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## REPRODUCTIVE RISK IN PREGNANT WOMEN WITH HEART DISEASES: THE LIVING WORLD GUIDING HEALTH CARE<sup>1</sup>

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### ABSTRACT

**Objective:** to understand the meaning of pregnancy for women with heart diseases; to unveil meanings of the worldliness of the being-there-women in reproductive risk in the experience lived/experience of high-risk pregnancy due to heart diseases.

**Method:** this is a qualitative study based on Heidegger's phenomenology. Seventeen women who got pregnant while suffering from a heart disease were interviewed between July and December of 2014 in a reference facility for maternal risk.

**Results:** the hermeneutic analytic movement allowed the emergence of meaningful units: knowing the risk and planning and ignoring how to avoid it, and getting surprised when finding out pregnancy; telling how they felt physically and emotionally during pregnancy; feeling safe due to the prenatal follow-up routine. The unveiled meanings led to weakness of the participants' knowledge about the reproductive risk.

**Conclusion:** nurses and health teams should consider the intersubjective care that favors health care comprehensiveness in their clinical practice. Discussions about the perceived risk by the pregnant women should be integrated to prenatal care guidance, positively impacting women's health. Martin Heidegger's phenomenology is considered as a reference that allows reaching results of qualitative research in the epistemological field of interest about the human essence through the experiences lived.

**DESCRIPTORS:** High-risk pregnancy. Heart diseases. Qualitative research. Nursing. Women's health.

## RISCO REPRODUTIVO EM GESTANTES PORTADORAS DE CARDIOPATIA: O MUNDO VIVIDO DIRECIONANDO O CUIDADO EM SAÚDE<sup>1</sup>

### RESUMO

**Objetivo:** compreender o significado de gestar para mulheres portadoras de cardiopatia; desvelar sentidos da mundanidade do ser-aí-mulher em risco reprodutivo no vivido/vivência da gestação de alto risco por cardiopatia.

**Método:** pesquisa qualitativa sustentada na fenomenologia Heideggeriana. Foram entrevistadas 17 mulheres entre os meses de julho a dezembro de 2014 que gestaram com cardiopatia em instituição de referência para risco materno.

**Resultados:** o movimento analítico hermenêutico permitiu a emersão das Unidades de Significação: saber do risco e tanto planejar quanto não saber como evitar, e se surpreender ao se descobrir grávida; falar como se sentiu física e emocionalmente na gestação; sentir-se segura pela rotina de acompanhamento pré-natal. Os sentidos desvelados apontaram para a fragilidade dos saberes das participantes acerca do risco reprodutivo.

**Conclusão:** o enfermeiro e a equipe de saúde devem considerar em sua prática clínica o cuidado intersubjetivo que favorece a integralidade da atenção à saúde. As discussões sobre o risco percebido por parte da gestante devem se integrar à condução do pré-natal suscitando um impacto positivo na saúde da mulher. Considera-se a fenomenologia de Martin Heidegger como referencial que permite alcançar resultados de pesquisas qualitativas no campo epistemológico de interesse acerca da essência humana por meio das experiências vividas.

**DESCRIPTORIOS:** Gravidez de alto risco. Cardiopatias. Pesquisa qualitativa. Enfermagem. Saúde da mulher.

# RIESGO REPRODUCTIVO EN GESTANTES PORTADORAS DE CARDIOPATÍA: EL MUNDO EXPERIMENTADO DIRECCIONANDO EL CUIDADO EN SALUD<sup>1</sup>

## RESUMEN

**Objetivo:** comprender el significado de gestar para las mujeres portadoras de cardiopatía, desvelar los sentidos de la mundanidad del ser mujer en riesgo reproductivo en lo experimentado/vivencia de la gestación de alto riesgo por cardiopatía.

**Método:** investigación cualitativa basada en la fenomenología de Heidegger. Fueron entrevistadas 17 mujeres entre los meses de Julio a Diciembre del 2014 y que gestaron con cardiopatía en una institución de referencia para el riesgo materno.

