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The spiritual dimension of palliative care in chronic kidney disease: an integrative review

A dimensão espiritual dos cuidados paliativos na doença renal crônica: revisão integrativa

La dimensión espiritual de los cuidados paliativos en la enfermedad renal crónica: revisión integrative

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ABSTRACT

Objective: to analyze the influence of the spiritual dimension on coping with chronic kidney disease in palliative care patients. **Method:** integrative review conducted between April and May 2023, including the Virtual Health Library, MEDLINE, LILACS and BDENF databases, SCIELO and the PUBMED portal. The analysis was carried out using the software IRAMUTEQ. **Results:** the sample consisted of 12 articles, which identified the needs of the subjects and their strategies for promoting spiritual well-being and the professional challenge in managing the disease and promoting the subject's autonomy. **Conclusion:** the spiritual dimension helps people cope with chronic kidney disease, but they don't have all their care needs met. A challenging factor in clinical practice is the lack of specialized palliative care staff in dialysis centers.

Descriptors: Renal Insufficiency, Chronic; Renal Dialysis; Peritoneal Dialysis; Palliative Care; Spirituality.

RESUMO

Objetivo: analisar a influência da dimensão espiritual no enfrentamento da doença renal crônica de pacientes em cuidados paliativos. **Método:** revisão integrativa conduzida entre abril e maio de 2023, incluindo a Biblioteca Virtual em Saúde, bases de dados MEDLINE, LILACS e BDENF, a SCIELO e o portal PUBMED. A análise foi realizada com auxílio do *software* IRAMUTEQ. **Resultados:** a amostra foi composta por 12 artigos, os quais identificaram as necessidades dos sujeitos e suas estratégias para a promoção do bem-estar espiritual e o desafio profissional no manejo da doença e na promoção da autonomia do sujeito. **Conclusão:** a dimensão espiritual auxilia no enfrentamento da doença renal crônica, porém os sujeitos não têm todas as suas necessidades de cuidados atendidas. Aponta-se como fator desafiador na prática clínica, a falta de equipe especializada em cuidados paliativos nos centros de diálise.

Descritores: Doença Renal Crônica; Diálise Renal; Diálise Peritoneal; Cuidados Paliativos; Espiritualidade.

RESUMEN

Objetivo: analizar la influencia de la dimensión espiritual en el afrontamiento de la enfermedad renal crónica de pacientes en cuidados paliativos. **Método:** revisión integrativa realizada entre abril y mayo de 2023, incluyendo la Biblioteca Virtual en Salud, bases de datos MEDLINE, LILACS y BDENF, SCIELO y el portal PUBMED. El análisis se llevó a cabo con la ayuda del *software* IRAMUTEQ. **Resultados:** la muestra estuvo compuesta por 12 artículos, los cuales identificaron las necesidades de los sujetos y sus estrategias para la promoción del bienestar espiritual y el desafío profesional en el manejo de la enfermedad y en la promoción de la autonomía del sujeto. **Conclusión:** la dimensión espiritual ayuda en el afrontamiento de la enfermedad renal crónica, pero los sujetos no tienen todas sus necesidades de cuidados atendidas. Se señala como factor desafiante en la práctica clínica, la falta de equipo especializado en cuidados paliativos en los centros de diálisis.

Descriptores: Insuficiencia Renal Crónica; Diálisis Renal; Diálisis Peritoneal; Cuidados Paliativos; Espiritualidad.

INTRODUCTION

Chronic kidney disease (CKD) is seen as a serious public health problem with an increasing prevalence and incidence. This pathology consists of damage and progressive loss of kidney function. Its classification is based on five stages ranging from kidney damage with slight loss of function to the stage of kidney failure (stage 5) in which the glomerular filtration rate falls below 15 mL/min[1,2].

Consequently, kidney damage in its advanced stages requires substitute treatment, with hemodialysis (HD) being the first choice, followed by peritoneal dialysis (PD). Despite the benefits, dialysis patients face various physical and emotional limitations because of the therapy, with negative repercussions, generating functional incapacity and work and personal transformations. Faced with these conditions, individuals tend to become isolated, anxious and depressed[2-4].

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In the provision of palliative care, when discontinuation of dialysis is a choice, nurses are responsible for implementation and advanced care planning, following the medical prescription, pain and symptom management, bereavement support, confirming the patient's wish for palliative sedation and the place of death[5].

