# Nursing care methodology in the phenomenological approach

METODOLOGIA DO CUIDAR EM ENFERMAGEM NA ABORDAGEM FENOMENOLÓGICA

METODOLOGÍA DEL CUIDAR EN ENFERMERÍA EN EL ABORDAJE FENOMENOLÓGICO

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**ABSTRACT**

It is necessary to understand the person who will receive care in order to provide zealous and authentic care. This requires the caregiver to carefully research the existential experience of the being who needs care. It demands, overall, that one knows how to question and to reflect on what is revealed. By believing in the fundamentals of phenomenology, the authors have been attempting to build a methodology in the *art of nursing care*. Being inspired by this perspective, they attempt to develop phenomenological thinking and skills so that they can *be with the other*, in an authentic mode of solicitude. In this article, reflections about the patient-being's comprehension are presented, and about a methodology of care, so that they can support the nurses in their day-to-day activities.

**KEY WORDS**

Nursing care.
Methodology.
Nurse-patient relations.

**RESUMO**

Para o cuidado zeloso, autêntico, é preciso compreender aquele que será cuidado. Isso requer um perscrutar atento do cuidador sobre a experiência existencial do ser que precisa do cuidado. Exige, sobretudo, saber perguntar e refletir sobre o que foi revelado. Acreditando nos fundamentos da fenomenologia, as autoras vêm buscando construir uma metodologia para a *arte de cuidar em enfermagem*. Inspiradas nessa visão, procuram desenvolver habilidades de um pensar e de um fazer fenomenológico para *ser-com-o-outro* num modo autêntico de solicitude. Neste trabalho, são apresentadas reflexões sobre a compreensão do ser-paciente e sobre uma metodologia do cuidado, para que respaldem o(a) enfermeiro(a) em seu cotidiano.

**DESCRITORES**

Cuidados de enfermagem.
Metodologia.
Relações enfermeiro-paciente.

**RESUMEN**

Para un cuidado realizado con celo y auténtico, es necesario comprender al sujeto que será cuidado. Eso requiere un preescrutar atento del cuidador sobre la experiencia existencial del ser que precisa del cuidado. Exige, sobre todo, saber preguntar y reflexionar sobre lo que le fue revelado. Basadas en los fundamentos de la fenomenología, las autoras buscaron construir una metodología para el *arte de cuidar en enfermería*. Inspiradas en esa visión, buscaron desarrollar habilidades de un pensar y de un hacer fenomenológico para *ser-con-el-otro* dentro de un modo autentico de solicitud. En este trabajo, se presentan reflexiones sobre la comprensión del ser-paciente y sobre una metodología del cuidado, para que respalden el enfermero en su cotidiano.

**DESCRIPTORES**

Atención de enfermería.
Metodología.
Relaciones enfermero-paciente.

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## INTRODUCTION

Originally, providing care to a person in a situation of disease reveals the meaning of the existence of nursing itself. The care provided to this patient-being projects and maintains nursing as a profession. The profession manifests and expresses its sets of knowledge, skills and attitudes. By giving care, nursing creates and re-creates the culture of care itself, which is essentially ethical.

> Caring is more than an act, it is an attitude. Therefore, it covers more than a moment of attention, zeal and unveiling. It represents an attitude of occupation, concern, responsibility and affective involvement with the other[1].

This author, based on Martin Heidegger's philosophy, says that care should be understood as a basic ontologic-existential phenomenon – a phenomenon that makes it possible for human existence to be human. In this sense, man is a being of care, which is a particular way of being for man. *Without care, we stop being human*[1].

