MEANING OF SPIRITUALITY FOR CRITICAL CARE NURSING

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ABSTRACT: The aim of this exploratory and descriptive study with a qualitative approach was to identify the meaning of spirituality for the nursing staff at an intensive care unit and to investigate how the professionals' spirituality values intervene in the care process. We conducted semi-structured interviews with thirty-four professionals working in an intensive care nursing team in a public hospital in São Paulo city. The categories were: The spiritual dimension and its meanings, composed of the subcategories: Faith and religious belief; Belief in a Higher Force/Power; Spiritual well-being and Attribute of the spirit. The other category was emerging: Between bond and conflict: the influence of values in care delivery to seriously ill patients, subdivided into: Religious values and Bioethics values. The multiplicity of meanings reflected the multidimensional nature of the spirituality concept expressed in the literature and was related to the nursing staff's emotional conditions in the relations of empathy and in existential issues.

DESCRIPTORS: Spirituality. Religion. Communication. Nursing. Intensive Care Unit.

SIGNIFICADO DE ESPIRITUALIDADE PARA A ENFERMAGEM EM CUIDADOS INTENSIVOS

RESUMO: Tratou-se de um estudo descritivo-exploratório, de abordagem qualitativa, que objetivou identificar o significado de espiritualidade para a equipe de enfermagem de Unidade de Cuidados Intensivos e investigar como os valores de espiritualidade dos profissionais interferem no processo de cuidar. Foram realizadas entrevistas semiestruturadas, com trinta e quatro profissionais da equipe de enfermagem intensiva de um hospital público do município de São Paulo. As categorias de análise foram: A dimensão espiritual e seus significados, composta pelas subcategorias: Fé e crença religiosa; Crença em uma força/poder superior; Bem-estar espiritual e atributo do espírito, e a outra categoria emergente foi: Entre o Vínculo e o conflito: a influência de valores no cuidado ao paciente gravemente enfermo, subdividida em: os valores religiosos e os valores bioéticos. A multiplicidade de significados refletiu a multidimensionalidade conceitual expressa na literatura e estiveram relacionadas às condições emocionais da própria equipe de Enfermagem, por interferirem nas relações de empatia e nas questões existenciais.

DESCRITORES: Espiritualidade. Religião. Comunicação. Enfermagem. Unidade de Cuidados Intensivos.

SIGNIFICADO DE LA ESPIRITUALIDAD PARA LA ENFERMERÍA EN CUIDADOS INTENSIVOS

RESUMEN: Estudio exploratorio descriptivo, de enfoque cualitativo que tuvo como objetivo identificar el significado de la espiritualidad en el cuidado de enfermería en la Unidad de Cuidados Intensivos e investigar cómo los valores de espiritualidad de los profesionales pueden intervenir en el proceso de cuidar. Fueron conducidas entrevistas semi-estructuradas con treinta y cuatro profesionales del equipo de enfermería intensiva en un hospital público de la ciudad de São Paulo. Las categorías de análisis fueron: La dimensión espiritual y sus significados, conformada por las subcategorías: Fe y creencia religiosa, Creencia en una fuerza/energía superior, Bienestar espiritual y Atributos del espíritu. La otra categoría descubierta fue: El vínculo entre los conflictos y la influencia de los valores en el cuidado de los pacientes gravemente enfermos, subdividida en: valores religiosos y valores bioéticos. La multiplicidad de significados reflejó la naturaleza multidimensional del concepto de espiritualidad expresado en la literatura y se relacionó con las condiciones emocionales del propio equipo de Enfermería en las relaciones de empatía y demás asuntos existenciales.

DESCRIPTORES: Espiritualidad. Religión. Comunicación. Enfermería. Unidad de Cuidados Intensivos.

INTRODUCTION

Technological development in health sciences enhances revolutions in the meanings attributed to health-disease processes, for patients as well as for technical health staff. Professionals increasingly seek further knowledge, to the extent that technological advances demand the development of protocols, which builds care based on the technical execution of procedures, team specialization, equipment handling and the building of competences and technical skills for care delivery to recoverable patients in severe conditions, which represent the center of work at an Intensive Care Unit (ICU).[1]

At the same time, the critical review of Nursing's involvement with technology emerges as the construction of human care sciences is fundamentally guided by the humanistic concepts of the term person, and has adopted mechanistic values in a hardly critical way. Hence, technology has influenced not only direct patient care, but also the values, knowledge, skills, health care policies, rules and responsibilities of the professionals active in this area.[2]