During the dialysis process and after its suspension, it is crucial that health professionals know how to detect and encourage the use of coping strategies by the patient, to contribute to the treatment and add therapeutic support to the person's integrality. From this perspective, religious/spiritual beliefs should be valued and encouraged to preserve the mental health and quality of life of patients with CKD[6,7]. Spiritual beliefs can stem from the need to understand the meaning of life and death, the link with the sacred or transcendent and may or may not involve the development of practices linked to religious organizations[8].

The integration of the spiritual dimension into palliative care for patients with chronic kidney disease has been increasingly recognized as an important component in improving the management of patient symptoms, as it can offer emotional comfort and hope, strengthen social ties and help in coping with the disease, benefiting quality of life and promoting a holistic approach to care[8].

It is therefore understood that attention to spiritual needs can have a positive influence on the lives of CKD patients undergoing dialysis therapy. However, it is worth noting that there are challenges to overcome in implementing this care, especially the training of the multidisciplinary team for a more individualized, comprehensive action based on scientific evidence directed at the spiritual dimension[9,10].

In this context, this study is justified, as it seeks to help health professionals understand the basis of therapeutic interventions capable of providing qualified care during the stages of treatment and palliation.

Given the above and the need to approach palliative care in all its dimensions, the study sought to understand how spiritual beliefs impact on the quality of life of chronic kidney patients. To this end, the following research question was posed: How can spirituality be integrated into palliative care when dealing with chronic kidney disease?

This integrative review aims to analyze the influence of the spiritual dimension in coping with chronic kidney disease in palliative care patients.

METHOD

This is an integrative review study, conducted between April and May 2023 and carried out systematically in six stages, according to the order of execution: 1. Identification of the topic and formulation of the research question; 2. Establishment of criteria for inclusion and exclusion of studies; 3. Definition of the information to be extracted from the selected studies; 4. Evaluation of the studies included in the integrative review; 5. Interpretation of the results; 6. Presentation of the review/synthesis of the knowledge learned[11].

The research question was designed using an adaptation of the PICO strategy, PICo, for non-clinical research, where P is the study population (patients with chronic kidney disease); I is the research interest (spirituality); Co is the context (palliative care)[12].

The following DeCS/MeSH descriptors were established: Chronic Kidney Disease; Spirituality; Palliative Care. The following search strategy was used: ((Chronic Kidney Disease) OR (Kidney Diseases) OR (Renal Dialysis)) AND (Spirituality OR religion) AND ((Palliative Care) OR “terminal care” OR “end of life” OR “terminally ill patients” OR “supportive care” OR “serious illnesses” OR “critical illnesses”).

All the articles found in the virtual health library, in the databases: International Health Sciences Literature (MEDLINE), Latin American and Caribbean Health Sciences Literature (LILACS), Nursing Database (BDENF), Scientific Electronic Library Online (SciELO), and the National Library of Medicine (Pubmed) portal, regardless of the date of publication, in English, Spanish and Portuguese, which address spirituality in palliative care in CKD and are available in full text with free access, were included.

Articles that did not answer the research question (avoidance of the topic), duplicate studies, literature reviews, doctoral theses, editorials, letters to the editor, clinical practice guides, book chapters and studies focusing on another chronic disease were excluded.

The article selection flowchart followed the PRISMA recommendations[13] (Figure 1).

