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Spiritual health in palliative care: a phenomenological inquiry into the indicators of the NOC outcome Spiritual Health (2001) and the preservation of dignity

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Abstract

Background

In palliative care, spiritual health constitutes a central anthropological dimension, yet its abstract character favours its invisibility in clinical practice. This study explored the manifestations of spiritual health at the end of life with the aim of identifying the most prevalent indicators of the NOC outcome Spiritual Health (2001), as a route towards the clinical operationalisation of this dimension and a contribution to the preservation of patients' dignity.

Methods

Qualitative study with a descriptive phenomenological design, grounded in Husserl. The analysis combined Giorgi's procedure for eidetic reduction with Colaizzi's seven steps for the structuring and validation of the findings; the exercise of epoché was applied for the control of bias. Nineteen patients with a life expectancy ≤ 3 months (Palliative Performance Scale, PPS ≤ 60) were included, recruited on a multicentre basis in the Community of Madrid (one hospital palliative care unit, one general hospital with a specialised unit, and six home-based support teams). Thirty-eight in-depth semi-structured interviews were conducted, between 1 and 3 per participant. The NOC outcome Spiritual Health was used as the conceptual reference framework of the study and as a hermeneutic lens of clinical translation applied to the eidetic findings already emerged from the data.

Results

Spiritual health emerged as a dynamic process structured in three interconnected dimensions: intrapersonal, interpersonal and transpersonal. Of the 23 NOC indicators considered, 16 obtained coded presence in the participants' discourse. The predominant indicators were "Meaning and purpose in life" (200103) and "Connectedness with inner self" (200116), followed by "Feelings of peacefulness" (200105) and "Spiritual contentment" (200122), constituting central axes for existential reconciliation and for the preservation of the intrinsic dignity of the person.

Conclusions

The operationalisation of the NOC outcome Spiritual Health through a phenomenological approach makes it possible to translate a clinically invisible dimension into a traceable and clinically actionable nursing language. This approach offers nursing an itinerary that links phenomenological rigour with ethical vigilance, contributing to safeguarding the dignity of the palliative patient during the process of dying.

Introduction and theoretical framework

Spirituality in palliative care forms part of the lived experience of those facing advanced chronic illness, from the moment of diagnosis to the end of life. Spiritual concerns are common among patients, but they frequently do not receive the attention they deserve: when they are addressed, they are associated with better quality of care, less clinically relevant anxiety, greater spiritual well-being and better end-of-life outcomes [1]. This gap between what is needed and what is received is reflected in actual practice, where up to 80% of patients continue to receive spiritual support of little effectiveness, which generates dissatisfaction with the way they perceive the assistance and care received from the multidisciplinary team [2].

The difference between what the patient needs and the care ultimately received is not a merely arbitrary matter. The obstacles to spiritual care in nursing have, as their main root, the scant visibility of this dimension within the profession itself, from which the remaining problems derive; among them stands out the lack of accurate documentation of spiritual needs in the clinical record, which causes spiritual care to lose weight against other care tasks [3]. The lack of documentary recording is not merely a bureaucratic issue: if a facet of care falls outside the records, it is neither evaluated nor shared within the team, and so it ends up depending on the personal perception of each professional attending the patient during their shift.

Standardised nursing languages offer one possible route for translating this invisibility into something that can indeed be documented and shared. The impact of NANDA-NIC-NOC on nursing practice worldwide has translated into positive effects on clinical reasoning, individualised care planning and interdisciplinary communication, although its adoption remains uneven across regions and limited by the training available [4]. Within this framework, the NOC outcome Spiritual Health (2001) proposes a set of indicators for approaching the patient's spiritual experience, although its original development responded more to a theoretical systematisation than to sustained empirical validation with the direct voice of patients.

This lack of validation with the patient's voice has a specific methodological root: translating a psychosocial phenomenon into a number from 1 to 5, as Echevarría Pérez warns, leaves unresolved what exactly that score means for the person who lives it, because the quantitative does not exhaust what the patient's words, nuances and perceptions can express [5]. Most of the instruments available for assessing the spiritual dimension in nursing share this same limitation: they measure the patient's experience from the outside, reducing it to a score on a scale, and the NOC outcome Spiritual Health itself is no exception. The qualitative approach, by contrast, allows access to that part of the spiritual experience that the scale does not manage to capture, gathering the patient's account in their own terms before translating it into any clinical language, precisely the type of evidence that still remains to be built for this specific NOC outcome.

To respond to that gap, this study employed a phenomenological inquiry that explores the manifestations of spiritual health at the end of life from the direct accounts of the patients, subsequently placing the eidetic findings in dialogue with the indicators of the NOC outcome Spiritual Health (2001) as a route

towards the clinical operationalisation of this dimension and a contribution to the preservation of patients' dignity.