**Resultados:** el movimiento analítico hermenéutico permitió la emersión de las Unidades de Significación: saber del riesgo y tanto planear como no saber evitarlo, sorprenderse al descubrirse embarazada, hablar cómo se sintió física y emocionalmente en la gravidez, sentirse segura por la rutina de acompañamiento prenatal. Los sentidos desvelados señalaron la fragilidad de los saberes de las participantes sobre el riesgo reproductivo.

**Conclusión:** el enfermero y el equipo de salud deben considerar, en sus prácticas clínicas, el cuidado intersubjetivo que favorece la integralidad de la atención para la salud. Las discusiones sobre el riesgo percibido por parte de la gestante deben integrarse a la conducción del prenatal, provocando un impacto positivo en la salud de la mujer. Se considera a la fenomenología de Martin Heidegger como una referencia que permite alcanzar los resultados de investigaciones cualitativas en el campo epistemológico del interés acerca de la esencia humana y por medio de las experiencias vividas.

**DESCRIPTORES:** Gravidez de alto riesgo. Cardiopatías. Investigación cualitativa. Enfermería. Salud de la mujer.

## INTRODUCTION

According to the Brazilian Mortality Information System (SIM), 53,523 deaths of women at childbearing age were reported in 2015.<sup>1</sup> Of these, 1,178 were indicated as maternal deaths, of which about 9% were related to indirect obstetric causes in the list of cardiocirculatory diseases that complicate pregnancy, childbirth and the puerperium. Heart diseases stand out with an incidence of up to 4.2% in the national territory, that is, eight times higher when compared to other countries.<sup>1-2</sup>

The possibility of surgical corrections of congenital heart defects, and the higher occurrence of coronary artery disease in women at present favor the increase of high-risk pregnancies due to heart diseases. In this perspective, the risk involved in pregnancy is associated with higher rates of maternal death, regardless of the classification of functional capacity of the heart; especially in pregnant women with congenital heart disease, there is an increased risk of the fetus developing structural abnormalities, associated with a higher occurrence of infant morbidity and mortality.<sup>3-4</sup>

Women with heart diseases are vulnerable because of their preexisting clinical condition and the possibility of complications during the pregnancy-puerperal cycle, as well as the sometimes unfavorable sociodemographic conditions, the delay of prenatal care in a reference facility, and the reproductive risk during the childbearing time. Thus, the reproductive health care of women at childbearing age ranging from 10 to 49 years is important, and requires, from the healthcare system, measures aimed at comprehensive care, especially with regard to the promotion of maternal health.<sup>5-6</sup>

Preconception counseling takes into account the specificity of heart diseases and the patients' health status to even contraindicate pregnancy in the presence of severe cardiac conditions such as severe pulmonary arterial hypertension, Eisenmenger's syndrome, aortic involvement in Marfan syndrome, aortic aneurysm, non-operated cyanotic congenital heart disease, major dilated or hypertrophic cardiomyopathy, and severe coarctation of the aorta.<sup>2,7</sup>

Nonetheless, the subjectivities that permeate the daily life of women diagnosed with heart diseases and who wish to become pregnant should be considered because, in addition to the pathophysiological aspects, there are social and spiritual aspects that, when unnoticed by health professionals, can make care less effective in promoting reproductive health.<sup>8-9</sup>

Nursing, as a profession of care for the human being, allows finding these specificities according to the worldview of those receiving care. Faced with the demands arising from women, nurses should be able to organize more complex and interactive practices that guarantee and improve the quality of care. Thus, subjective aspects as important as those involving the physical dimension should be considered.<sup>8</sup>

From the point of view of scientific production, Brazilian nursing has sought to reflect on its activity among women who experience high-risk pregnancies. However, with regard to indirect causes such as heart diseases, this production is still incipient, due to the lack of studies, especially those of a qualitative nature.<sup>10-11</sup>

In this context, it is worth noting the applicability of Martin Heidegger's phenomenology

to nursing research on women's health, the scope of which is care considering the human being. This theoretical, philosophical and methodological framework makes it possible to understand the singularities experienced in everyday life through the description that allows turning the attention to things in themselves when seeking the meaning of being, which is the premise of the Heideggerian thought.<sup>12</sup>