Today, important paradigmatic changes are found in the health sciences. The modification of the health concept the World Health Assembly (1983) proposed is a good example of the changes in conceptual constructs in this area, which human beings gradually outline to attend to their existential needs.[3]

Nowadays, the health concept also includes the not material or also spiritual dimension. After that Assembly, the World Health Organization created the Quality of Life Group, which includes the Spirituality, Religiosity and Personal Beliefs (SRPB) domain in its generic quality of life assessment instrument, the Word Health Organization's Quality of Life Measure (WHOQOL).[3]

The formalization of this new domain not only established a new way of being in the world, but the need to broaden scientific knowledge with regard to the recognition of spiritual needs, of patients as well as the population in general. Thus, aspects transcending human beings, to higher cosmic structures than the limitation matter imposes, reinforce the mechanisms that enhance the way we interact with the other and with the world.[4]

The approximation between science and so-called religious themes has been more intense and has occurred through different routes. Science and spirituality are on the agenda as never before. The process of returning to the human values of care, associated with the cultural importance of religious aspects as itinerant in the cure/rehabilitation process of diseases have undoubtedly been fundamental mechanisms for the spirituality discourse to enter into health care.

In general, spirituality has been described through more common conceptual elements, which are: 'sense', related to an ontological meaning for life, resulting from a wide range of experiences; 'values', comprising culturally accepted beliefs and patterns, estimated through common behaviors for certain people; 'transcendence', referring to experiences that permeate the field of subjectivity; 'connectivity', closely related to the relationship with God, with others, with nature and oneself and, finally, 'becoming', characterized by the human being's search for an unfolding of life, the search for a full meaning for one's existence.[5] Religion, in turn, can be understood as the systemization of ritualistic and symbolic elements, which shape and determine the way people access the divine and the sacred. The execution of these rites is called religiosity.[5] Religiosity and spirituality mark the new age, especially as from the moment when religious/spiritual beliefs and practices have demonstrated their strong influence on the help to cope with very different situations of unbalance in people's health, preparation for death, and even in professionals' interpersonal relations. This fact became particularly relevant as from the year 2000, when publications on spirituality in health considerably increased.[6]

Researchers[7] observed that, to the extent that the health team identified spiritual needs of recently passed away patients' relatives, coping with mourning was the best, as affective bonds tended to extend to belief in a future life, beyond physical life.[7] Another important aspect, found in another study, was the fact that, as the severe disease progresses, existential issues tend to be more recurring in the discourse of family members and patients than concerns with technological and clinical approaches.[8-9]

In the analysis of the movement between care delivery and self-care at an Intensive Care unit, researchers[10] observed that nursing professionals displayed feelings that enhanced humanized and holistic care; the adopted welfare model, ruled

by standardizations, however, did not permit the identification of these feelings during care, which aroused frequent conditions of psychological suffering in the team, mainly because members shared an environment surrounded by pain, suffering and losses.[10]

After exploring current issues and the relevance of spirituality and religiosity as a theme for nursing, and with a view to further exploring the topic in the Brazilian context, the aims of this study were to: identify the meaning of the spiritual dimension in care delivery for the nursing team at the Intensive Care Unit and verify whether the nursing team's spirituality values interfere in the care process.

In this study, the concept of human being proposed in the Theory of Transpersonal Caring[11-12] was used, so that human beings human beings are conceived based on transcendent principles and are not restricted to temporal issues, but interact through their own dimensions, including the ability of coexistence between past, present and future, and continue to exist even after the death of the physical body. Non-verbal communication aspects were also observed in nursing, especially regarding issues related to proxemics, kinesics and paralanguage.[13]

METHOD

A qualitative, exploratory and descriptive study was developed at the ICU of a University Hospital in São Paulo. The population consisted of 34 nursing team members (nurses and nursing technicians) from the adult ICU, working morning, afternoon and night shifts, who accepted to participate in the study. Working at ICU for at least six months was adopted as an inclusion criterion. The intent of using this criterion was to enrich the discourse contents.

Initially, the project was forwarded to the Research Ethics Committee at the study institution (Process number 695/06). After its approval, the professionals were contacted and those who agreed to participate signed the Informed Consent Term, after receiving adequate information about the study aims and guaranteed anonymity, among other items in the term, which also guaranteed information confidentiality.

