



SPIRITUALITY AND RELIGIOSITY OF DOCTORS WHEN COMMUNICATING BRAIN DEATH TO THE FAMILY MEMBERS

A ESPIRITUALIDADE E A RELIGIOSIDADE DOS MÉDICOS NA COMUNICAÇÃO DA MORTE ENCEFÁLICA AOS FAMILIARES

LA ESPIRITUALIDAD Y LA RELIGIOSIDAD DE LOS MÉDICOS EN LA COMUNICACIÓN DE MUERTE CEREBRAL A MIEMBROS DE LA FAMILIA

Ivaldo Menezes de Melo Junior¹, Lenilde Duarte de Sá², Fabio Nepomuceno³, Eveline de Almeida Silva⁴, Kerle Dayana Tavares de Lucena⁵, Layza de Souza Chaves Deininger⁶

ABSTRACT

Objective: analyzing the presence of religiosity and spirituality in communication done by the doctor to the family before the impending death situation of a young adult patient. **Method:** a descriptive study with a qualitative approach. In the field research there was used the procedure for collecting information in the form of oral history thematic. There were interviewed ten doctors intensivists of an Emergency and Trauma Hospital of Joao Pessoa/Paraiba. The research project was approved by the Research Ethics Committee, CAAE: 01974512.9.0000.5188. **Results:** after analysis of the interviews, two main themes were determined << Communication and humanized care: the physician before the family >> and << The influence of spirituality and religiosity in communicating brain death to relatives >>. **Conclusion:** doctors use their spirituality and religiosity to facilitating communication with family members about the possibility of death of a relative. Thus, religion, regardless of which is, provides subsidies to facilitating communication. **Descriptors:** Brain Death; Spirituality; Religion.

RESUMO

Objetivo: analisar a presença da religiosidade e da espiritualidade na comunicação feita pelo médico aos familiares diante da situação de morte iminente de um paciente adulto jovem. **Método:** estudo descritivo, com abordagem qualitativa. Na pesquisa de campo foi utilizado o procedimento de coleta de informações na modalidade de história oral temática. Foram entrevistados dez médicos intensivistas de um Hospital de Emergência e Trauma de João Pessoa/PB. O projeto de pesquisa foi aprovado pelo Comitê de Ética em Pesquisa, CAAE: 01974512.9.0000.5188. **Resultados:** após a análise das entrevistas, dois eixos temáticos foram determinados << Comunicação e cuidado humanizado: o médico diante da família e << A influência da espiritualidade e da religiosidade na comunicação da morte encefálica aos familiares >>. **Conclusão:** os médicos utilizam a sua espiritualidade e religiosidade para facilitar a comunicação com os familiares sobre a possibilidade de morte de seu parente. Assim, a religião, independente de qual seja, proporciona subsídios para facilitar a comunicação. **Descritores:** morte encefálica; espiritualidade; religião.

RESUMEN

Objetivo: analizar la presencia de la religiosidad y la espiritualidad en la comunicación realizada por el médico a la familia antes de comunicar la situación de muerte inminente de un paciente adulto joven. **Método:** un estudio descriptivo con abordaje cualitativo. En el campo de la investigación se utilizó el procedimiento de recogida de información en forma de la temática historia oral. Fueron entrevistados diez médicos intensivistas de un hospital de emergencia y trauma de Joao Pessoa/Paraiba. El proyecto de investigación fue aprobado por el Comité de Ética en la Investigación, CAAE: 01974512.9.0000.5188. **Resultados:** después del análisis de las entrevistas, dos temas principales se determinaron << Comunicación y atención humanizada: el médico ante la familia >> y << La influencia de la espiritualidad y la religiosidad en la comunicación de la muerte cerebral a los familiares >>. **Conclusión:** los médicos usan su espiritualidad y religiosidad para facilitar la comunicación con los miembros de la familia sobre la posibilidad de la muerte de un familiar. Por lo tanto, independientemente de cual religión sea, proporciona subsidios para facilitar la comunicación. **Descriptores:** Muerte Cerebral; Espiritualidad; Religión.