For Heidegger, human beings are *entities* launched in the world who show themselves in their possibilities, in their ways of being, which constitutes the worldliness, an extraordinary concept that means the structure of a moment of *being-in-the-world*. World, based on this paradigm, is not geographically circumscribed and limited, but an extension of being of individuals that, through language, describe significant experiences.<sup>12</sup>

Therefore, this is the relevance of this study that sought to fill scientific gaps by answering the guiding question of how to understand the reproductive risk in the lived world of the *being-there-woman-who-got-pregnant-with-a-heart-disease\**, contributing to nursing care and health care for women with a reproductive risk. Thus, the objectives were: to understand the meaning of getting pregnant for women with heart diseases; to unveil the meanings of *worldliness* of the *being-there-women* at reproductive risk in the experience lived/experience of high-risk pregnancy due to heart diseases.

## METHOD

This is a qualitative, descriptive study, using a phenomenological approach based on Martin Heidegger's thought. In order to reach the proposed objective, we sought a way of access to the *entity* that represents, in this study, the women who experienced pregnancy with a cardiopathy. For Heidegger, the human being *becomes an entity* in the *world* and establishes relations with him/herself, with other people, and with instruments they approach by virtue of their daily experiences.

In addition, according to the philosopher, the human being is the only one capable of moving from the ontical or factual occurrence - contemplated by *tradition* in the objectivity of the scientific evidence of the natural sciences - to the ontology or phenomena occurrence. The latter emerges as conscientious data of each *being* when questioned, based on the *entity*, about their factual experiences.<sup>12</sup>

\* Expressions in italics refer to Martin Heidegger's theoretical, philosophical, and methodological framework.

The entity sought in this study was women with heart diseases who became pregnant and were assisted in a reference hospital for maternal risk in Brazil. The data collection or field stage took place from July to December 2014. The records of the high-risk prenatal service were consulted using a retrospective search for personal, clinical and obstetric data of women with the experience of pregnancy - July 2014 to July 2013 - in which the diagnosis of cardiopathy had originated the risk classification.

The inclusion criteria were: women with a cardiopathy of any type who were experiencing or had experienced pregnancy at some point in their lives; women who underwent prenatal follow-up at the outpatient clinic of the referred scenario, or who were admitted to the institution during the pregnancy-puerperal cycle. Women with mental and minor illnesses were excluded.

Telephone contact was made to the possible participants explaining the purpose of the research and inviting them to participate. Seventeen women accepted. The technique used for data collection was open interviews, which took place mostly in the research scenario, through the guiding questions: How was it for you to experience pregnancy with a heart disease? How did this pregnancy occur? How did you feel? What did this mean to you? Would you like to say something else?

The interviews were recorded in a digital device and then transcribed, with an average duration of 32 minutes. The hermeneutical analytical movement focused on seeking clues about the showing of women through their languages. After listening and reading the interviews exhaustively, the meanings expressed by women as essential structures responsive to the phenomenon of interest, the objective of this study, were highlighted. Because of this sufficiency and because there was no different mention of ideas, the continuity of interviews was considered unnecessary.

By means of approximation of meanings, meaningful units (US) emerged as categories a posteriori. The analytical course denoted, from the US, two methodical moments enunciated by Heidegger as vague and median understanding, and interpretative or hermeneutic understanding. The former took place due to the comprehensible unfolding of the occurrence of facts, representing the way in which women understood themselves in their life/experience, which served to indicate a preliminary direction of research.<sup>12-13</sup>

Hermeneutics in the ontological occurrence, or in that of unveiling meanings, allowed the in-

terpretation based on Martin Heidegger's thought, configuring the phenomenal entirety.<sup>12</sup> The discussion was based on the interpretation or unveiling of meanings based on authors who corroborate the thought of the philosopher, and other researchers that are shown to be relevant to the study issue.

The anonymity of the participants was ensured through the use of an alphanumeric code represented by the letter "P" followed by the corresponding number, and in the order in which the interviews occurred (P1, P2, P3 ... P17).