Research team and reflexivity

The interviews were conducted by the principal investigator (FLN), a nurse, doctoral candidate and graduate in Nursing from the University of Murcia (UMU), with a Master's degree in Palliative Care from the Universidad Pontificia de Comillas (Madrid), eight years of clinical experience in hospital palliative care (Hospital Laguna, Madrid) and five years in home-based palliative care teams (ESADP). The triangulation team was composed of Paloma Echevarría Pérez (PhD, Dean of Nursing, Universidad Católica San Antonio de Murcia) and Daniel Muñoz Jiménez (PhD, Nursing Research Supervisor, Hospital Clínico San Carlos, Madrid), who reviewed the anonymised data for triangulation purposes, without direct participation in the conduct of the interviews.

There was no prior relationship between the researcher and the participants before the study; first contact was established through a brief interview presenting the study and signing the informed consent form. Participants were aware that the interviews formed part of the development of a doctoral thesis, as well as of the use of the NOC outcome Spiritual Health as the reference framework of the domain explored.

Study design

A descriptive phenomenological, cross-sectional qualitative design was adopted, grounded in Husserl's phenomenology [6], with the aim of understanding in depth the essence of the spiritual experience in patients at the end of life. The analysis followed a methodological sequence in two moments: first, Giorgi's procedure guided the eidetic reduction of the accounts, allowing the identification of meaning units free from the researcher's prior categorisations; second, Colaizzi's seven steps [7] were used as a procedure for structuring and validating the findings already reduced eidetically, without intervening in the initial reduction phase.

The NOC outcome Spiritual Health (2001) [8], whose official definition describes it as connectedness with self, others, higher power, all life, nature, and the universe that transcends and empowers the self, was incorporated as a hermeneutic lens of clinical translation applied a posteriori to the eidetic reduction already performed. This methodological decision responds to a twofold objective: to preserve the descriptive purity of the phenomenological method in the discourse analysis phase, and to endow the eidetic findings with a standardised clinical language that is transferable to nursing practice. The NOC did not operate, therefore, as an a priori category directing the phenomenological reduction, but as a translational framework applied once the themes and subthemes had emerged from the data themselves.

Participants and study setting

The study was carried out on a multicentre basis in the Community of Madrid, in units specialising in palliative care with different levels of care complexity: (1) the Laguna Palliative Care Unit, a multidisciplinary 47-bed unit dedicated to the comprehensive care of patients in an end-of-life situation; (2) the Hospital Clínico San Carlos, with 30 beds in its specific palliative care unit; and (3) six publicly owned Home-Based Palliative Care Support Teams (ESAD), operationally based at the Arroyo Medialegua Health Centre and providing coverage in several population centres within their catchment area. The multicentre design incorporated clinical populations that were heterogeneous in complexity, care modality (hospital/home-based) and sociodemographic profile, which enriched the diversity of experiences and favoured the transferability of the results.

Purposive convenience sampling was used, prioritising informants with reflective capacity and a willingness to engage in clinical dialogue about their spiritual interiority, while at the same time guaranteeing accessibility and continuity of the therapeutic relationship throughout the interview process.

Inclusion criteria

Age ≥ 18 years, diagnosis of advanced chronic illness with a life expectancy ≤ 3 months, assessed by means of the Palliative Performance Scale (PPS) [9] with a score ≤ 60. This scale was chosen over the PaP Score because the latter is more sensitive for anticipating death exclusively within the last 30 days of life [10].

Preserved cognitive capacity, confirmed by means of the Montreal Cognitive Assessment (MoCA) [11] when available in the recent clinical record, and the Confusion Assessment Method (CAM) [12], in order to ensure the adequacy of consent and the reliability of the accounts. Both tests were reviewed from the clinical record; they were not administered for exclusively research purposes to patients in a situation of frailty and end of life.

Functional command of Spanish allowing effective communication.

Signature of the informed consent form and a clear willingness to explore aspects of interiority/spirituality linked to the end-of-life process, verified after the inclusion of the patient as a possible participant, during the explanation of the study and the signing of consent.

In addition, priority was given to participants with an affinity already identified with the NOC outcome Spiritual Health in the clinical record and in the nursing progress notes, through observable indicators such as expression of hope, search for meaning or serenity, with the sole purpose of determining eligibility; this preselection did not influence the narrative generated during the interview, preserving the phenomenological authenticity of the discourse.

Sample flow

Of 41 patients initially identified as eligible, 19 completed the study. Exclusions were due to: refusal to participate (n = 3); death before completion of the interview process (n = 9); and supervening cognitive impairment that invalidated eligibility (n = 10; of these, 2 cases were detected during the course of the interview itself owing to sudden cognitive deterioration). The material from the 22 patients not included in the final sample was discarded in its entirety; the 19 final participants completed the interview process and all of their material was used in the analysis. The final number of participants was determined by the principle of data saturation, stopping data collection when the accounts ceased to contribute new elements to the understanding of the phenomenon. The sociodemographic, clinical and cognitive characteristics of the participants are detailed in Table 1.