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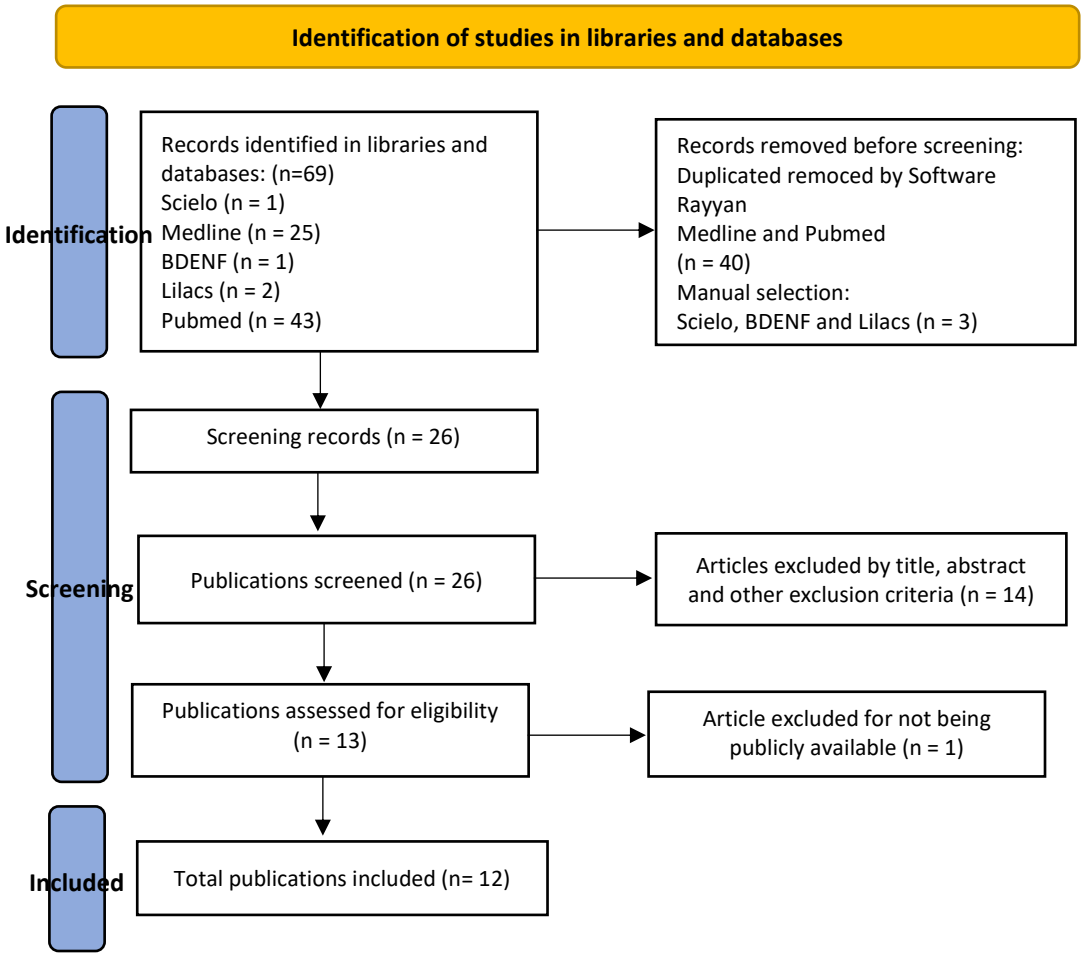

Figure 1: Flowchart for the identification, screening, eligibility and selection of articles in the integrative literature review. Brasília, DF, Brazil, 2023.

The Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires (IRAMUTEQ®) software was used for the content analysis, which carries out quantitative analysis of textual data based on vocabulary similarity and on tables, individuals/words. The corpus was made up of the content of the selected studies, translated, excluding tables, charts and references, organized in a single text file. In this way, the corpus analyzed by the software was formed by compiling the 12 selected articles.

RESULTS AND DISCUSSION

After the search carried out between April and May 2023, a total of 69 full-text articles were found, from 2005 to 2022, of which 25 were in MEDLINE, two in LILACS, one in BDENF, one in SciELO and 43 in the Pubmed portal. The articles selected from Medline and the Pubmed portal were exported to Rayyan® software, where it was possible to read and extract duplicates (n=40), as well as manually selecting duplicates from the SciELO, BDENF and Lilacs databases (n=3). A total of 43 duplicates were found, leaving a total of 26 articles, of which 12 were selected according to the inclusion criteria.

The main data relating to the articles was collected: country, year of publication, objectives, type of study, level of evidence (LE) and main conclusion (Figure 2).