The research was conducted following the provisions of resolution no. 466/2012, with the respective certificates of presentation for ethical analysis (CAAE) no. 32286714.2.0000.5238 and 46073215.2.3001.5259, being approved with the reports 1.103.165 and 1.139.507.

## RESULTS

The 17 participants had a mean age of 30 years, and the diagnoses of a heart disease were related to rheumatic heart disease (6), with three being respectively concomitant to murmur, mitral insufficiency and mitral valve lesion; ischemic heart disease (2), with one being followed by arrhythmia; congenital heart disease (1); arrhythmia (2), with one being diagnosed with Wolff Parkinson-White syndrome; mitral insufficiency (4); dilated cardiomyopathy (2), with one being followed by peripartum cardiopathy.

The participants had 40 pregnancies, 33 deliveries, and 6 abortions. The average of the shortest inter-delivery interval was eight years. All the women were aware of their heart disease diagnosis before pregnancy.

The analysis of the existential movement of the women with heart diseases based on the experience lived/experience of the risk pregnancy allowed the emergence of three meaningful units. Thus, the women at reproductive risk who got pregnant while having a heart disease meant: *knowing the risk and planning and ignoring how to avoid it, and getting surprised when finding out pregnancy; telling how they felt physically and emotionally during pregnancy; feeling safe due to the prenatal follow-up routine.*

### Knowing the risk and both planning and ignoring how to avoid it, then getting surprised when finding out pregnancy

The women meant that they both planned the pregnancy, being aware of the risk, and did not know how to avoid it. When planning the preg-

nancy, the participants did it based on themselves, on what they already understood about how risky it was to become pregnant with a heart condition, according to the speeches selected from the stories: *I thought of everything, it was planned [...]. But since I was already under treatment, I wasn't at much more risk, there would always be a risk, that's why I decided to have my child (P1).*

*I wanted to get pregnant [...] it was when I underwent the tests that I wised up, I said: now I have to take care of myself, take the medicine and see what's going to happen from now on (P9).*

*It was very difficult, I was very scared, but at the same time that I had fear, I had the desire to be a mother, I knew that I could not get pregnant again, if I got pregnant the child would risk being aborted because of the medicine that I took and it could even cause my death [...] (P15).*

*I got pregnant because I wanted to, it wasn't an accident [...]. And I tried to come here, knowing it was a high-risk pregnancy (P16).*

On the other hand, women did not know how to avoid pregnancy and were surprised when they found themselves pregnant, as the following statements show:

*In fact, the doctors even say I'm sterile, that I have almost no hormone at all, you know? [...] I already had this story, you know? But it was much lighter than what I have today (P2).*

*I got very desperate when I found out, because this pregnancy was the result of an adventure [...] I had been using condoms since I discovered the heart disease, I stopped taking medication, I used a condom and I was using condom on the day, I don't know how I got pregnant (P3).*

*It wasn't a planned pregnancy [...]. I mean, in the beginning, it was a surprise because I couldn't avoid with medicine, nor with injections, so it was not desired in the beginning [...] I was afraid when I found out I was pregnant (P10).*

*Oh, it was something new, because I even thought I couldn't get pregnant [...] right when I knew, I was kind of lost, kind of surprised (P11).*

*[...] I discovered the pregnancy, it was a very big scare because I was not taking care of myself and I did not know how to take care of myself (P14).*

### Telling how they felt physically and emotionally in the pregnancy

The women detailed that in the first months they were not very well, they were sick, had nausea and vomiting. They mentioned that these symp-

toms had nothing to do with the heart disease, explaining that they were normal in pregnancies, that their heart was calm, controlled with medicine from the beginning, stated by the speeches: *The pregnancy was normal, good pressure, it was all good [...]. I only had a lot of nausea* (P1).

*There was a lot of vomiting, I felt sick, had falls, and at every maternity that I came to: you can't stay here, you are high-risk [...]. There was nothing to do with the heart, because I was taking the medication, so my heart was very calm [...]* (P2).