But what exactly is care in nursing? Our condition of nurses and nursing teachers allows us to observe the existence of a movement that is tacit and contradictory about that what care is in our profession. Although there have been more and more studies that attempt to clarify the meaning of caring in nursing, viewing the possibility of breaking away from the medical-biological model, the idea that caring is a technical act, a procedure, still persists. This means that care preserves the same meaning of the techniques, which can be executed by any member of the nursing team, in a subject/object relationship. Moreover, several commonplace expressions used in the daily routine of work, such as seeing a person as a whole, seeing the patient/client as a holistic being, humanizing the care provided, among others, are representations that mask the reality of the professional activity. At the same time as they suggest more humanized and differentiated ways of caring, in fact, they rest on theoretical-methodological assumptions that are consonant with the biomedical paradigm. In other words, the patient is still seen as a depositary object of logical-rational knowledge, i.e. the object of actions of this conception of care. Such a way of dealing with the *nursing care* phenomenon is habitually accepted, and it seems to make further practical discussions about its nature more difficult.

However, there are many nurses, especially those involved in teaching and research, who have proposed the imminent necessity of revisiting true care as a practical word of order. According to this new perspective:

> Contrary to what many people think, revisiting care is not a rejection of the technical aspects or the scientific aspect. By focusing on caring, we intend to emphasize the characteristics of interactive process and the flow of creative, emotional and intuitive energy that make up the artistic side, in addition to the moral aspect[2].

Investigations that prioritize philosophical, cultural and psychosocial aspects attempt to apprehend the meaning of caring and care, each with its specific approaches. However, most of them have points of convergence, peaking with the main obstacle when they are placed in the nursing healthcare practice: They are still investigating the nature and the mastery over nursing. There are many nursing theories, but few that regard the prescriptive aspects, suggesting instruments for practice. Besides, in their concepts and propositions, the meaning of care/caring is not always placed as the nursing way of being itself. It is observed that:

> Nursing theory appears in the historic development of the profession as the most recent stage, after the scientific production of the category reached three previous stages regarding the emphasis of the studies. Nowadays, as a continuity of this evolution, we are approaching the analysis and philosophical proposition, in an attempt to reflect on the nature and mastery of nursing, highlighting conceptions about the process of care and its meaning in the life of people who seek the current healthcare systems[3].

In short, nursing has tried to understand the human being in its totality, disregarding a fragmented being that is often revealed as a depositary of their actions. Actions that are supported by objective, technical-scientific knowledge, in a subject-object relationship, emptied of any sort of expressive nature. Actions that are far from being configured as the art of helping and caring, in the broad sense of existential ethics and aesthetics.

Among the several currents of thought, some nurses have sought fundamentals in phenomenology as their philosophical proposal to support their reflections. Focusing on the phenomenology of care, postulated by Martin Heidegger (1889-1976), they attempt to visualize this act as something that is inherent to the human dimension, i.e. present in the ontologic constitution. Here, care is not considered as the object of practice, but as the structural totality of human existence, which is indispensable for interpreting the being. In this sense, care constitutes the essence of the beings in their existential conditions.

Existing is caring for being. It is exerting the power of being oneself, in any situation experienced in daily life. The *being in the world*, which essentially receives care – *caring for oneself* and *caring for being with others*. In coexistence, the way in which the being is concerned with the other is treated by solicitude[4].

In the face of this interpretation, one can think that, in nursing actions, there is the patient-being and, on the other side, the being-nurse, both bringing care in their essences. This allows for patient-nurse communication, where each of them is found in a constant state of care for themselves and solicitude for the others.

By identifying ourselves with this perspective, our purpose is to reflect on care, regarding some of the assumptions of phenomenology, and to build a methodology for

the *art of nursing care*, emphasizing the existence and the autonomy of the being.

## THE BEING AND ITS COMPREHENSION

In phenomenology, especially according to the heideggerian philosophy, man is understood as *being-there* (Dasein), always projecting towards coming-to-being. This means that it is an entity that can only be in the world as its existence in its temporality. In this horizon, the concept of time is confounded with the concept of existence. We do not experience the time, we are the time[4]. The life flow is processed there, as well as the awareness of death.

Therefore, it is only by existing (Dasein) is that one can be apprehended as a revelation. Man cannot be understood outside the meaningful relations that constitute their own world. Starting from the perspective that it is necessary to understand the being in question in order to be able to help him, it is therefore necessary to approach the web of significant relationships of the world of those whom we will interact with. In other words, healthcare professionals should comprehend the one who will receive care as existing there and now. All the comprehension should be situated.

