contexts, requiring the ability to mobilize resources in situation (Rey, 2009; Rey, 2022). If competence is always situated, then "spiritual competence" too must be conceived as something constructed through immersion in meaningful contexts, cultural dialogue, and reflective practice. It is not enough to proclaim that "everyone has a spirituality": it must be made active, thinkable, practicable.

Pedagogical reflection reminds us that words such as "ethics," "empathy," or "resilience" do not magically emerge without elaborative processes. Likewise, spirituality demands symbolic mediations, narratives, and interpretive practices: without these, it remains a "vague feeling," lacking the tools needed to relate to others and to support those who are facing death.

How, then, can spirituality emerge as a formative competence without slipping into confessionalism? The answer, some argue, must pass through a conscious use of the cultural history of religions as symbolic resources, not as imposed doctrine. For centuries, religions have in fact functioned as "schools of spirituality": offering symbols, rituals, and practices to accompany dying, to give meaning to pain, to build memory and community. This heritage can be valued in secular educational contexts: not as adherence, but as symbolic material to be analyzed, deconstructed, and made accessible to those who do not belong to those traditions.

From another perspective, perhaps more viable given the personal nature of competence, it is necessary to begin, in a cognitivist key, with a meta-reflection on the professional's own religious experiences, helping them to discern the symbolic processes, trajectories of meaning, and ritualizing impulses that shape them. This does not exclude the knowledge of other religious traditions and the importance of multi-religious literacy, but it allows one to recognize a personal itinerary of spirituality that, like one's personal ways of interpreting the professional role, constitutes the unique repertoire of one's professional practice and makes it concretely and practically effective.

In this sense, the task of healthcare education is mediated by three operative axes. First, pluralistic openness: offering students contact with diverse religious traditions (Christian, Buddhist, Islamic, Jewish, secular philosophies) as symbolic resources to know and read critically. Second, pedagogical rather than prescriptive character: spiritual languages are not proposed as truths to be embraced, but as interpretive tools that students can bring into dialogue with their own experience. Third, critical reflexivity: students are invited to confront the tensions between symbolic narratives and their own worldview, to distinguish what they can appropriate from what remains distant, to autonomously elaborate their own language of meaning.

These axes can be translated into concrete educational practices: clinical simulations in which questions of meaning arise; role-plays in which students are invited to "respond" not only technically but with attentiveness to the existential dimension; autobiographical narratives or testimonies of illness and loss; reflective group debriefings (of the Balint type) oriented not only toward emotions but toward the questions of meaning that arise in caregiving. Only in such contexts, where the relational dimension is real and participatory, can spirituality be activated as competence: not as sterile theory, but as exercised sensibility.

This line is not merely theoretical: empirical studies and interventions show that well-designed educational programs can improve spiritual competence (or the ability to provide spiritual care) among healthcare professionals. For example, an experimental study in Malaysia evaluated a "Nursing Spiritual Care" module applied to 122 palliative care nurses: the experimental group, after two weeks of training, showed a statistically significant improvement in spiritual competence compared to the control group ($p = 0.001$) (Ahmad et al., 2024).

Other studies confirm this trend with different methodologies. Hsieh, Hsu, Hinderer et al. (2023) designed a scenario-based (OSCE) course for clinical nurses: results indicated that simulations improved spiritual vision, perspectives on spiritual care, and spiritual competence itself, though long-term effects on the official SCCS score required adjustments. Convergently, a broad meta-analysis on nurses' competence in spiritual care showed that, globally, competence is "moderate", and that the factors most influencing it include educational background, participation in spiritual care courses, religious practice, and empathy (Wang et al., 2024).

Similarly, studies in China (Zhang et al., 2023) and Iran (Farokhzadian et al., 2025) confirm that spiritual competence is, on average, only moderately developed among nursing students, but can be significantly increased through targeted courses, simulations, continuing education, and critical reflection.

All these findings converge toward one conclusion: spiritual competence is underdeveloped in most healthcare professionals, but it is neither immobile nor unchangeable, and far from absent; it can be enhanced through carefully designed educational pathways. Its thematization, indeed, becomes fundamental in light of the experience of limit and existential breakdown that constitute a normality in healthcare practice.

A further dimension to consider is the effectiveness of spiritual interventions for patients: some reviews report that spiritual interventions (religious or not) contribute to reducing suffering, improving quality of life, and preparing for the end of life (Balboni et al., 2022). This strengthens the argument that spirituality is not an accessory, but a constitutive part of integral care.

The great pedagogical challenge remains that of secularity. It is not about neutralizing spirituality, but about proposing it in ways that respect individual freedom. In this light, spirituality becomes an "educational device of meaning", not a dogma. Students are not passive recipients but interpreters: they learn to read symbols, to engage in dialogue with narratives, to construct, within their professional identity, a style of accompaniment that does not impose but offers presence, listening, and meaning.

Finally, a well-designed education must also provide for qualitative and reflective assessment mechanisms: it is not about measuring "how spiritual" a person is, but about facilitating the passage from symbolic ignorance to active competence, about accompanying awareness and professional growth.

Conclusions - Educating for Limit-Care: The Spiritual Call of Death in Healthcare Contexts

Confronting death within healthcare and educational training does not mean adding yet another chapter to an already established body of knowledge, but rather restoring centrality to what permeates every human experience: the limit. It is the limit that grounds freedom, that renders life thinkable and care authentic. Illness unveils it, death consummates it, and pedagogy embraces it as an opportunity for learning and transformation.

In this framework, death education, death literacy, and spiritual competence are not specialist tools, but essential alphabets that give voice to what is so often silenced. They teach us that death is not merely a clinical event or a private matter, but a social and educational experience, capable of opening up possibilities for meaning and for shared responsibility.

For professionals in health and education, the task is not to "explain" death, but to learn how to dwell within it: accompanying those who face it, sustaining those who remain, and allowing their own professional self to be transformed. Training, in this perspective, is not about neutralizing vulnerability, but about cultivating the capacity to bear it, to give it narrative and symbolic form, to translate it into care.
Ultimately, the goal is to educate practitioners who not only know how to heal or assist, but who are also able to bear witness: to stand, to listen, to welcome; ensuring that, in the face of death, the dignity of life is reaffirmed. For perhaps, as the great narratives across the ages remind us, the ultimate task of care is not to conquer the end, nor to unravel its enigma, nor to anesthetize its inevitably tragic profile, but to inhabit its mystery with humanity, remaining present to it, and allowing it to renew the very meaning of life itself.

Author contributions

First author authored the paragraphs: "Introduction - The Limit as the Key to Care: Life, Illness, and Death"; "Spiritual Competence, Situatedness, and Secularity in Education and Healthcare Education"; "Conclusions - Educating for Limit-Care: The Spiritual Call of Death in Healthcare Contexts".
Second author authored the paragraphs: "Educational Care and Death: Attending to the Other, to Transitions, and to the Professional Self"; "Death Literacy Pathways for Accompanying Life".

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