For data collection, the structured self-report technique was used, guided by an interview script with the following key questions: what does spirituality mean to you? and Do you think your faith/belief (in God or some other divine being) influences the care you delivered? In what way?, which provided support to interpret and reach the goals set. The interviews were individually held at a private room in the Intensive Care Unit, with a mean duration of 20 minutes. The reports were tape-recorded and subject to content analysis, whose approach was linked with hermeneutics, permitting further exploration of subjectivities in the collected reports. The analysis lines were delimited through pre-analysis, material exploration, result treatment, inference and interpretation.[14] The study took place between the start of 2007 and 2008.

For the sake of organization, the reports fragments were identified, with N and T indicating Nurse and Technician, respectively. The number following the letter indicates the discourse's position in the development of the content analysis technique.

RESULTS

Out of 34 professionals who participated in the research, 30 were female and four male. Ages ranged between 24 and 56 years (±26.3), while time of work at the ICU varied between 6 months and 15 years of experience (±10.2).

Concerning religion, 15 referred Catholicism. Among these, four affirmed active religious practice. Eight professionals cited Protestantism, all of them active. Three mentioned Spiritism as their religion of choice, two of whom indicated religious practice. One referred being a member of the Adventist church and church attendance at least once a week. One professional affirmed Buddhism as a religious form of keeping contact with the spiritual level and one mentioned being an active practitioner of Candomblé. Three indicated no religious bond and two professionals indicated more than one religious bond, although without specifying which.

Based on the reports and the methodological framework used for analysis, two central categories and six sub-categories emerged as the corpus of discussion for this research, as follows: The spiritual dimension and its meanings, comprising the subcategories: Faith and religious belief; Belief in a Higher Force/Power; Spiritual well-being and Attribute of the spirit. Between bond and conflict: the influence of values on care delivery to severely

ill patients, subdivided in two branches: Religious values and Bioethical values.

The spiritual dimension and its meanings

Faith and religious belief

The most prominent subcategory in the discourse expresses the close relation between spirituality and the expression of religious life, as illustrated by the following fragments:

[...] *I think it's,* [pause] *it's* [pause], *hm, difficult. But I think that spirituality is related to religion. We need religion for support, to believe in God. I think that spirituality is closely connected with religion* (N32).

[...] *I think it's always connected with some religion. Some religious entity, no matter which* (N34).

[...] *we deal with different kinds of people, various types of emerging spirituality* [in the sense of religion]. *Some people follow this* [religious] *line, some follow another, so certain types we are able to identify by talking and so. You ask about religion, often it's there, connected* [...] (T24).

For most participants, spirituality is the same as faith and religiosity. Another relevant aspect refers to the Western model of religion, which is based on the monotheist concept of God, as He, the Supreme Being of creation, is responsible for human beings' destiny, interconnected with certain organizational models of religious thinking.[15] A fundamental characteristic of spirituality discourse could be observed as religious meaning, as follows in the discourse examples:

[...] *it's, it's connected with faith* [...] *I believe in God, the Supreme, he who created all things.* [...] *because I believe in the bible and bible talked a lot about our body, the body would be the flesh, the spirit and the soul* (T04).

[...] *I think it's believing in something, which for us Christians is God, it's Jesus, and founding your life on that. It's as if you've got something superior you can rest on at times of difficulty* (T08).

Look, for me, spirituality is the human being's ability to believe [pause], *religious beliefs, believing in something religious* (N11).

Another aspect that emerged in the subcategory of Faith and religious belief was the fact that health professionals turn to religious discourse when confronted with patients or family members' condition of weakness:

[...] *the patient who's in pain, depressed, away from home* [...]. *He's in need of care. So we tend to overcome that, transmitting peace, dedication, stimulating faith that he'll get better. This helps a lot, if you ask him to trust in God, because soon you'll get out of here cured. Because it's God's merit because He created us* (T01).

Other reports put forward religion as a means to achieve spirituality, as observed in the following excerpts, in which religious influence basically rests on the premise of God as an established entity:

[...] *I think it's the means* [religion] *through which the person finds peace. It's difficult to find peace, but religious offers that, at least to me* (N07).

[...] *what reveals spirituality to you is your faith. If you have faith* [pause followed by a sudden change of subject] *because nobody has ever seen God, never. In this case, my God is black and yours is white, because it's written there* [in the bible] *that He is image and likeness* [...] (T12).

Especially in the modern world, religion has revealed a trend, since clerical development and the sublimation of the capitalist system, to monopolize the spiritual.