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Year/ Country	Type of study/ NE	Objectives	Main conclusion
1. 2009/ Africa[14].	Randomized clinical trial/LE-2	To examine whether spiritual well-being is associated with acceptance of possible treatment outcomes.	Spiritual well-being was associated with the willingness to accept possible poor health outcomes of life-sustaining care.
2. 2010/ Canada[15].	Qualitative cross-sectional/LE-5	To assess the end-of-life care preferences of patients with CKD.	Current end-of-life clinical practices do not meet the needs of patients with advanced CKD.
3. 2010/ Canada[16].	Prospective cohort/ LE-3	To describe the nature, prevalence and predictors of spiritual care and support needs in CKD.	Patients had substantial needs for spiritual care and support. There were no clear predictors of high spiritual or supportive care needs.
4. 2012/ USA[17].	Prospective qualitative study/LE-5	To investigate how CKD patients and their families make decisions and cope with dialysis treatment.	Palliative care addresses careful attention to the beliefs, questions and prayer and ritual needs of patients and family members.
5. 2014/ Brazil[18].	Cross-sectional qualitative correlation/LE-5	To relate mental health and spiritual well-being of hemodialysis patients.	Poor mental health was associated with lower spiritual well-being.
6. 2017/ Africa[19].	Exploratory, qualitative and descriptive/LE-5	Describe the palliative care needs of CKD patients without renal replacement therapy.	Palliative care was considered a priority in CKD. Spiritual/cultural beliefs were a source of hope, understanding and acceptance of the disease.
7. 2017/ USA[20].	Qualitative cross-sectional/LE-5	To explore the preferences of dialysis patients regarding symptom management and advance care planning.	Preferences described: avoidance of medication to relieve symptoms, decision making and conversations about advance care planning with family.
8. 2019/ USA[21].	Cross-sectional cohort/LE-3	To assess CKD patients' knowledge and attitudes towards end-of-life treatment and care.	Desire for more frequent discussions about their illness, prognosis and end-of-life care planning.
9. 2019/ Malasia[22].	Qualitative cross-sectional/LE-5	To explore the experiences of suffering in CKD patients on dialysis, based on dimensions of suffering.	Spiritual suffering occurs when patients perceive a loss of purpose and meaning in life.
10. 2020/ USA[23].	Cross-sectional by convenience/LE-5	To study informed decision making about dialysis and attitudes and beliefs in dialysis patients.	Need for information for decision-making about dialysis and end-of-life care, attention to spiritual, social and psychological issues and access to palliative care.
11.2021/ USA[24].	Quantitative cross-sectional/LE-5	To examine the association between the importance of religious or spiritual beliefs and palliative care needs in dialysis.	Religious/spiritual beliefs were important to the majority of participants and the need for an integrative approach that focuses on these beliefs.
12. 2022/ China[25].	Cross-sectional qualitative correlation/LE-5	To investigate palliative care needs and symptom burden in hemodialysis patients.	CKD patients on hemodialysis have a significant symptom burden and moderate palliative care needs.

The LE of the studies followed a hierarchical classification: level 1 - systematic reviews of randomized studies; level 2 - randomized clinical trial; level 3 - cohort study or non-randomized experimental study; level 4 - case-control study, case series or controlled historical studies; level 5 - qualitative studies.[26].

After including the articles, the iramuteq® software cleaved the corpus into 276 text segments (TS), using 227 TSs (82.25%). A total of 9821 occurrences (words, forms or vocabularies) emerged. Two axes were identified: Axis 1: Personal strategies that anchor coping with the disease, made up of classes 2 and 4; and Axis 2: Institutional strategies that anchor disease management, made up of classes 1, 3, 5 and 6.

The content analyzed was categorized into six classes called class 1: Professional unpreparedness in addressing individual needs, with 31 TS (13.7%); class 2: Need for spiritual well-being, with 43 TS (18.9%), class 3: Considerations about the subject's self-management and autonomy, with 36 TS (15.9%) class 4: The relevance of personal beliefs and religiosity, with 39 ST (17.2%), class 5: Impact of CKD on subjects' quality of life, with 32 ST (14.1%) and class 6: Integrative approach to symptom management, with 46 ST (20.3%), as shown in Figure 3.