*Everything is controlled [...] okay, cholesterol is controlled, glucose with no problems until now, and everything is okay. [...] swaying on the bus, then I get sick, all that* (P3).

They said, according to their understanding that if on the one hand pregnancy was calm, on the other hand, it was also turbulent, stressful: *[...] my cardiologist has always said: do things slowly. Everything that I do in a hurry makes my breathing [...]* (P5).

*Turbulent. Yeah, a lot of stress [...]* (P8).

*My pressure is not easy [...] being with high blood pressure, suffering an abortion, or losing my baby for some reason or even that I could die was always a concern, because the doctor said that there was a risk [...] then there was a lot of talk with the psychologist [...]* (P12).

Other excerpts from the speeches indicate that despite trying to keep their normal activities they meant that being pregnant with a heart disease made them feel very tired, with shortness of breath even to speak, and uncontrolled heartbeat: *[...] I can no longer work for a while ... just starting to climb stairs makes me tired again, shortness of breath, even sleeping is difficult, difficulty breathing* (P6).

*[...] my heart was like that, if I went up and down stairs I would get tired, if I walked a lot, the tiredness was too much, I was no longer bearing my belly weight either* (P9).

*I was always oscillating, because as they explain: there comes a time when our heart has to work for two, for me and for him, mine can't work for me, let alone for the baby, and then I felt a lot of shortness of breath, and very tired* (P15).

### Feeling safe due to the prenatal follow-up routine

The women described the way they were treated by the professionals in the pregnancy follow-up, and during hospitalizations that were necessary. This understanding was revealed by the following statements: *the support they give, the first consultation I*

*had here was with the nurse, it was a wonderful consultation [...]. I felt very safe here, because of this, because they do everything, in any kind of exam there is a professional that they can offer you* (P2).

*Oh, it's great, wonderful, with the obstetrician, with a cardiologist, a nutritionist [...]. I went through the nursing consultation first [...]* (P3).

*Oh professional, it was very well. Look at my pregnancy, they were very attentive, they did not let me miss anything [...]. I was admitted because of Marevan* (P4).

*It was great, my follow-up [...] I came here three times a week to have an ultrasound, I also came three times for the prenatal care, since I chose not to be admitted* [P10].

*Sometimes I came here, and we have a lot of lectures here, a lot of support... I virtually lived here in the hospital, and it was my second family* (P15).

Others meant the routine of prenatal care in the face of the pregnancy risk due to heart disease: *Whenever I come here, the doctors say that there is still one thing that has not improved [...] after the surgery, because they say that this normal opening is 7, mine was 0.7, totally closed, then I underwent it now, it is only 1.2 and it does not improve, we will see into it only after pregnancy* (P6).

*I just stayed at home, going to the doctor and undergoing ultrasounds, ultrasounds, ultrasounds, and came here all the time. I thought that I could, because of the job leave, enjoy life, that I would be able to go out with my family, but I can't do anything, only go to the doctor, go to the doctor, go to the doctor* (P9).

*[...] I came here three times a week to undergo the ultrasounds, I also came three times for the prenatal care, since I chose not to be admitted, I said that I would come, I did not stop coming* (P10).

## DISCUSSION

Regarding the cardiopathy, it is considered a risk factor that can be established as a previously diagnosed clinical condition, or as a clinical complication during pregnancy. The traditional classification, which is based on scientific evidence, is based on the probability of maternal mortality from heart disease, stratifying it in heart diseases that are high-risk, intermediate-risk and lower-risk to pregnancy. Thus, the pregnant cardiac patient has the pregnancy risk continuously reclassified, being seen based on the heart disease that determined the guidelines and protocols of follow-up of the puerperal-pregnancy cycle.<sup>24</sup>

In this study approach, facticity is interpreted as anything to which the *being* is subject to in her

existence that she has not chosen to experience.<sup>12-13</sup> In this study, the *being-there-women* find themselves in the facticity of being a heart disease carrier, projecting themselves as *beings-in-the-world* based on this fact: risky pregnancy due to a heart disease. In this condition, they are at reproductive risk without this being their option. By signifying the awareness of risk, they did not do so based on their possibilities, but on what was said or imposed to them. The risk experienced already denoted the imposition of science regulating, designating and controlling the exceptions.