Belief in a higher force/power

This subcategory revealed the meaning of spirituality as an idea of belief in a higher force or power.

To me, spirituality means that you believe in something, in something higher [...] *I think that spirituality does not boil down to religion* [...] (T17).

Spirituality [...] *is related to something you believe without seeing it; a higher force you seek to justify some excerpts of your life, and a support that is not* [physically] *present* (T33).

The following discourse appoints some degree of reconstruction/re-signification of the spirituality idea, departing from a system of beliefs to an idea of spiritual needs that is elaborated differently:

[...] *what I consider spirituality today differs from what I understood a couple of years ago. Today, I consider spirituality as a relation I have with a Higher Being, whom I call God* [...] *that's what I understand as spiritual. A couple of years ago, it was a synonym of religion for me. I think that concept changed as I gained maturity, not only personal but professionally, and I managed to perceive that people have needs which often are not religious, but spiritual* (E19).

Personal development, through contact with the other, with a wide range of situations in life, permits the review of concepts and the broader way in which the world is perceived and gains meaning.

Spiritual well-being

The discourse of spiritual well-being contains the purpose and meaning of life for people, which suggests a decrease in the conflict established in interpersonal relations in health regarding different religious branches. The following fragment expresses that perspective:

[...] *ah! I think it's a state of mind, something you believe, that you feel well, that does you good. Something you believe and that does you good. I think that's it. That's what I think* (N05).

Based on the above fragment, the idea of spiritual well-being leaves people in a certain state of benevolence, whose meaning of the spiritual dimension as a state of well-being would imply changes in the communication skills practiced every day.

Attribute of the spirit

This subcategory is closely related with the etymological meaning of spirituality and is part of the attributes of the spiritual dimension. It is interesting that this does not exclude the other conceptions, but provides reflexive contents, applicable in the categorical structures discussed earlier.

I think spirituality comes from spirit, so I think that's it (T14).

For me, spirituality refers to spirit, to the person's spirit, and what I consider as spirit is that thing that's, that accompanies the physical body during existence. It's the thing that makes the person is, be [pause], *have different needs, live and perceive things in different ways* (N18).

[...] *spirituality is everything you see inside the person. Not her body, you know* [...] *it's what we were not seeing, it's not the person's body, but her spirit. Because, often, we* [body] *may be sick, but the spirit isn't* (T29).

It is peculiar that the fundamental axis that sustains the philosophical base of nursing care is centered in this subcategory, as understanding the spiritual dimension as an attribute of the spirit implies granting human beings an undeniably transcendent characteristic, and the aim of care attitudes should be interacting with this dimension.

Between bond and conflict: influence of values on care delivery to severely ill patients

This category comprises two subcategories: religious values and bioethical values, and evidences relations of bonding and conflict.

Religious values

Especially in Brazil, religious values are predominant in people's moral, social and spiritual orientation. This subcategory emerged from the relation between religious values and the care attitude towards patients in severe conditions.

When the person is weak, in bed, and even dying, it's [pause] *we perceive that the issue of religion, of faith* [...]. *There's a [...] one patient's history* [...] *who was hospitalized for six months with us* [...] *we created a very strong relation of complicity because of the religion* [...] *we used to talk the same language* [...] *comforted each other* [...]. *One day I brought this patient a hymn* [...]. *She was so down that weekend, at the end of the shift, she became very happy* [...] *and then, afterwards, she started to sink, started to sink* [silence] *she died around carnival* [...] *It's a feeling* [...] *not like a patient like so many others who come, who come and go; I felt that she was a patient who had something we had to finish together* [silence] (T03).

The form of religious manifestation often does not follow the theoretical premises that rule it, as transcendence is not a possibility but a certainty all religions dictate, each in its own way. In the following discourse, the barrier created in care is notorious, given the religious difference and existing conflict when professionals also face difficulties to deal with the wide range of situations that occur at the unit:

[...] *when I am dealing with the patient, I try, yes, not to show a lot of my spirituality* [religion] *because I don't know if it's compatible with him. I'm afraid of creating an aversion because I don't know what faith he professes; so I'm afraid of invading the person's space* [...] *I keep my distance (T15).*

I think it influences a lot [...]. *We've got a patient here at the ICU* [...]. *Each day I think something: Why? What happens to her? Was it a fatality? Something spiritual? Is it a punishment?* [...] *I don't know if I fulfill my obligation there* [...] *of this spiritual thing, that is, I don't stop by her side to talk* [...] *to know if she wants to tell me something, if she wants to ask me something* [long pause, eyes filled with tears], *out of fear really, you see, because I don't know how I'm*

going to deal with it if she asks me questions like: 'why did this happen to me?'(N11).