Table 1

Distribution of participants according to sociodemographic, clinical and cognitive variables PPS: Palliative Performance Scale. MoCA: Montreal Cognitive Assessment (score; "--" indicates that the test was not administered because it was not available in the recent clinical record). CAM: Confusion Assessment Method (NEG: negative).

Code	Age	Marital status	Children	Education	Religious affiliation	Euthanasia request	PPS	MoCA/CAM
P1	70	Widowed	Yes	University	Catholic	No	50	--/NEG
P2	74	Married	Yes	Primary	Believer	Yes	60	--/NEG
P3	58	Divorced	Yes	University	Believer	No	60	--/NEG
P4	68	Married	Yes	University	Jehovah's Witness	No	50	--/NEG
P5	65	Divorced	No	University	Jehovah's Witness	No	40	30/NEG
P6	64	Married	Yes	Primary	Catholic	No	50	--/NEG
P7	91	Married	Yes	University	Catholic	No	50	--/NEG
P8	80	Widowed	Yes	Primary	Catholic	No	50	28/NEG
P9	79	Married	Yes	University	Catholic	No	60	--/NEG
P10	88	Married	Yes	Primary	Atheist	No	50	27/NEG
P11	45	Divorced	No	University	Orthodox	No	50	--/NEG
P12	63	Married	Yes	University	Catholic	No	40	--/NEG
P13	82	Widowed	Yes	Secondary	Catholic	No	60	--/NEG
P14	88	Widowed	Yes	Secondary	Catholic	Yes	50	--/NEG
P15	63	Single	No	University	Atheist	No	50	--/NEG
P16	68	Divorced	Yes	University	Catholic	Yes	60	--/NEG
P17	64	Single	No	Secondary	Catholic	No	60	--/NEG
P18	60	Married	Yes	University	Catholic	No	60	30/NEG
P19	75	Widowed	Yes	University	Catholic	Yes	40	--/NEG

Data collection

Data collection was organised around one to three in-depth semi-structured interviews per participant, lasting between 45 and 80 minutes, conducted between January 2024 and March 2025. Nineteen patients took part, with a total of 38 interviews. The semi-structured interview guide (Appendix) consisted of open questions aimed at exploring the dimensions of the phenomenon, such as the relationship with the

transcendent, the meaning of spirituality in the face of the end of life, spiritual conflicts or distress, supportive practices, experiences of transcendent connection and legacy, without literal formulation of the NOC indicators in the questions. The NOC outcome Spiritual Health [8], with its 23 official indicators, was used as the conceptual reference framework in the overall design of the study; of these 23 indicators, 16 obtained coded presence in the participants' discourse during the subsequent analysis.

Data collection and analysis were developed in an iterative and interdependent manner, integrating intra-participant and inter-participant processes. At the intra-participant level, successive interviews with the same patient made it possible to deepen progressively into their lived experience, clarifying emerging meanings through a progressive refinement of the existential questions already contemplated in the guide. At the inter-participant level, the preliminary findings from the analysis of each interview informed the development of subsequent interviews with other participants, through a constant comparison approach oriented towards exploring discrepant cases and theoretical variability. This circular strategy between collection and analysis strengthened the credibility and internal coherence of the study, and oriented saturation not only as the repetition of codes, but as the consolidation of meaning.

All interviews were conducted individually, with audio recording by means of a professional Zoom H1n recorder, fostering an atmosphere of trust and rapport. The information was complemented with field notes and the researcher's analytic memos recorded in ATLAS.ti, which made it possible to document the emotional weight and the context of the interactions.

Ethical considerations

The study obtained a favourable opinion from the Research Ethics Committee of the Universidad Católica San Antonio de Murcia (UCAM), reference CE092309, and from the participating centres (Appendices). Respect for the dignity and autonomy of the patient was guaranteed by means of informed consent delivered at least seven days in advance in order to ensure adequate deliberation. The data were anonymised by means of codes (P1, P2…), and the material collected (audio recordings, transcripts) was stored on an encrypted external drive and in the cloud using 256-bit AES encryption.

Although no physical risks were identified, consideration was given to the possible psychological impact of dialogue on finitude and on the painful life experiences evoked during the interviews, guaranteeing immediate emotional support through the multidisciplinary palliative care teams at any sign of spiritual distress or moral suffering.

The research process was designed with constant ethical supervision and active protection of the dignity of the participants, given their high vulnerability. The researcher maintained a compassionate presence and constant reflexivity in order to control the bias derived from his own emotional impact, allowing the dialogue to advance while respecting silences and adapting to the rhythm of each participant's vital energy. The ethical commitment to protect the dignity of the patient prevailed at all times over research aims.

Study rigour

The criteria of Lincoln and Guba (credibility, dependability, transferability and confirmability) were applied. A central element of methodological rigour was the application of the epoché [13], through which the researcher deliberately suspended his prior opinions, religious beliefs and established theories. This was prepared before fieldwork by means of a detailed list of personal and professional assumptions (list of preconceptions, Appendices) and a reflective diary in which emotions, convictions and anticipations were recorded, noting how they were placed "in brackets" before each interview. During the encounters, meaningful pauses, open non-suggestive questions and impartial paraphrasing were maintained. After each session, reflexivity memos were written, labelling any emerging interpretation as a hypothesis and not as a conclusion, and contrasting it with the literal text of the accounts.