Thus, the exception imposed by tradition is the risk classification between minimum and maximum attributed to women who become pregnant with some disease or who, during the pregnancy-puerperal cycle, develop health and/or fetal health problems. The risk approach as an expression of scientific objectivity establishes a degree of health care according to the probability of damages identified from the markers and gestational risk factors, with these being the way in which women are introduced into the health system.<sup>2,7</sup>

The participants of this study used technically common expressions for the pregnancies that involve risks, such as the control with laboratory, image tests, names of the medicines, and even the degree of opening or closure of the heart valve. According to phenomenology, when they repeat the professionals' speeches, without necessarily understanding what they say, they show themselves through the speech mode.<sup>12-13</sup> Being satisfied with the repetition of what has already been said, the participants reveal that they accepted the health care that was and is offered by the system to all pregnant women who have heart diseases without questioning or refuting such actions, repeating and passing them on as if they were genuine in their understanding.

Women with heart diseases who wish to become pregnant need to be guided about the prognosis, implications, and consequences for their heart condition. Especially women with unattainable pregnancies should be early identified in order to be prepared for understanding their reproductive risks, preventing morbidity and mortality associated with them,<sup>4,9</sup> which ratifies the relevance of the subjective approach.

In this context, the meaning of ambiguity was revealed, "in which everything seems to have been understood, grasped and authentically discussed when, in essence, it was not. Or it seems that it was not when, in fact, it was."<sup>12,238</sup> In an ambiguous way,

the *being-there-women* think that they understood the risk when, in fact, they did not; the evidence of this is that they planned a pregnancy. They think they did not understand, when they had already understood and were surprised to find themselves pregnant.

Planning or not, they did so not based on their possibilities, but on what was already established and determined for all women with heart diseases by the statistics of maternal morbidity and mortality from indirect obstetric causes, by morbid events in previous pregnancies, and even by what they understood about medical recommendations during the outpatient follow-up of their cardiologic disorder.

A retrospective cohort study comparing perceptions and motivations of pregnant women with and without congenital heart diseases concluded that the severity rating of the pathology differed between physicians and patients. Ten of twenty women underestimated their disease status. Factors influencing women's perception and understanding of their pathologies may have lessened the impact of the disease itself, such as: reliance on clinical and surgical care, past experiences of living with the congenital heart disease and not having their quality of life changed. Counseling not to become pregnant was not enough to deter their desire of becoming mothers, denoting poor understanding of the increased risk of a pregnancy.<sup>14</sup>

Similarly, when confronting the perception of risk among pregnant women with low and high pregnancy risk due to a congenital heart disease, it was evidenced that both groups bet that advances in medicine are capable of reversing situations and complications arising from pregnancy risk.<sup>9</sup>

Therefore, the relevance of effective multi-professional follow-up with an ontical-ontological approach is indicated to understand the knowledge gaps, to assist in the decision-making on getting pregnant or not, among other aspects of the world of life, and of the *being's* inherent subjectivities.

This is because it is necessary to consider that risk perception is subjective, being based on women's worldview and life experiences. Their social context should also be considered, as well as the degree of perception they have about the control of risk and the confidence they place in the information received. The way pregnant women notice pregnancy risk determines their behaviors and self-care decisions in the pregnancy-puerperal cycle.<sup>15</sup>

In a qualitative meta-synthesis on the perception of risk in high-risk pregnant women, the interaction with the professionals was evidenced as one of the main factors that influence the perception of

risk for women. Increased numbers of consultations, and greater contact with doctors are in some cases the basis for increased safety. However, in other situations, even with proximity, information from professionals is not well understood by women.<sup>16</sup>

This consideration implies a reflection on the communication logic of reproductive risk among nurses and other professionals and patients, especially in view of the number of pregnancies, births, abortions and inter-delivery intervals expressed by the results of the present study, as well as the fact that the cardiopathy as a chronic disease places childbearing women at permanent risk.