Religious values were also manifested from a curative perspective, through divine intermediation, as observed next:

[...] *I think it's very important to have a religion, like, I think that a person who says: 'I don't believe in anything', what do you mean you don't believe in anything?* [emphatic voice]. *You need to have a base. I have that and it supports me. So I think that, in a way, it does influence care* [...] *how often have I said: believe in God, you'll get better, you will get better madam, with God's grace' (T08).*

They get to trust us through the word of God. When you're going to deal with the patient, even if he's apparently unconscious, sedated, but you [...] *start to talk about God: 'look, God, he's good, he's marvelous; even if you cannot talk, but you can think good things about God. He'll cure you, he'll get you out of this bed, he, you know, because God has the power for all this, you just have to believe in him'* (N24).

In the presence of prolonged pain and situations in which some kind of bond is created, the professionals expressed conflicting aspects in the care interaction, as well as religious/spiritual aspects to cope with the situation:

[...] *there are some cases in which* [...] *you go home and then, when you're going to pray, going to talk to God, you remember asking something for that patient, not for all of them, no* [...], *but there are some cases in which you keep on thinking: 'oh dear, my God, take a closer look at her now'* [...]. *You know, it doesn't matter how much you see, you keep a little bit of faith; for the family* [...] *and you kind of start to put yourself in their place, and if it were a relative of yours?* (T31).

It is important to take care of the patient with kindness, with love, with religion, with good belief [...] *it's not that God's going to cure, because God won't be able to cure everyone who's there, on the brink of death. I think each person has his time to die. I hope that the person won't suffer that much, because sometimes we see that here at the ICU* [...] *it takes time, even because of the drugs used, noradrenalin* [...] (T22).

The religious values showed a close relation with the care aspects in situations of human suffering. This factor could be observed in the use of the designation "God" in participants' reports.

Bioethical values

This subcategory emerged from discourse whose contents pointed towards a less religious analysis in the approximation process for care relations. It appeared in a more humanistic context that legalizes nursing work. This fact, however, does not include the presence of conflicts, of human values in view of painful events in life, as observed in the following fragments:

[...] *I find it important to respect. Respect* [religious belief], *it can help in something he wants, understands* (T05).

[...] *look, I've got a very private saying* [...] *that I don't do to others what I don't want them to do to me. And my right as an employee starts when I take good care of a patient, I'm a caregiver, you see?* [...] *If he dirties himself ten times, I'm here, ten times I have to clean it* [...]. *But I have to stay there, you see, because that's my profession, that's my job. So, it's not a matter of whether my religion influences that (T12).*

[...] *what influences is the respect I feel, it's the sensitivity, it's my way of being, so that influences my care* (N23).

[...] *I always attempt to treat people as I would like to be treated. I can't let my faith, my religious belief interfere to the extent of being harmful or prejudiced, or of wanting people to be alike* [...]. *So I think that it does influence, yes. But not in a way that bothers, because sometimes I think that people mix up things a lot* (N18.)

It was evidenced in the discourse that the bioethical relations are established in the field of principlism. The four known principles of this philosophical current, which is part of Western culture: benefaction, non-malefaction, autonomy and sense of justice.[20]

DISCUSSION

The theoretical/philosophical base of Transpersonal Caring aims to provide nurses and health professionals in general with intellectual and sensitivity tools to establish spiritual involvement and, when this occurs, the material gains new meaning towards the true sense of human interactions, which is the spiritual being.[12-13]

The repercussions of the conceptual kaleidoscope on spirituality in the participating professionals' clinical practice were evidenced in the first category: The spiritual dimension and its meanings. This finding is in line with the existing discussion in literature about the wide range of spirituality meanings that have been at the center of philosophical, religious and scientific discussions among current scholars in this area.[15]

In the health context, the link between spirituality and religiosity can result in severe ethical problems if professionals are not attentive to the limits of using the resource of faith as a conduct to build a therapeutic bond with patients and families. This fact is relevant, as the quality of relations is the essential element of effective care and, as observed in this study, the system of beliefs directly influences the care bonding process. Any negative interference in interpersonal relations that provokes limited or impossible contact can be considered a severe care problem.[19-20]