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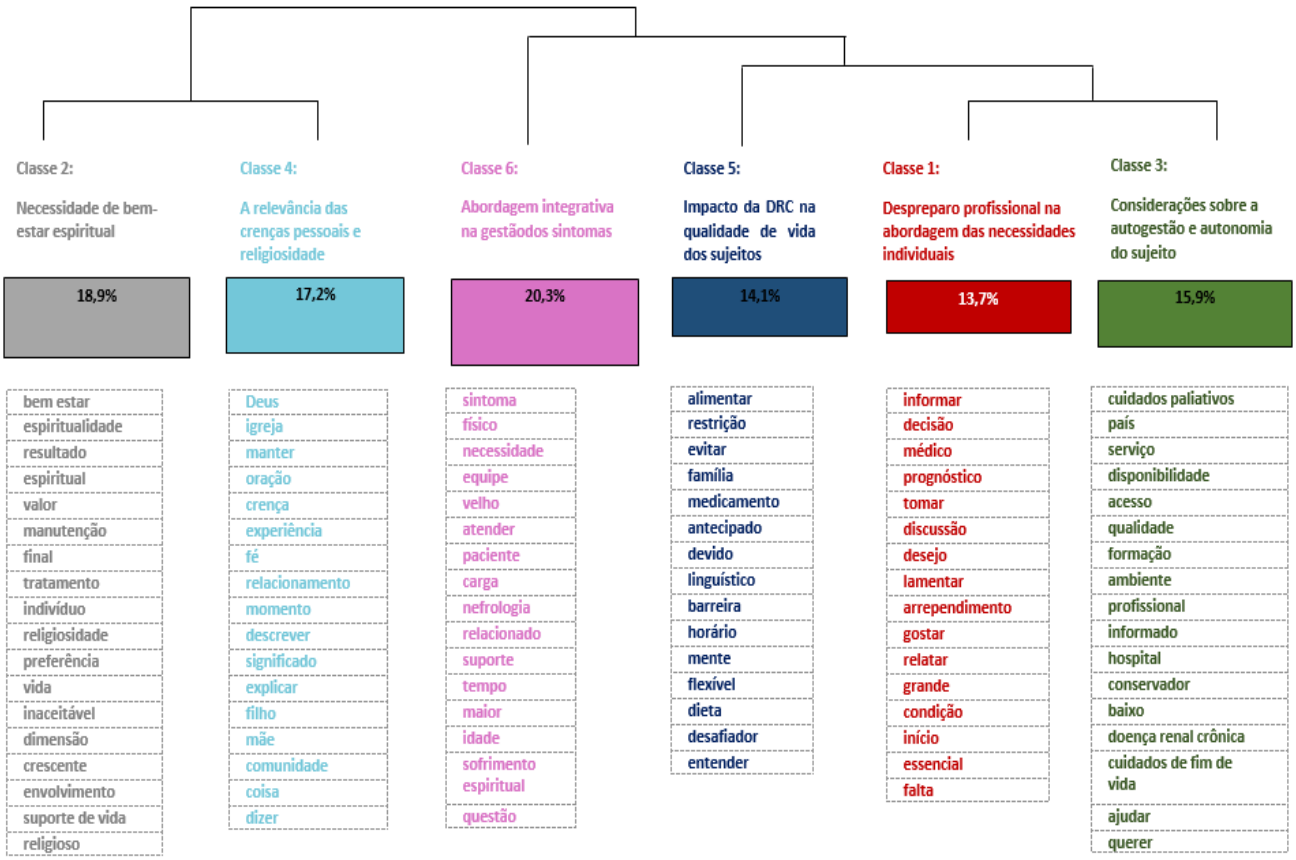

Figure 3: Dendogram of the analysis of the articles selected for the study. Brasília, DF, Brazil, 2023.

Personal strategies that anchor coping with the disease

Hemodialysis treatment is perceived by chronic kidney patients as deprivation of liberty. This idea has a negative impact on their emotions, generating feelings of anguish and has been considered the main factor preventing them from accepting adherence to treatment[27].

Faced with the restrictions imposed by hemodialysis, the participants feel bored and uncomfortable during therapy, above all because the treatment takes them away from social interaction. The therapy routine and its debilitating symptoms are barriers to work, which impacts on the financial well-being of the family unit, and they are unable to find work due to the treatment routine[20,25].

Another aspect, portrayed as the most distressing, was food restriction, since this context culturally isolates the individual and is challenging for families. Lack of sleep was also mentioned, as it led subjects to miss hemodialysis because they didn't sleep well and because it was difficult to wake up in time for therapy. It is worth pointing out that the start of hemodialysis is a period of adaptation and the body needs time to adjust. During this period, frustrations are experienced due to unpreparedness in the face of changes related to additional medication, new dietary restrictions and the hemodialysis regimen[18].