Still, regarding knowledge of the beings, some authors had already warned about the investigations performed in this sense, after the *consolidation of the technical-scientific thinking*, since the *precedence of proceeding before existence*[5]. This means that, in order to know man, the investigator had to meet the objectivity of modern science, resorting to theories and procedures that validate and solidify their findings, disregarding questions about the meaning of the being itself.

When trying to clarify the heideggerian ontology, other authors state that the interpretation of the being should not treat the *objects* in the sense of research objects. One cannot disregard the being, transforming it into an *object-thing*, in order to acquire the so-called scientific objectivity. All philosophical and historical disciplines, even those that deal with *organic human life, due to being strict, are also inexact*[6]. For this author,

> An investigation about the meaning of the being does not find its necessary lead primarily in the elaborated concept of the being […]. The vague, common comprehension of the being may be so contaminated by traditional theories and opinions about the being that they will become sources of comprehension[6].

*The wise*, he who knows about one's existence, *is replaced by the objectivity of the investigator*[5]. We could say that the wisdom of existing had much of what the ancient therapists were looking for. They sought an existential message in the disease and the symptom, in an attempt to understand and care for man as a whole, opposite to our current modern scientific tendency, which founds and isolates whatever it wants to study – in this case, the man that one wants to provide care to. By attempting to restrict human nature, there is the objectivation of what is existent. The existent man is transformed into an object of investigation, like any other.

This way of conceiving scientific activity, as expected, also rules over nursing, as a science that attempts to know and provide care to man. This conception still holds the belief that only research acknowledged as scientific, supported by methodological theories and instruments precisely elaborated for what we want to know, promotes strictness and guarantees the studies that usually support our professional actions. Rarely does one resort to the wisdom of existing to build new theoretical or practical knowledge. This action is sometimes shown to lack consistency in view of the current dialogue among nurses, who preach the importance of humanization in the whole universe of the activities developed by these professionals.

It is worth noting that philosophy, when dealing with humanism, regards

> The essence or nature of man, so that the homo can once more become *humanus*. However, for so, humanistic thinking should engage in the task of leading the man from *inhuman* and *anti-human* to human, to reach the original sphere of his own being. The *humanitas* of man rests on its own nature […][6].

In view of the reflections about the knowledge of being and the true meaning of humanism, we glimpse the possibility of subverting the conventional standards of empiricism, up until now followed by us nurses. We choose another way to comprehend and help the being, the main reason for our professional actions. Through phenomenology, we intended to discover a new *method* of action, in the hope of attributing a new meaning to the humanization of caring in our daily practice with the patients.

In a change of attitude, we thought of addressing the being-patient in order to listen to him to prioritize care and share the actions with him. Therefore, we can recognize him as a being capable of taking care of himself, always projecting himself in search of a better coming-to-being and, at the same time, a being that is capable of seeking and welcoming the nurse's solicitude when convenient. It is certain that acting, harmonizing the wisdom of existence with the wisdom of techniques and other professional interventions would be the best choice when one wants to help someone to *face health and disease healthily*[1].

In this interaction, we hope to reinvent, together – being-patient and being-nurse – the authentic way of providing and receiving care. Our concerns are focused on freeing the being from impersonality and finding an active being-patient that is aware of his existential responsibilities. In nursing literature, we find authors with concerns that are similar to ours[7-8]. However, the great challenge that was posed to rescue the humanization of care under the

existential perspective of man was the transposition of the ways of the philosophic reflection and the construction of another way of acting that would be feasible in our professional world-life. In this attempt to transcend the world of ideas and elaborate a methodology for the comprehension of nursing care, we were led to rethink and reformulate concepts that were fundamental to us, which are reported next.