In the analysis phase, the meaning units were horizontalised through repeated review of the audio recordings and transcripts, preserving the phenomenological reduction; eidetic variation was used to distinguish the particular from the structural patterns of the phenomenon, confirming that no category derived from prior theoretical judgements but from its recurrence and richness in the narratives.

After the verbatim transcription of the accounts, member checks were carried out to verify that the meaning units identified accurately captured the participant's experience. The study adhered to the standards of the COREQ (Consolidated Criteria for Reporting Qualitative Research) guideline [14].

Results

The phenomenological analysis made it possible to identify spiritual health as a dynamic process, structured in three interconnected dimensions: intrapersonal, interpersonal and transpersonal. Of the 23 indicators of the NOC outcome Spiritual Health contemplated in the design of the study, 16 obtained coded presence in the discourse of the 19 participants (Supplementary Table 1).

Theme 1: Intrapersonal dimension — Reconciliation with one's own being

Subtheme 1.1: Meaning as the axis of existential reconciliation (200103)

"Meaning and purpose in life" (200103) reached universal presence in the sample, constituting the central axis of this dimension. Life review emerged as an act of autonomy over one's own history: by placing quality of life, understood as a life full of meaning, before mere biological prolongation, participants defended their right to a biographical closure coherent with their identity.

"What matters is not living longer, it is living what I have left with meaning" (P3.3). "I have done more good than harm in this life, and that leaves me at peace" (P14.1).

The patient's identity was reaffirmed by naming their own history, from early biographical memories to the moral balance of their own life course (P14.1, P15.1.1), and this narrative functioned as a support for personal dignity against the risk of reducing the patient to their clinical condition.

Subtheme 1.2: Introspection as a route to inner reconciliation (200116)

"Connectedness with inner self" (200116) also reached universal presence, constituting the second axis of this dimension. Introspection emerged as a process that allowed participants to name their own suffering and to recover decision-making capacity over their inner experience.

"You are opening up a part of me that was closed" (P4.2). "I have taken that weight off my shoulders" (P4.1). "It makes me angry. I want to do things and do things" [regarding the loss of autonomy] (P6.1).

Clinical accompaniment, by enabling a space of inner clarification, allowed contents previously postponed out of fear to find a place. The relief expressed by P4.1 ("I have taken that weight off my shoulders") reflects a process of self-forgiveness; the reaction of resistance of P6.1 to the loss of autonomy may be interpreted as an expression of the fact that the deep self remains active in the face of physical decline.

Subtheme 1.3: Peacefulness and spiritual contentment (200105, 200122)

"Feelings of peacefulness" (200105) and "Spiritual contentment" (200122) both reached universal presence in the sample. Both indicators emerged from the process of integration of the self, expressed as an active acceptance of the present.

"This is me, this is how I look and this is the life I have now been given to live" (P3.2). "What has to be, will be" (P12.1.1). "I have my doors open towards death, towards peace and towards calm" (P13.1).

The statement of P3.2, consisting in naming her situation without mitigation or dramatisation, illustrates how serenity allowed participants to maintain agency over their own pace and discourse even at advanced degrees of physical frailty. Spiritual contentment, for its part, manifested itself as a state of biographical acceptance linked to the perception of validated affective bonds, as reflected in the testimonies of P12.1.1 and P13.1 cited above.

Subtheme 1.4: Self-forgiveness as a route to pacification (200107)

"Ability to forgive" (200107) showed high prevalence in the sample. Forgiveness towards oneself allowed participants to resolve unresolved personal guilt, releasing energy for a more serene closure of the life process.

"What I want is not to carry any weight with me, or anything left unresolved" (P5.2). "I have tried, at least, to do it myself, with myself. That is, to ask him for forgiveness, even though he is no longer here" (P1.3).

The testimony of P5.2 illustrates the urgency of “putting one’s affairs in order” as an examination of the past undertaken from a stance of indulgence towards oneself. The account of P1.3 shows that this process did not require external reciprocity: the sincerity of the inner dialogue with himself sufficed. **[**Figure 1 **near here*]**

Theme 2: Interpersonal dimension — The bond with others

Subtheme 2.1: Sharing thoughts and feelings (200117)

“Connectedness with others” (200117) reached universal presence. Dialogue at the end of life transcended the basic communicative act: it functioned as validation of the patient’s lived experience.

“There needs to be more closeness, and for them to listen to us more” (P11.1). “And the fact that you are here right now listening to me is very gratifying. That is to say, you are giving me your time, making a gift of it to me” (P6.1).

The trust generated in the clinical relationship made it easier for participants to share contents they had not communicated in other contexts: “What I have told you, I have not told anyone else” (P12.2).