It is known that most of the time, in emergency cases, the choice of treatment is made by the doctor and, consequently, patients have little time to understand the information they receive. In these cases, acceptance of the therapy is linked to the health team's guidelines, focusing on survival, the risks of refusing treatment and the need to adapt to the difficulties arising from the condition to be faced[27].

A study carried out in Canada with 584 patients found that more than half of them started dialysis because of a doctor's recommendation (51.9%) or because of family wishes (13.9%). No differences were observed in terms of age, gender, race, length of time on dialysis, level of education or marital status between those who regretted and those who did not regret choosing to start therapy[15]. Corroborating these findings, research shows that more than 60% of patients regretted starting dialysis, which suggests a lack of autonomy, emotional support and knowledge when it comes to making decisions[16,21,23,28].

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Another study carried out in Pakistan with 522 dialysis patients to find out about end-of-life decisions and preferences found that 47% of the patients interviewed wanted their families to take over medical decisions if they became unable to make decisions for themselves, while 27% preferred their doctor to make decisions on their behalf. Around 80% reported dependence on their doctors for information about their state of health, 54% said they agreed to start dialysis because of a doctor's recommendation, while 28% said it was their own choice, and only 4% relied on emotional support from religious leaders during their illness process[23].

However, neither doctors nor family members are accurate in predicting patients' wishes about life support, including the intention of continuous dialysis, and most nephrologists do not feel well prepared to make end-of-life decisions for their patients15. It is noteworthy that 90.4% of CKD patients reported that their nephrologist had not discussed prognosis with them and only 38.2% had filled in an advance directive, indicating end-of-life clinical practices that do not meet their needs[15].

A North American study found that 80% of the sample needed information about treatment options, including stopping dialysis, planning for the future in case of death and physical symptoms managed by the nephrology team. They recognized the importance of conversations about palliative care in helping their families to understand their wishes and reduce anxiety when making future decisions[15]. Similar results were found in other studies with North Americans and Latinos[20,21].

Despite recent technological advances and an increase in the life expectancy of hemodialysis patients, the quality of life has not changed appreciably. Adverse situations related to health, survival, limitations in activities of daily living, losses and biopsychosocial changes are still experienced. These stressful situations result in psychiatric symptoms, especially depression and anxiety[18].

In this context, the approach to the spiritual and cultural dimension gains relevance in the advance care plan with the family in order to anchor trust in decision-making. However, the family is reluctant to engage in such conversations[22,23]. The importance of spiritual beliefs was associated with different domains of palliative care planning, including resuscitation preferences, discussions about discontinuing dialysis and priorities in decision-making. These findings suggest the potential value of an integrative approach including spiritual beliefs in the care of this population. It should be emphasized that throughout the treatment and care process, the spiritual dimension is an alternative in pain management during the pathological period, since it increases the amount of neurotransmitters involved in the control of algias[1,7,24].

Findings from a study of 51 African-Americans on dialysis indicate that the assessment of spiritual needs is a significant action in palliative care and that religious beliefs give meaning to life, as well as the relevance of religious practice in maintaining a bond with a transcendental being[14].

Spiritual and cultural beliefs, including faith and prayer, are ways of moving forward despite the limitations of the illness. Subjects express the value of spiritual and cultural beliefs in maintaining hope, understanding and accepting the terminal diagnosis[22].

It was also found that 84.3% of patients would like to have spiritual support as part of the palliative care program and 56% considered it important to incorporate psychosocial and spiritual approaches in nephrology centers; only 15.8% reported having spiritual support for social/emotional support during the course of the disease and its treatment, and 83.4% reported not knowing what palliative care is[15].

Spiritual well-being has already been negatively related to psychological stress, sleep disorders, psychosomatic complaints and poor mental health, corroborating other studies and suggesting that it is a protective factor against psychiatric disorders. In addition, individuals who desired continuous use of life-support treatment had significantly lower spiritual well-being compared to those who favored comfort care[14,18].

The benefits of spirituality shown in CKD were related to the strengthening of hope, social support, coping with pain and mental health, including lower risk of suicide, fewer depressive symptoms and improved perception of quality of life[8].

Adapting to the disease and recognizing the need for professionals to address spiritual issues has begun to change the cultural environment in healthcare. A recent study revealed that for the majority of patients it was important to have their concerns addressed, as well as trust in the nephrology team for support[16].