## REBUILDING THE LOGIC OF THINKING AND PRACTICING CARE

If we do not want to perform our role of caregivers with the logic of positivist sciences, where the biomedical model influences the way of addressing and providing care to the patient, we have to change our perspective of the *being in a situation of disease*. For so, we need to stop looking for pre-established *necessities*, *case studies* and other proposals of the sort, used in professional practice, and work with the patient, prioritizing the perceptual experience, his experience with the disease of the existential body. By changing this focus, we acknowledge the ontologic condition that he has to understand himself and find himself as a being of possibilities, capable of directing the way they would like to care for themselves, even at the moments that they need to share this task of self-care with others. Now, we do not identify this patient as a *passive-patient* who delegates the care of his *needs* to the healthcare professionals, including us, as the only guardians of knowledge that can help him.

## REDISCOVERING THE BEING IN THE ACT OF CARING

When we believe that we can find a new opening for the being-in-a-situation-of-disease in order to discover him through the existential meanings and his priorities regarding care, we recover what had been forgotten about him with the methods that had been used until then to address him in the search for information that would support our practice. This happened because most of the methodological instruments used for this objective direct the investigation, taking the priorities as a reference according to the criteria of the healthcare professionals, or even the signs and symptoms of the pathology afflicting the patient. Using these initial reflections, we slowly built a model that pointed towards a new perspective of action, thus making approximation, comprehension and interaction with the patient feasible, so as to guarantee him the choices about care, according to his perception.

## RISKING A NEW BEGINNING: THE QUESTIONS

In an attempt to acknowledge the freedom of the being-in-a-situation-of-disease to expose how he feels when he seeks a healthcare institution, we chose to abolish the scripts used in the existing *nursing processes* and choose, at first, two broad questions that would allow him to speak about his experience with the disease, with hospitalization (if such was the case), or about any other situation that could have afflicted him at the moment of the professional approach. The questions aim to get to know the suffering of the patient with the disease, his capacity for self-care and his expectations regarding the work of the healthcare professionals.

After analyzing the quality of several questions elaborated, we chose those that are found in the wisdom of the common sense world. When we focus on the spontaneous, naïve everyday language, *going back to the same things* of the phenomenological approach, they were there, in the significant experience of the world of human coexistence, sometimes ignored by the *scientific knowledge*. It was in this intersubjective world of our social, family life and particularly in the nursing activity that the chosen questions were used when we wanted to demonstrate interest for the other and availability to help him. The methodology of comprehension that we proposed started, therefore, to become more concrete with the following questions:

a) *How do you feel, sir/madam?* - choice for the first meeting with the patient.

b) *Tell me how you are feeling today (or now), sir/madam* - choice for subsequent approaches during the evaluations (Attachment - topic 1 - patient's report). According to the answers of the patient, we will rebuild our work pathway.

## WILLINGNESS TO LISTEN IN ORDER TO UNDERSTAND: THE REPORT

At first, the proposal is to overcome what is possible to see and suppose in order to retake the world of experience and find man there, in his personal way of dealing with the subjectivity of his history.

By considering *language as the house of the being*[9], we will discover the meanings that will allow us to understand the experience of the patient as it is experienced. In the patient's report, therefore, the essence that needs to be reconsidered will emerge, to individualize the interaction for care practice. When we listen, without impositions, the being in front of the actuality of the disease, we will share the right to participate effectively in the decisions of his fate in the act of caring.

In an attempt to tread through the whole dimension of human experiences with this perspective, the being-nurse is requested to go beyond the limits of the words of the being-patient, and, with the skills to observe, to focus on the underlying significant subtleties, their tone, looks, gestures and attitudes. From there, it will be easier to apprehend the meanings of the discourse and to complement them with the statements included between the lines of non-verbal language. *Listening to discourse is not simply listening to words. What we listen to is, primarily, the silent*

*voice of the speaker, which is the mysterious scope of those who address us with words*[6]. It should be added that

> discourse is a true gesture and contains sense […]. Discourse retakes the gesture and the gesture retakes the discourse, they communicate through my body, just like the sensorial aspects of my body are immediately symbolic of each other […][10].

In addition, the unveiling of the presence of someone as an incarnated body happens through looks, tone, sighing, gestures and other significant manifestations capable of being perceived. They are the person, who is *immediately or directly present in me*[10].