Subtheme 2.2: The expression of love (200106)

“Ability to love” (200106) showed high prevalence in the sample. Love manifested itself as a practice that affirmed the identity of the participants in the face of the end of life, becoming linked to spiritual contentment (200122).

“My son is the most important thing in this life. I have done everything for him, not for myself” (P14.1). “It has given me the gift of being a good wife; I think I have also been a good sister” (P10.1).

This bond also introduced an ethical concern towards loved ones: several participants adjusted their requests and silenced part of their distress so as not to burden those around them. P14.1 expressed it thus: “I do not want my son to suffer”.

Subtheme 2.3: Legacy and biographical closure (200103, relational plane)

In its relational dimension, indicator 200103 reflected how participants projected their identity beyond their own death, through the transmission of a legacy of values.

“What is truly transcendent is passing on to my children how one must live” (P16.1). “The way my children remember their father” (P13.1) [regarding the wish to remain in the memory of their loved ones].

This search for relational transcendence points to the generative dimension of the person, that is, to generativity/legacy, which Chochinov identifies as one of the central components of the dignity-conserving repertoire in the patient at the end of life [15]. The legacy of values transmitted sustains the

biographical continuity of the patient in the memory of their loved ones, granting meaning to their own life closure. **[**Figure 2 **near here*]**

Theme 3: Transpersonal dimension — Openness to the transcendent

Subtheme 3.1: Faith as support in the face of uncertainty (200101)

"Quality of faith" (200101) showed high prevalence, being the most frequent indicator of this dimension. Faith emerged as a resource that helped participants to moderate fear and to reinterpret their suffering.

"What kind of relationship are you supposed to have with God? Let him do with me whatever he sees fit… He is already doing it" (P12.1.1). "God has a plan for us. He does not give us more than we can bear" (P11.1).

Even in accounts with little formal religious adherence, faith operated as a unifying framework of experience: "If we could gather up all human things and put them into a potion, that would be God" (P3.3).

Subtheme 3.2: Spiritual worldview and hope (200104, 200102)

"Achievement of spiritual world view" (200104) and "Quality of hope" (200102) both showed high prevalence. Death was frequently described as a passage with symbolic meaning, sustained by the expectation of reunion with loved ones.

"I would dream that, when I died, I would go to the most beautiful thing they speak of: paradise, heaven, with my parents, with my mother, with my family, and I would be there with them" (P17.1). "I believe there is something beyond what we can see" (P19). "I was born to die, and that I am clear about" (P5.1).

Subtheme 3.3: Prayer, spiritual experiences, worship and rites (200109, 200108, 200110, 200111, 200112)

"Ability to pray" (200109) showed high prevalence, followed by "Spiritual experiences" (200108), also with high prevalence. "Ability to worship" (200110), "Participation in spiritual rites and passages" (200111) and "Interaction with spiritual leaders" (200112) showed low prevalence, concentrated in a small number of participants with explicit denominational affiliation.

"When I pray I calm down" (P1.3). "I feel that there is something hearing me in this emptiness" (P17.1).

In participants with explicit denominational affiliation (Jehovah's Witnesses, Catholics), worship and rites functioned as points of biographical and communal anchoring: "I feel that when the time comes, let her be the one to take me [Mary]. To come and fetch me, I mean" (P1.1). Interaction with spiritual leaders also

emerged in this subgroup: “When I was admitted here, I spoke with the parish priest […] I told him I wanted spiritual care once a week” (P1.1).

Subtheme 3.4: Participation in spiritual reading (200115)

“Participation in spiritual reading” (200115) showed moderate prevalence, concentrated in participants with a spiritual practice that had been structured prior to the end-of-life process. Figure 3 summarises the indicators that structure this dimension, with their corresponding level of prevalence in the sample.
[Figure 3 **near here*]**

Discussion

The findings of this study situate spiritual health at the end of life as an active process of reconstruction of personal integrity in the face of the threat of fragmentation imposed by extreme vulnerability. The operationalisation of the NOC outcome Spiritual Health (2001) stands as a bridge between ethical reflection on dignity and the precision that must be required of clinical nursing practice.

The reconstruction of meaning as an imperative of justice

Meaning and purpose in life (200103) emerged as the indicator of greatest ontological density in the study. This finding is consistent with the thesis of Cassell, for whom suffering affects the person as a whole and not an isolated organ or function [16]. Against clinical models that might read the life review of our participants as anxious rumination, our phenomenological perspective interprets it as a narrative interiority necessary for biographical closure, which constructs meaning around one’s own lived history.

Unlike readings that associate advanced illness with a state of existential passivity, our findings show an active spirituality: the participants’ sense of dignity depended, to a large extent, on the perception of worth they maintained about themselves, in line with Chochinov’s dignity model [15, 17]. A tension arises, however, when that desire for meaning collides with the coldness of institutional care: at that point, the nurse acts not only as a provider of care, but as a guarantor that the transcendent dimension of the patient is not rendered invisible by the eminently biomedical logic of the healthcare system.