Spiritual suffering occurs when patients perceive a loss of purpose and meaning in life, which gives rise to negative feelings such as: self-punishment due to a life of excess, fear and lack of perspective, the feeling of being a burden on the family, concern about self-image, dietary restrictions and denial of the disease. In this sense, it is worth highlighting the importance of strategies for coping with the disease and its daily difficulties. Although there is a

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growing impact of spirituality, several authors point to the lack of studies addressing its relationship with areas of health[22,28].

Women have already been identified as more likely to need help to overcome fears, just as HD patients were more likely than pre-dialysis and PD patients to need help to find peace of mind and determine the meaning of life. Women with longer treatment periods, higher family incomes and who practice their religion are the ones who use religious coping more positively[14,27].

Among the personal strategies for coping with the disease, faith and religion contributed positively to the meaning that the subjects and their families found in their dialysis experiences, regardless of the results of the decisions made regarding treatment. Faith was related to hope and combating fear, while religious practices were important in daily management and contributed to directing circumstances, maintaining a connection with God and the community[17].

In addition, both the health team and the patients consider religion to be important in the evolution of CKD, considering its ability to bring comfort, support, strength and hope for an improvement in quality of life[29].

Institutional strategies that anchor disease management

Kidney patients undergoing conservative treatment (stage 5 patient, no dialysis) are often referred to palliative care, but there is no structure to favor this transition for patients on dialysis. The nephrologist should consider early referral of dialysis patients with unrelieved physical, psychosocial or spiritual suffering to palliative care[22].

It should be noted that although the aforementioned authors consider the referral of suffering patients without relief, palliative care is advocated from the diagnosis of CKD, since it prevents and relieves suffering through early identification, correct assessment and treatment of pain and other problems[30]. Therefore, all patients with CKD should be considered for palliative care.

Given the above, nurses, social workers and spiritual counselors are perceived as important agents for providing emotional, social and spiritual support, although spiritual counselors are not included in the multi-professional team of dialysis programs in Brazil. This care is carried out as “religious assistance”, by volunteers or religious leaders, which is different from the North American and European contexts[9,15].

The definition of roles between the members of the multidisciplinary team is necessary to act in the provision of palliative care, such as symptom management, advanced care planning and psychosocial and spiritual support[15].

It is clear that patients with CKD do not have their spiritual care and support needs met in dialysis centers, and appropriate services are essential to adequately manage the challenges of living with a chronic disease. This fact can be used to help guide interventions aimed at improving the quality of life and autonomy of these patients; such interventions will require health professionals to better understand the spiritual needs, resources and preferences of patients[31].

Although professionals recognize the importance of respecting patient autonomy in adhering to treatment, they understand that the risk of physical complications justifies the need for dialysis treatment, with less attention to subjectivity. The lack of information leads to the acceptance of decision-making by the nephrology team, subjecting the patient to various types of treatments so as not to displease family members, which reinforces the understanding of the lack of autonomy15. On the other hand, patients resent not participating in the treatment selection process, and are passive, understanding that this is primarily a medical decision[27]

Considering that unmet physical, emotional, psychosocial, spiritual, informational and practical needs in the dialysis therapy process are significantly associated with negative symptom burden, the need to integrate palliative care into standard nephrology practice at an early stage is emphasized[25].

Issues related to self-transcendence have been considered as important or more important than physical symptoms, however spiritual distress is often ignored or dismissed and often manifests as physical or psychological problems and shares many features and conditions of depression including hopelessness, worthlessness and a sense of meaninglessness. In addition, it can be exacerbated by psychosocial symptoms, social disturbances and other physical symptoms such as pain, diagnostic and therapeutic confusion[16].

In this context, an assessment is essential to identify the specific services and assistance most desired by patients, being the first step in developing instructions adapted to individual needs[16].

The nurse is responsible for interpreting the patient's spiritual needs and recognizing their influence on coping with health problems or life processes. Due to their closeness to the patient, the nurse is the professional responsible

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for comprehensive care, who should promote and enable the use of religiosity/spirituality in the process of coping with the disease, preventing an attitude of pessimism and discouragement when faced with the disease and, consequently, a decline in the patient's general health[31].