¹Physical Therapist, Mastership, Physiotherapy Coordination, Faculty of Medical Sciences of Paraiba/FCM. João Pessoa (PB), Brazil. Email: ivaldomenezes@yahoo.com.br; ²Nurse, Professor, Department of Nursing, Federal University of Paraiba/ UFPB. João Pessoa (PB), Brazil. Email: lds@hotmail.com; ³Physiotherapist, Mastership, Faculty of Medical Sciences of Paraiba/FCM. João Pessoa (PB). Email: fnepomuceno1@hotmail.com; ⁴Physiotherapist, Mastership, Federal University of Paraiba/UFPB. João Pessoa (PB), Brazil. Email: evelinesilva2@hotmail.com; ⁵Nurse, Doctoral student of Decision Models in Health, Federal University of Paraiba/UFPB. João Pessoa (PB), Brazil. Email: kerledayana@yahoo.com.br; ⁶Nurse, Mastership student of Decision Models in Health, Federal University of Paraiba/UFPB. João Pessoa (PB), Brazil. Email: layzasousa12@hotmail.com

INTRODUCTION

Communication is an important tool for the construction of an intensive care unit (ICU) more humane, harmonious and efficient, seen that communication is a dynamic process involving information sharing, purposes and rules between people, where the objective information, honest and frequent is always the most important needs of patients and families in the ICU.¹

Health professionals can pursue, at every opportunity, act as facilitators and processors of this reality in the ICU and could lead their practice from their beliefs, whether by spirituality and/or religiosity, particularly in the act of communicating the imminent death of their patients.

Spirituality is a human propensity to seek meaning of life through concepts that transcend the tangible: a sense of connection to something larger than itself, which may or may not include a formal religious participation.²

Religiosity is an organized system of beliefs, practices, rituals and symbols designed to facilitate proximity to the sacred and the transcendent, and spirituality as the personal quest for understandable answers to existential questions about life, its meaning and its relationship with the sacred or transcendent.³

Spirituality and health religiosity are a clear paradigm to be established in daily clinical practice. It is essential to recognize that these different aspects are correlated in multiple interactions. Thus, the object of study was spirituality and religiosity of the medical professional in the process of informing the family about the diagnosis of brain death of its loved one affected by a cranial trauma, especially because it is most often in young patients who will have their lives interrupted so abruptly. Thus, we raise the following issues: How the doctor informs the family about the imminence of death? Spirituality and religiosity are present in the communication to the family before the impending death?

Given the above, this study aims to:

- Analyzing the presence of religiosity and spirituality in the communication done by the doctor to the family before the impending death situation of a young adult patient.

METHOD

This is a descriptive study with a qualitative approach. In the field research there was used the procedure for collecting

information in the form of oral history. This becomes a means of seeking clarification of conflicting situations, controversial and contradictory, guided by the resources given by the sequence of questions that should lead to the subject clarification.⁴

There were interviewed through a tape recorder ten intensivists physicians, two women and eight men, of the Emergency and Trauma Hospital Senator Humberto Lucena, located in the city of João Pessoa, Paraíba, Brazil, where was chosen the scene of the research, to be a reference hospital in the State of Paraíba and due to the large contingent of injured suffering cranial trauma. The interviews were conducted in April 2012, soon after the project was approved by the Institutional Review Board (IRB) at the Health Sciences Centre (SCC) of the Federal University of Paraíba/UFPB, CAEE: 01974512.9.0000.5188.

To run the transcription process the following procedures were used: transcription of the recorded material, textualisation, transcreation, and identification of vital tone, conference and authorization for use and publication and analysis of empirical data produced.

To preserve the names of the employees, the narratives were presented with nicknames for each respondent, when there were chosen names of great doctors, men and women, of the World history. Including two women: Merit Ptah and Agnodice, and eight men: Luke, Avicenna, Aesculapius, Hippocrates, Jivaka, Cosme, Patch Adams, Damian.

The stage of processing of information collected in the interview gave birth to two themes, from the research objective: << Communication and humanized care: the physician before the family >> and << The influence of spirituality and religiosity when communicating death brain to the family >>. Data were analyzed qualitatively and with descriptive approach.

RESULTS

Results are presented from the interpretive process that is implied in the dialogic structure of the interviews, since both both the interviewer and the developer extract meanings from the meeting.