From individual autonomy to the relational impulse

In the interpersonal dimension, the results call into question the idea of an autonomy centred exclusively on individual self-determination. Our participants placed love (200106) and legacy (200103, in its relational plane) as central anchors of their identity. This turn towards a relational autonomy is consistent with the approach of Gómez-Vírseda et al., who hold that the autonomy of the patient at the end of life is partially conditioned by their physical and cognitive vulnerability, and that other significant persons, such as the health professional, the family or the spiritual figure of reference, play a legitimate role in the patient’s process of self-discovery, without this necessarily amounting to undue pressure [18].

There is, however, an ethical risk that deserves discussion: that the family may act as a filter that silences the patient's truth. Some studies indicate that family involvement improves the quality of death [19]; our findings suggest that, alongside such involvement, the professional must sustain a space of honest dialogue that allows the patient to verbalise what "cannot be said" in other settings, but which needs to be uttered in order to heal relational bonds, as illustrated by the verbatim of P12.2 in Subtheme 2.1.

This same relational logic, read now in its projection towards the future and not only towards the present bond, connects with the concept of generativity/legacy in Chochinov's dignity model: the possibility that one's own existence may have an effect that transcends death constitutes, for a substantial proportion of our participants, a central source of meaning and of sustained dignity [15].

Faith and mystery: resource or conflict?

On the transpersonal plane, Quality of faith (200101) operated as a catalyst of hope, transforming dying from a biological collapse into a passage with symbolic meaning. There is a documented tension in the literature in this regard: some studies associate a high level of religiosity with a greater demand for futile or aggressive therapeutic measures [20]; others, by contrast, show that when it is specifically the care team itself that attends to the spiritual dimension of the patient, and not only the support of their external religious community, patients tend to opt for more proportionate and less interventionist care plans near the end of life [21]. Our findings are consistent with this second line: in the context of this study, faith did not appear associated with demands for therapeutic futility, but was integrated by the palliative care team itself as one further component of accompaniment.

Welcoming this dimension requires the professional to cultivate their own interiority in order to be able to sustain the despair of another without this leading to compassion fatigue, in line with what has been proposed by Nouwen and by Bermejo regarding the figure of the "wounded healer" [22, 23]. Such presence, sustained from the recognition of one's own vulnerability, constitutes a moral requirement of palliative accompaniment, not merely a desirable quality of the professional.

A reading from personalism: dignity as a point of arrival, not of departure

It is appropriate, finally, to situate these findings in relation to Sgreccia's ontological personalism, which understands the person as a psychophysical unity that is fully realised in relationship and in the giving of self [24]. This framework is not introduced here as a confessional reading of the data, since our sample includes participants with diverse religious affiliation and also with little explicit religious adherence (Subtheme 3.1), but as one of the bioethical languages available for naming what the findings themselves already show autonomously: that the dignity of our participants did not appear as an abstract attribute to be defended in discourse, but as a conclusion reached after observing how meaning, introspection, bonding and openness to the transcendent operate jointly. Sgreccia offers a vocabulary consistent with that conclusion; Chochinov's model offers, in parallel, an empirical-clinical framework equally compatible with it. Both languages, the bioethical-personalist and the clinical-empirical, converge in this study without the need to subordinate one to the other.

Strengths and limitations

A central strength of this work is its multicentre design, which made it possible to capture the spiritual experience in different care settings (hospital and home-based) within the Spanish public health system. The triangulation of the anonymised data with two senior researchers (Paloma Echevarría Pérez and Daniel Muñoz Jiménez) and the systematic use of analytic memos reinforced the confirmability of the findings. To this is added the active application of an iterative process of data collection and analysis, both at the intra-participant and the inter-participant level, which made it possible to adjust the development of the interviews on the basis of the preliminary findings and to orient saturation towards a genuine consolidation of meaning, adding value in terms of methodological rigour to the study as a whole.

As a limitation, the study was carried out in a predominantly Western cultural framework, with a strong presence of Judaeo-Christian heritage among the participants, which may limit the transferability of some indicators, particularly those linked to worship, rite and interaction with spiritual leaders, to more culturally and religiously diverse contexts. Compliance with the COREQ criteria contributes, nonetheless, to the transparency and auditability of the process for researchers who wish to replicate the study in other settings.

A second limitation refers to the early loss of participants: of the 41 patients initially identified as eligible, 22 did not complete the process (9 owing to death, 10 owing to supervening cognitive impairment, 2 of them detected during the interview itself, and 3 owing to refusal to participate); the material collected from these 22 cases was discarded in its entirety, retaining only the complete data of the 19 participants who completed the study.

A third consideration, methodological in nature and pertaining to the study itself, was that the interview guide was constructed on the basis of the 23 indicators of the NOC Spiritual Health outcome as a conceptual reference framework, and that the phenomenological analysis applied this same outcome as a hermeneutic lens of clinical translation over the eidetic reduction already performed. This decision was taken deliberately in order to preserve the descriptive purity of the discourse analysis, complementing it with an explicit and sustained exercise of epoché throughout the whole process; even so, as occurs in any phenomenological study that engages in dialogue with an external conceptual framework, it should be acknowledged that the prior familiarity of the research team with the NOC forms part of the understanding from which the data were interpreted, and this is declared with transparency.