The necessary promotion of health is highlighted for women at reproductive risk from the perspective of health education since childhood and adolescence when there is a diagnosis of rheumatic fever and congenital heart disease.<sup>9</sup> Such an educational process that will culminate in adulthood requires a plurality of considerations arising from the experiences of women and their families in their social, environmental and singular determinants.

This understanding favors and brings nurses and other professionals closer to compliance with the principle of comprehensiveness of health care, the values of which should be considered beyond the biological range,<sup>17</sup> allowing the women to reveal themselves as the subject of their own care, as protagonists, and aware of their decisions of planning or avoiding pregnancy in the face of reproductive risk, as opposed to the ambiguous mode in which it was shown.

In this context, listening to the women with cardiopathy regarding how they understand the risks involved in the pregnancy-puerperal cycle enables nurses and health teams to establish the necessary intersubjectivity for the opening of the *being-there-women*.<sup>18</sup> It is noteworthy that it is very important to seek the lived world in order to plan health care for these women, transcending positions based on the biomedical, technical, and therefore reduced model.<sup>19</sup> In this comprehensive approach, decision-making is conceived as dialogical without the unilaterality that is characteristic of the positivist paradigm.

Therefore, the aim is not to give up on the protocols of scientific tradition, but rather to use them based on the relation I-you, which does not overlap with the being of the human, favoring the process of health care as a helper. It is necessary that the professional advises the woman about the implications and possible consequences of being pregnant with a cardiopathy, especially when the

classification of pregnancy risk related to the type of heart disease is detrimental to maternal-fetal health.<sup>7</sup>

From this analysis, the possibility of adding a new aspect to the reflection on reproductive health care for childbearing women with heart diseases is highlighted. Although the participants were aware of their reproductive risk, hermeneutics indicated a fragility in their knowledge, given their superficiality. The focus of the counseling process has led to women's understanding of the language of science centered on pregnancy risk. Thus, they assimilated the guidelines given by health professionals, approaching and incorporating them into their daily life, without necessarily doing so from themselves.<sup>20</sup> For the *being-there-women*, to follow the medical recommendation, to take the medications to the heart, and to avoid pressure change represented what would ensure the avoidance of greater risks.

It is also pointed out that the number of participants and the single scenario may constitute a possible limitation of this study. However, the understanding of the women at reproductive risk due to a cardiopathy in the face of women's health comprehensiveness was reached, and constitutes a relevant finding because it allows the construction of care based on the *being-there-women* who showed themselves in daily life being high-risk pregnant women, considering the methodical marks and the scientific contributions of the analysis.

## CONCLUSION

By unveiling the meanings of the worldliness of the *being-there-women* at reproductive risk in the experience of a high-risk pregnancy due to a cardiopathy through the immersion in its uniqueness, this study allowed reflections about the redirection of care of the health system to the pregnant women at risk, and contributed to the promotion of comprehensiveness based on changing the way of looking at women with a heart disease, and seeing them as beings of possibilities, always projecting the search for a better *come-to-be*.

In this sense, public policies for women's health care in the areas of risk pregnancy have improved in the provision of healthcare services centered on the biomedical model, from a factual point of view. However, the series of ministerial and scientific propositions focuses less on the subjective questions that surround pregnant women with a heart disease, and more on the scientific evidence determined by the positivist paradigm.

It is also important to consider that the results clarified the perspective of the multiprofessional work in which nursing is inserted and that, in their clinical practice, nurses and other professionals can offer emotional and educational support during all moments of care during consultations, examinations and other opportunities of contact with the women with a cardiopathy at reproductive risk. However, discussions about perceived risk on the part of the pregnant women should be integrated with the conduct of prenatal care, with a positive impact on women's reproductive health.

Whether individually or in groups, the exchange of experiences, the free expression of feelings, the possibility of reflecting with the professionals about the situations that involve pregnancy allow better coping of this condition, in which the women in their ways of *being* and staying in the world should occupy an important place. Finally, the Heideggerian phenomenology is considered as a reference that allows achieving results of qualitative research in the epistemological field of interest about the human essence through lived experiences.

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