Main theme	Fragments
Communication and Humanized Care: the doctor before the family	What you have to do at the moment to report the imminent death is trying to put yourself in the position of a father. It is trying, to the fullest, to put in place that family, so you can transmit all necessary information in a process being scalable and irreversibly. Then you put yourself in place, show sensitivity to the situation, comfort somehow find out the family's religious beliefs. I always try to learn each other's belief (LUKE). Seeking thus approach the family depending on what I know a little of it. The level of education, the moment of suffering, the impact that it is causing to the family and also its religion ... (PATCH ADAMS). [...] I expose some details from the clinical point of view. For from there they [the family] start to assimilate the patient is very serious and we would not be able to leave the table even with all established therapeutic strategy (AGNODICE). [...] I see that the doctor has security than it is diagnosed, and that from the moment he realizes that the situation will become irreversible, it can, in a way, talk to family and already prepare it, especially if it's a family you note that do not have much knowledge, for it to go becoming aware of a fact that will occur within hours or days (AESCULAPIUS). [...] I try to have a doctor / patient / family relationship very open, always playing fair. You cannot be sometimes deceiving, wanting to ease a situation that does not exist, so we have to be objective, realistic ... Of course you have to understand the side of the family, as the difficulty of facing grief! Do not be harsh in no time, as there are many ways to tell the truth of what is happening without being cold (COSME).

Figure 1. Time to inform the family about the possibility of the imminent death of its relative.

Main theme	Fragments
The influence of spirituality and religiosity in the communication of brain death to family members	My religiosity influences directly this time of communication of death, because it was mainly for this reason that I started to look deeper into the study of religions. I was able to learn many things, including that this information should be given in staff, mainly due to organ procurement, transplantation, because then it becomes even more difficult the acceptance of family (DAMIAN). [...] So, whenever I see a patient in critical condition, not only in brain death, but in imminent death, I always ask the family: What is your religion? Because when the family wants to do something to alleviate the relative suffering. And a lot of times, you do not say that this may be the last time. So I always ask: You bring someone? And most always want to bring someone to say a prayer (MERIT PTAH). [...] I have the idea that there is the absolute from the material point of view, which is death, our only certainty. And the absolute spiritual point of view, that is God (JĪVAKA). We must not give up investing because there is always hope and I call it God, without any difficulty, and then yes with the developments, achievements ... I always try to go to the family that we are only professionals use the tools. I always say: doctor, nurse, practical nurse, physical therapist, nutritionist, everyone is there within that service to help, but who gives the end point is God. (AVICENA) [...] about my religion and spirituality, I see that now influence enough. Previously I was a religion in that thought, died and over! And the day you die will go to hell or to heaven. My education was Catholic, traditionalist, believing that man evolved from Adam and Eve and Noah existed and built an ark. I learned that faith is something that not of to discuss. Faith is something that is inside out. (HIPPOCRATES)

Figure 2. Spirituality and religiosity on the family communication about the irreversibility of the clinical chart of the patient with IC.

DISCUSSION

♦ Communication and Humanized Care: the doctor before the family

The situation of imminent death of young adult patients in the ICU becomes every day a constant. Therefore the health team of that sector must be prepared for these difficult times. The doctor, in particular, to be directly responsible to diagnose brain death, also communicates at first the family about the clinical condition of its relative. Therefore, this professional is believed that it should be prepared for this function, ie, present technical and scientific capacity, but with a

humanized vision and acting ethically in its behavior.

Proper communication between the doctor, the patient, and the family and the multi-professional team of the ICU is one of the main factors that interfere in satisfaction, both patients and from that who work in the sector. For proper information, the physician should be aware about therapeutic limits and must learn to treat the patient and its family during the process of dying, so its will feel safe to talk about death. Ideally, the professional responsible for providing the news was experienced, both from a technical

point of view, the ethical and it was, whenever possible, the same station.⁵

The family deserves special care from the moment of communication of diagnosis, since that time has a huge impact on them; they see their world crashing down after the discovery of a potentially fatal illness struck one of its members. This means that, in many instances, exceed their psychological needs of the patient and, depending on the intensity of emotional responses triggered, familial anxiety becomes one of the most difficult aspects of handling.⁶

From this type of conduct it is important to point out that humanization is the act or effect of becoming human, where such an act is realized by the experience of all site activity and the people who work there, giving the patient the treatment it deserves as a human person, according to the circumstances in which he finds himself during hospitalization. Thus the ability to speak and listen to establish the level of humanization of achievement to their fellow men, since all things in the world only become human when they pass through dialogue.⁷⁻⁸

Humanized care faces to the comprehensive care where it is necessary to customize the service, making it the most individual possible based on the principles of ethics, respect and love.⁹ With regard to family participation there is the importance of including family members and dear patient people as active participants in the communication process and decision making.¹⁰⁻¹¹

The humanized care are not intended to replace or reject the curative medicine, but add to this with greater amplitude of the size of treatment, focusing especially the patient and its family, to the detriment of the disease.¹²