Conclusion and ethical implications

This study describes spiritual health at the end of life and, in doing so, brings efficiency to its clinical detection: the identification of a reduced set of indicators of the NOC Spiritual Health outcome present in the whole of the sample, namely meaning and purpose in life, connectedness with inner self, feelings of peacefulness and spiritual contentment, offers nursing a priority and manageable horizon of exploration, instead of a diffuse domain that cannot be encompassed in daily practice. This operationalisation brings

the “total pain” described by Saunders [25], which already included the spiritual among its constitutive dimensions, closer to a clinical intervention that can be evaluated and documented, without thereby reducing the spiritual experience to an administrative datum.

This contribution responds to a real need of palliative care: the spiritual demands of the patient are frequently addressed without specific training, partly owing to the scant academic exploration of the spiritual process at the end of life from a clinically operative perspective. Having common, empirically grounded indicators, no longer 23 dispersed areas but a core of practically universal presence in palliative patients, allows nursing to address the spiritual dimension with the same systematicity with which physical symptom control is addressed, without this entailing a reduction of spirituality to a closed protocol.

This framework also constitutes a starting point for further developing research aimed at training new professionals in its clinical application, contributing to ensuring that spiritual care ceases to depend on the individual sensitivity of each professional and becomes consolidated as a plane of care as necessary and as teachable as symptom control during the end-of-life process. What is not documented tends to remain outside the field of clinical attention, and that invisibility may end up affecting both the quality of the care received and the dignity with which the person passes through the end of their life.

This descriptive evidence does not benefit nursing exclusively through the NOC: by identifying in a traceable and reproducible way which dimensions of spiritual health are present in practically all palliative patients, it also lays a common basis on which the rest of the multidisciplinary team can articulate its own research. For medicine, the finding that effective pain control is associated with improvements in spiritual well-being [26] opens an inverse line of research, still little explored: whether the active approach to the four universal indicators of this study may, in turn, modulate the patient’s response to the pharmacological treatment of pain. For psychology, these indicators offer an operative bridge between spiritual well-being and the already validated diagnostic frameworks of the DSM, making it possible to generate new evidence on their relationship with anxiety and depression at the end of life. For social work, the introspection (200116) and the expression of love (200106) documented in this study offer a framework for identifying and responding to alterations in family dynamics that frequently emerge, yet are rarely systematised, during the end-of-life process. For chaplaincy and pastoral care, where empirically based research on the effectiveness of spiritual accompaniment remains scarce [27], meaning and purpose in life (200103) and legacy (200103, in its relational plane) provide a validated narrative anchor on which to build and evaluate life review interventions. A shared and empirically grounded language across professions thus opens new avenues of research and intervention in their respective fields, favouring end-of-life care that is genuinely integrated around the person.

Declarations

Ethics approval and consent to participate	This study was approved by the Research Ethics Committee of the Universidad Católica San Antonio de Murcia (UCAM), reference number CE092309, and by the participating healthcare centers. Written informed consent was obtained from all participants, provided at least seven days prior to the interview to allow adequate deliberation.
Consent for publication	Not applicable.
Availability of data and materials	The datasets generated and analysed during the current study are not publicly available. Under the terms of the informed consent signed by participants, and in accordance with Regulation (EU) 2016/679 (GDPR) and the Spanish Organic Law 3/2018 on the Protection of Personal Data and Guarantee of Digital Rights, personal data and interview data remain restricted to the named research team (Paloma Echevarría Pérez, Daniel Muñoz Jiménez, and Francisco Lencina Navarro). Requests for access by parties outside the research team would require a new data protection assessment and institutional authorization, and are not guaranteed; such requests will be evaluated on a case-by-case basis following publication. The corresponding author's analytic memos are available in full upon reasonable request.
Competing interests	The authors declare that they have no competing interests.
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Authors' contributions	Francisco Lencina Navarro (FLN): conceptualization, methodology, data collection, formal analysis, writing – original draft, writing – review & editing. Paloma Echevarría Pérez (PEP): supervision, data triangulation, writing – review & editing. Daniel Muñoz Jiménez (DMJ): supervision, data triangulation, writing – review & editing. All authors read and approved the final manuscript.
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Declaration of AI use	The empirical data collection, phenomenological reduction (Giorgi), structuring and validation of findings (Colaizzi), NOC indicator coding and verification against ATLAS.ti exports, theoretical interpretation, and all conclusions presented in this manuscript were conducted exclusively by the authors. AI-assisted tools were used solely for language refinement and translation of author-generated content, and did not contribute to data analysis, interpretation, or the generation of any substantive scientific content. The corresponding author takes full responsibility for the accuracy and integrity of all content in this manuscript.