There are gaps in professional training, leading to difficulties in approaching and discussing patients' subjectivity. Added to these difficulties are the insecurity of professionals and the increasingly automated management of care based on medical records[32].

Therefore, dialogue and listening are fundamental elements in clinical practice, and it is through them that the bond between team and patient is established. The bond allows for a closer experience, which in turn provides the return of feelings such as empathy, care and patience to listen to others and important reflections on professional practice[32].

Health care professionals may not understand the patient's wishes; lack the skills to recognize when the conversation should occur; be unwilling to pursue this line of discussion; have their own personal, spiritual, or ethical opposition to stopping dialysis treatment; or feel intellectually or emotionally unprepared to discuss such issues[28].

Some strategies can be used to improve professional performance in order to avoid refusal and abandonment of treatment, such as: early assessment and diagnosis, prior nephrological monitoring, multidisciplinary approach and humanization of dialysis services. If the patient's decision is irreversible, the informed consent form is essential. In addition, the expansion of bioethics committees is important to protect health professionals and patients' interests[29].

The spiritual dimension in palliative care is recognized as essential for quality practices. Prayer, for example, is a simple activity that does not generate costs and can be easily implemented, without causing changes in the hospital routine3. Although the term “spiritual care” is recent in Brazilian health, studies have explored this theme and the World Health Organization recognizes the importance of spiritual care in palliative care[9,10,31].

In Brazil, there are still gaps in the reflection on this topic and it is necessary to build “spiritual care” instruments with theoretical-practical foundations and culturally adapted to establish a response to the real needs of patients and families, in addition to encouragement and international cooperation between researchers[9].

North American studies have already established well-defined concepts, parameters for professional training and intervention models related to spiritual needs with a focus on quality of life, including psychotherapy and multidisciplinary, physical and mental interventions[9].

In the European context, hope is associated with spirituality and studies are based on the idea that the issue of quality of life may not fully encompass the effect of spiritual care. Both studies point out that it is urgent to conduct research on the impact of education in “spiritual care” on the health of the sick individual, the family and the multidisciplinary team[9].

Research shows that spiritual interventions have a positive impact on patients in palliative care, improving parameters such as depression and anxiety[9-10,33]. In addition to promoting beneficial effects for patients, family members and helping professionals to offer more comprehensive and humanized care, there is little training and willingness, as well as a lot of insecurity in including spirituality in the care of kidney patients[2].

The spiritual dimension was considered an indispensable component in assisting patients with no chance of recovery, as it promotes improved well-being by relieving pain and other symptoms[10]. It is necessary to have the healthcare team monitor the development of a therapeutic plan that takes into account individual needs. Monitoring all dialysis parameters, as well as seeking to achieve recommended standards and adherence to treatment, can bring improvements in various aspects of patients' lives[34].

Therefore, the development of new research, including means of assessing spirituality and its cross-cultural adaptation, is essential to support spiritual care and improve the quality of life of this population[10].

FINAL CONSIDERATIONS

The benefits of the spiritual dimension in the treatment of chronic kidney patients are associated with better coping with treatment, symptom management, strengthening of hope and better mental health, with a lower risk of suicide, fewer depressive symptoms and an improvement in the perception of quality of life.

Therefore, it is understood that enabling greater autonomy, comfort and relief in all dimensions (physical, mental, emotional, spiritual) in coping with chronic disease and in preparing for death is essential and is the desire of patients.

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Studies confirm that spiritual needs are rarely met and that professional support is essential during the course of the disease and in decision-making; however, it is a great challenge. Obstacles in clinical practice include the lack of preparation of the health team and the lack of specialization in palliative care in dialysis centers.

A limitation in publications based on recommendations and inclusion of palliative care in the treatment of CKD is highlighted. Studies with greater evidence related to more comprehensive professional practice are needed, emphasizing the spiritual dimension and not only the techniques for treating chronic kidney disease.

Therefore, it is understood that more studies and information are needed on the principles involved in the palliative care approach in order to provide quality of life according to the limitations involved. Greater clarification is important to break paradigms and promote a cultural and personal change, both for the patient and the health team.

Public policies should consider the implementation of spiritual care in palliative care in Brazil. Spirituality is a crucial dimension in palliative care, and its recognition and integration are fundamental for a comprehensive and individualized approach.

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