In death took possibility, it is very important that there is a conversation between the medical staff and family to clarify the case. This communication must be clear, in a suitable place and passing serenity to the family that is going through a difficult time. The cases which have more difficulty as young patients or acute conditions require a better professional relationship with the family and that this is more aware of events. While we know that the range of words available for use on these occasions is small, in the case of a challenge that becomes difficult for any health care professional who deals with death, particularly physicians, we need at the moment leave aside the technical communication and make use of humanization. Therefore, vocational training

directed to the care value as it is necessary.¹³ Doctors kept a balance in your training on the theme of humanization to the detriment of more scientific technical matters.¹⁴

Given the information provided, we can observe the different emotional reactions of family members such as anger, guilt, accusation, grief and denial, which must be taken into account for the communication of this fact; this should be planned in addition to clinical aspects. In this context, the improvement of the structured dialogue should be part of the therapeutic arsenal of the teams.

In the communication of bad news, information has a special meaning because it leads the families of patients to a state of emotional crisis, and for health professionals, this situation creates tension. Many of these professionals manifest difficulties to establish contact with family members of deceased persons. This is mainly due to the lack of training for this type of communication.¹⁵

It is vital that the doctor in touch with the family to provide information about the disease and the general state of its loved one, seeking to clarify the equipment that will be around its family for the unknown environment they will experience in ICU is not scary and not increase their stress level. Furthermore, this relationship is a key to improving the quality of health services, which doubles up as many components as the customization of care, humanization of care and the right to information.

♦ The influence of religiosity and spirituality in the communication

The communication of brain death to the family is a difficult task for doctors, mainly because after this news will be asked to family donation of organs and tissues for transplanted. This may highlight ethical dilemmas permeated by religious, spiritual, cultural, economic and / or social aspects; requiring health care providers a holistic view, because only then it will have satisfactory results in their conduct.¹⁵

When you talk about spirituality, the fact of being spiritual is the first sense of ontological nature, which refers to a characteristic of the human being. Spirituality leads the individual to, from its knowledge; carry out its vital choices because every conscious human activity brings with it a spirituality that drives its reflective and purposeful activities.¹⁶

Spirituality and religiosity routinely are present in hospitals and in the ICU, where, in the silence and anxiety present in moments of

farewell to life, prayers and meditations are oratories and chapels in hospitals.¹⁷ However, it is within the family itself, in waiting rooms, who see the greatest spiritual mobilization at the time that communicates the severity of a patient. So, the doctor can be sensitive to this situation of pain, despair and denial of death of a loved one.

The doctor in the conception of diversity should listen and try to understand the point of view of the family. Listen respectfully does not require that the doctor agrees or modify its own views. Family members who realize that the physician understands and cares about them may be more willing to consider the doctor's opinions on the prognosis and treatment. When responding to spiritual and religious concerns of relatives and their needs, doctors can help them find comfort the end of life. This practice is common in the East, when you have an anthropocentric view of health, life and death, because they are never considered as natural phenomena, but human, cultural and taking the own human beings themselves and in their culture the first and fundamental explanation.¹⁸⁻¹⁹

The factor spirituality and religiosity, as related elements, helps immeasurably in the understanding of human finitude, although it is essential that these factors can not be reduced to the therapeutic nostrums. Nevertheless, there is an emerging literature that shows a salutary impact on the belief religious practices to the well being of the patient and its family. Also, if spirituality is seen as the search for transcendent meaning, then all human, secular or religious, beings must deal with spiritual matters. Disease severity of a patient, can therefore be seen by doctors as biological term, but yet also becomes a spiritual and religious challenge, therefore a human need to search through the religions for answers about death and dying.²⁰

Most religious doctrines see death as a key moment in the life of human beings, because it determines the passage to the afterlife. On the other hand, for humans less religious, death can hinder personal achievements as well as their life projects. Death rather than annihilate the meaning of life, stimulate the responsible actions of human beings, given that the awareness of finitude makes humans enjoy the possibilities of meaning of life alerting the conscience of not pass the times will, making the most of their choices.²¹

The various religions offer different angles to understand death. Thus, religion has played a leading role in matters of the visions of death, offering individuals positive visions of death, such as the afterlife, courage and

natural end, also providing a lower perception of death as failure, which would give a meaning to death.²²

The religious aspect is fundamental in the process of accepting and trying to minimize the suffering of those who see the severity of the condition of a patient hospitalized in the ICU or in cases of terminal illness. This aspect is often gone unnoticed.