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Figures

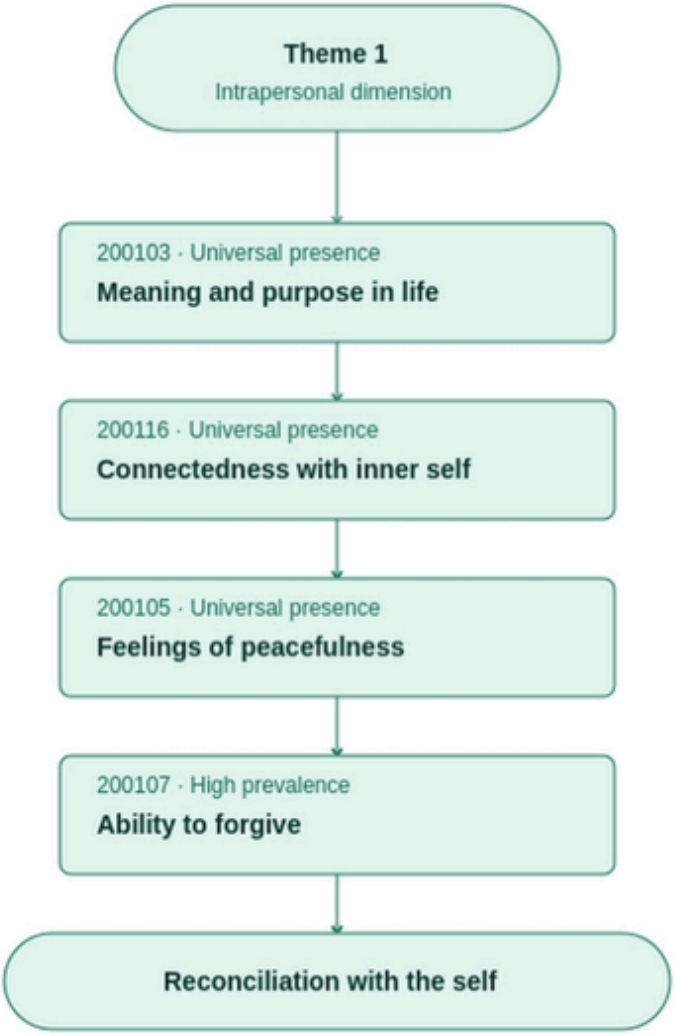


Figure 1

summarises the four indicators that structure this dimension, with their corresponding level of prevalence in the sample.*

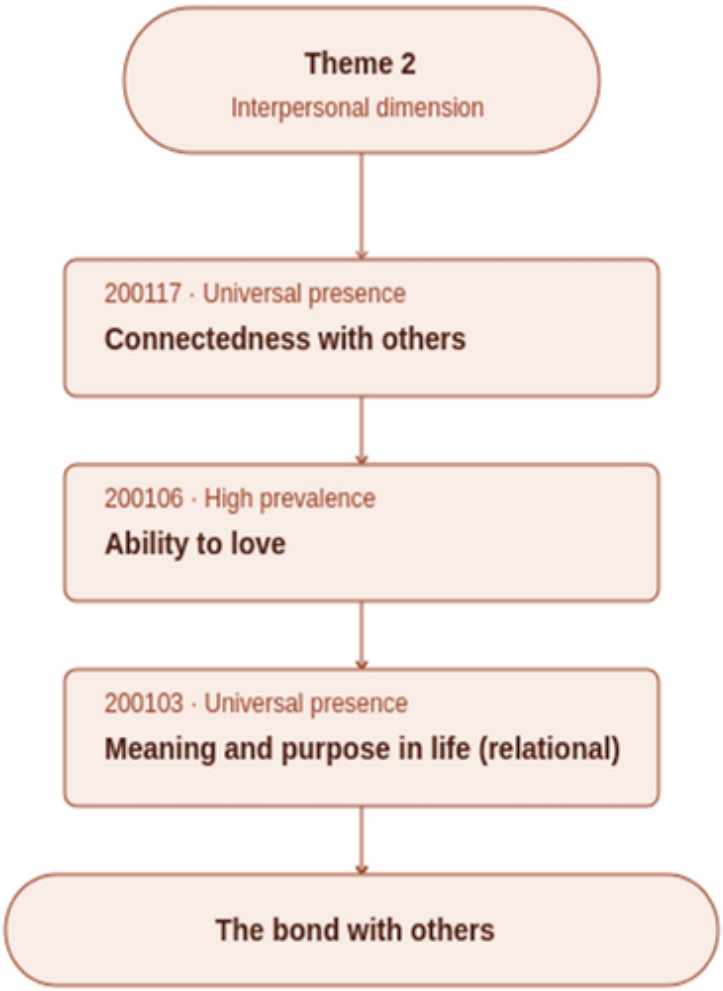


Figure 2

summarises the three indicators that structure this dimension, with their corresponding level of prevalence in the sample.*



Figure 3

summarises the indicators that structure this dimension, with their corresponding level of prevalence in the sample.*