The importance of this fact for critical care is significant, as religious life tends to direct ruled actions by religious symbolism, whose elementary characteristics are the (ceremonial and/or ritual) expressions, based on specific rules, deriving from the set of experiences originating in a very diverse range of cultural traits of humanity. [21]

In this sense, religious beliefs and ritualistic practices are the most common mechanisms people use at times of disease and, the more severe, the more intense the religious connection and decision making about the direction of treatment become, under the influence of the religious context the patient is inserted in.[22-23]

Stimulating beliefs whose variables remain far below human knowledge would put both the ethics and esthetics of health care at risk.[24] Given the urgent need to see to patients' spiritual needs as well, though, nursing should direct its efforts towards the development of care attitudes with a more spiritual than religious sense. Some caution is due, though, when dealing with religious themes, as discretionarily superimposing one belief as a mediator of care practice would entail irreparable ethical damage for professionals.

As an attitude towards the challenges of life, faith refers to the capacity to imagine, to formulate new questions for the construction of new meanings for life.[25] As evidenced in the subcategory Belief in a higher force/power, it could be ascertained that, for the professionals, the involvement of faith in care relations is linked with silent incursions in the attempt to understand and search a broader sense for life, distanced from religious life and close to a broader idea of connectivity with all things.[18]

A certain preference can be observed in spiritualist philosophical currents' use of 'higher force' or 'power' as, for many philosophers, defining God would mean reducing him to the human condition. This fact does not mean that the existence of a more-than-human intelligence is denied, as responsible for the organization of the universe, as classical philosophy rests on the energetic values of constructing and maintaining the organization of the universe and on themes related to the meaning of life and death. Nightingale's concept od God, for example, is very similar to this categorical structure, as the matriarch of modern nursing use the male pronoun to refer to God and called him Divine Mind or Universal Spirit.[26]

Another emerging theme in the study was related to some professionals' trend to use the term Spiritual well-being to conceptually access a less palpable or perceptible dimension than what the purely religious sense offers. In the same sense, the meaning of spirituality as an attribute of the spirit touched a metaphysical field that is widely explored in Transpersonal Caring Theory[12-13], although the elaboration of the reports obtained in this study did not permit any leverage for this important research field. Perhaps this fact is explained by the great difficulty to establish connections between professionals and patients capable of producing spiritual experiences in care[12-13].

In general, one important ethical aspect became acute when the professionals talked about situations of clinical instability. This fact reflected the thin lines that separate the discourse of stimulating patients and families from a false religious illusion. Experienced religiosity scholars suggest that professionals should stay alert when referring to God or other divinities before patients when the patient/family's system of beliefs has not been previously identified.[27]

From a philosophical viewpoint, both spirituality and bioethics dialogue with health. The contact between bioethics and spirituality, however, seems to be an epistemic movement, as spirituality in health has appeared more in people's convictions than it has been expressed in actual human relations and this fact tends to negatively influence care relations.[27]

In a way, the category Between bond and conflict: the influence of values on care delivery to severely ill patients expressed the professionals' difficulty to deal with their own feelings and values as bonds are created with some patients. Thus, one may understand that, independently of the religious branch, spirituality is a core component of the human condition. [28]

CONCLUSION

It could be identified that, for the nursing team at the Intensive Care Unit under analysis, the spiritual dimension has at least four distinct meanings: Faith and religious belief, Belief in a higher force/power, Spiritual well-being and Attribute of the spirit. It is observed that these multiple meanings were directly related with the care delivered to patients and families and predict the professionals' own emotional conditions, as they interfere directly in the relations of empathy and in their existential issues. Spirituality values hardly appeared in the professionals' discourse. The influences of Religious Values and Bioethical Values were detected in the care process for patients in severe conditions. These values have mostly created ambiguous situations of bonding and conflict in healthcare, as professionals feel insecure when dealing with patients whose religion differs from their own. The bioethics values were based on the relation of non-maleficence.

Concerning the implications for nursing, it can be inferred that establishing faith and hope as mechanisms for a multidimensional understanding of human beings becomes fundamental to understand the process of health recovery and healthy coping with illnesses. Study limitations referred to the lack of empirical data for Brazilian nursing for the sake of comparison with the identified categories. For future research, it is strongly recommended to cross professionals and patients' perceptions of spirituality's meaning, so that new elements can emerge and launch new research perspectives.

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