God (not the case, only the Christian God) is considered the spiritual center of power to face the moments of risk of death, regardless of the religion then. In this sense, despite considering the subjectivity of the individual, the human being is the answer to many of their questions and doubts in a transcendental one, which is not in the world, but it is for the world, that is, a kind of divine force that sustains and gives existence to the individual. This transcendent occupies and fills the void of humanity.²³

The spiritual dimension to the confrontations of life comes at the expense of meaning, direction and hope. One is poor, socially and personally, in a sense, and, therefore, we try to reason, even metaphysical, to live and to die. We seek to make sense of earthly existence, a task to be performed in the course of life, but are not sure that this mission ends with death.¹⁷

If this last event of life is not experienced, because we are consecutively unable to reflect and talk about our death, the experience should be full when reached its present there as it is not the end of life, but the "passage" to another life that happens. Thinking this way, death then ceases. Consequently, despite the belief of human beings, often unshakable, about life after death, it is not known whether it actually exists. Everything remains shrouded in mysteries and questions of essentially religious and spiritual nature.

Regardless of religion practiced by our respondents, we can find in their speeches a humanized action through their religiosity, making it clear that this factor is increasingly addressed in health practices, as a way of promoting care and comfort to patients and their families.

FINAL REMARKS

We call attention to the communication between doctors and relatives, because the basis of humanization is in communication, and it must be present in the ICU as a facilitator and not as a stressor. The dialogue between people is disappearing every day, and as a result we have in the case of ICU, an

impersonal staff, low level of interpersonal and small scientific growth relationship because there is no exchange of experiences. So what could grow every day through communication and externalization of small ideas, ends stagnating for complacency in relation to a reality that even with so many problems, is still working.

Found in the statements of the medical professionals concerned about the importance of communication between the multidisciplinary team and the family, from the admission to the ICU, featuring a good welcome to the patient and their relatives. Within this dialogue perspective, we can highlight the influence of spirituality and religiosity used by doctors as a key factor in building a good humane care.

It was evident that all use the spirituality and religiosity to facilitate communication with family members about the possibility of death of a relative. For doctors believe that beyond the technical and scientific information, family members need to feel the support needed in that moment of pain and anguish. And it is through these dimensions that they find a way to ease the pain felt at that time by family members. So, religion, regardless of which professes, becomes an important factor in communication in the ICU.

REFERENCES

1. Knibel M, Celli CBP. Comunicação no Processo de Humanização em uma Unidade de Cuidados Intensivos (UCI). In: Faria MDGL. Humanização em Cuidados Intensivos. São Paulo: AMIB; 2004.
2. Guimarães H P, Avezum A. O impacto da espiritualidade na saúde física. Rev Psiquiatr Clín [Internet]. 2007 [cited 2013 Dec 20];34(supl. 1):88-94. Available from: <http://www.hcnet.usp.br/ipq/revista/vol34/s1/88.html>
3. Peres JFP, Simão MJP, Nasello AG. Espiritualidade, religiosidade e psicoterapia. Rev Psiquiatr Clín[Internet]. 2007 [cited 2013 Nov 24];34(supl. 1):136-145. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0101-60832007000700017
4. 4.Meihy JCSB, Holanda F. História Oral. Como Fazer, Como Pensar. 2nd ed. São Paulo: Contexto, 2010.
5. Moritz RD. Como Melhorar a Comunicação e Prevenir Conflitos nas Situações de Terminalidade na Unidade de Terapia Intensiva. Rev Bras Ter Intensiva [Internet]. 2007 [cited 2013 Dec 15];19(4):485-9. Available from:
6. Mendes JA, Lustosa MA, Andrade MCM. Paciente Terminal, Família e Equipe de Saúde. Rev Bras Psicol Hospitalar[Internet]. 2009[cited 2013 Dec 12];12(1). Available from: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1516-08582009000100011
7. Guanaes A, Souza R P. Introdução: Objetivos, Conceito, Histórico e Filosofia. In: Faria MDG et al. Humanização em Cuidados Intensivos. São Paulo: AMIB; 2004.
8. Carvalho GDA, Acioly CC, Santos SR, Valdevino SC, Alves AP. Necessidades espirituais de pacientes na terminalidade: vivência de Enfermeiros assistenciais. J Nurs UFPE on line [Internet]. 2014 [cited 2013 Jan 20]; 8(4):808-13. Available from: www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/8793.
9. Vila VSC, Rossi LA. O significado cultural do cuidado humanizado em unidade de terapia intensiva: "muito falado e pouco vivido". Rev Latino-Am Enferm[Internet]. 2002 [cited 2013 Nov 15];10(2):137-144. Available from: <http://www.scielo.br/pdf/rlae/v10n2/10506.pdf>
10. Burlá C. Palição: cuidados ao fim da vida. In: Freitas EV. Tratado de geriatria e Gerontologia. Rio de Janeiro: Guanabara, 2002.
11. Sorcinelli R, Johnson-Hurzeler R, Abbott JW, Thistle D, Flatow FA. O tratamento do paciente terminal: a assistência terminal, uma forma para a vida. In: Busley JG, White H, Rairns TV, Silenearh RA. Assistência ao Idoso: aspectos clínicos do envelhecimento. Rio de Janeiro: Guanabara Koogan; 2003.
12. Felício ECS, Pereira EF, Gomes D. Cuidados paliativos e fisioterapia: reflexões atuais. Cadernos [Internet]. 2006 [cited 2013 Nov 12];12(2):87-92. Available from: http://www.saocamilo-sp.br/pdf/cadernos/39/cuidados_paliativos.pdf
13. Starzewski Junior A, Rolim L C, Morrone LC. O preparo do médico e a comunicação com familiares sobre a morte. Rev Assoc Med Bras [Internet]. 2005 [cited 2013 Sept 20];51(1):11-6. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-42302005000100013.
14. Machado KDG, Pessini L, Hossne WS. A formação em cuidados paliativos da equipe que atua em unidade de terapia intensiva: um olhar da bioética. Rev Bioéthikos [Internet]. 2007 [cited 2013 Feb 20];1 (1):34-42. Available from:

<http://www.scamilo.edu.br/pdf/bioethikos/54/bioethikos.pdf>

15. Santos MJ, Moraes EL, Massarollo MCKB. Comunicação de más notícias: dilemas éticos frente à situação de morte encefálica. Mundo Saúde [Internet]. 2012 [cited 2013 June 15]; 36(1):34-40. Available from: www.saocamilo-sp.br/pdf/mundo_saude/90/03.pdf

16. Anjos M F. Para compreender a espiritualidade em bioética. Mundo Saúde [Internet]. 2007 [cited 2013 Feb 12];31(2):155-160. Available from: www.saocamilo-sp.br/pdf/mundo_saude/53/01_para_compreender.pdf

17. Pessini L, Bertachini L. Humanização e Cuidados Paliativos. 5th ed. São Paulo: Loyola; 2011.

18. Bernard LO, Ruston D, Kates LW, Arnold RM, Cohen CB, Faber-Langendoen K et al. Discussing Religious and Spiritual Issues at the End of Life: A Practical Guide for Physicians JAMA [Internet]. 2002 [cited 2013 Feb 12];287(6):749-54. Available from: <https://meded.duke.edu/practice/wp-content/uploads/2012/10/End-of-Life-spiritual-issues.pdf>.

19. Munanga K. Saúde e diversidade. Saúde Soc [Internet]. 2007 [cited 2013 Sept];16(2)[about 5 screens]. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-12902007000200003.

20. Astrow AB, Puchalski CM, Sulmasy DP. Religion, Spirituality, and Health Care: Social, Ethical, and Practical Considerations. Am Med J [Internet]. 2001[cited 2013 May 23];110:283-287. Available from: www.ncbi.nlm.nih.gov/pubmed/11247596

21. Frankl VEE. Psicoterapia e sentido da vida: fundamentos da logoterapia e análise existencial. 4 ed. São Paulo: Quadrante; 2003.

22. Pinho LMO, Barbosa MA. A morte e o morrer no cotidiano de estudantes de enfermagem. Rev Enferm UERJ [Internet]. 2008 [cited 2013 June 15];16(2):243-8. Available from: www.facenf.uerj.br/v16n2/v16n2a17.pdf

23. Ramos V B. Espiritualidade no contexto hospitalar: uma visão filosófica e cristã arraigada no Carisma de Champagnat. Cajur; 2007.

Submission: 2014/07/06

Accepted: 2014/12/02

Publishing: 2015/02/01

Corresponding Address

Kerle Dayana Tavares de Lucena
Residencial Atlântico
Av. Juarez Távora, 2997 / Ap. 401
Bairro Torre
CEP 58040-022 — João Pessoa (PB), Brazil