The patient's language speaks in a particular way. Therefore, the mediation of our subjectivity with the patient's will occur if we are alert to perceive, in his discourse, the aspects that either bring verbal senses or not. The proposal is to write down, in a proper nursing form, everything that was seen as important in the *existential anamnesis* of the one of whom the information is sought, and for those who want to find the true individuality of care. Acting like that, we will apprehend the first meanings that are responsible for starting the construction of an individual theoretical base that will be taken as a reference to guide the upcoming dialogues that we will have with the being-patient and, in the course of our professional actions, design and prioritize care together.

## SEEKING THE SENSE OF THE SIGNS AND SYMPTOMS IN THE ACT OF TOUCHING: THE BODY EXAMINATION

The body in a situation of disease cannot be seen as the one made known to us by anatomy or, more commonly, the isolating methods of diagnostic analysis – simply as a group of organs. In the inspection, during the physical examination, we need to be aware of the phenomenal body that uniquely and personally experiences the phenomenon of the disease. We are not only touching to feel and analyze the physical body, but to feel the being in his entire dimension, contained in an incarnated existential body. *Perceiving our body means perceiving our situation in a given physical and human environment, because our body is the same situation while it is effectively performed*[10]. We consider that *the body is not an object*[10]. Therefore, the body that we move and touch, by examining the being-patient, is not restricted to *a group of juxtaposed organs, but a synergic system from which all functions are retaken and connected in the general movement of the being in the world, as the immobilized figure of existence* […][10].

The description of the procedure should contain everything that was observed by the professional. The records will allow us to relate the subjective characteristics of the units of meaning of the existential-body with the objective evidence of the organic body, because *the scientific themes and the objective thinking cannot find a single body function that is totally independent of the structures of existence*[10].

The experience revealed in the discourse, the pathological evidence and the senses of the signs and symptoms identified by the nurse during the body exam are the sources of meanings, in which care will be sought and selected, according to the priorities expressed in the discourse.

The parts of the form reserved for the description of the existential body include the professional's observations and the patient's considerations mentioned during the inspection, in addition to his expectations regarding professional help. If necessary, other information should be registered in the patient's medical record or reported by the nursing team (Annex – Topic 2 – body examination).

## BANNING INSIGNIFICATIONS: THE UNITS OF MEANING

The methodological pathway follows with the search for the group of meanings that give sense to the being-there that experiences a disease, included in the report and the examination of the living body. Even if the declarations do not meet our expectations regarding the basic necessities that are usually investigated, the intention here is to identify the priorities manifested by the patient regarding the care to be prescribed (Annex – topic 3 – building care together).

In order to become familiar with the magic world of the subjectivities veiled in discourse, as mentioned, we have to break away from the deterministic interpretation of the structures of the psychophysical body. The world of subjectivities is organized differently, which demands different thinking-acting in order to apprehend it.

When nurses share this conception, they need to revisit their professional limits and admit that they can be with the patient, helping him significantly and with involvement, without the notion that each person has to decide about *taking care of oneself*. Even when the being-patient cannot take care of himself, he can make the decision about which type of care he wants to receive from others. In this conception, knowledge is not imposed, and nobody attempts to suppress the responsibility of caring of man's coming-into-being. By welcoming this perspective, after reading the reports, we will identify and relate the units of meaning, including the patient's expectations of the professional help he would like to receive. (Attachment – topic 3.1 – units of meaning for care).

## BUILDING THE ACTIONS FOR CARE TOGETHER: THE PRESCRIPTION

By permanent questioning about the meaning of caring, we will build, with the patient, a true way of performing care actions the patient requests, directly or indirectly, identified and listed in the units of meaning. At this stage, and every time it is necessary, the person will be oriented about the disease and the different professional actions,

including their benefits and even the side effects of the possible treatments. It is expected that this will make him feel safer when choosing either to receive the indicated prescribed medications or not.

The encounter between professional-patient intersubjectivities, in the acts of speaking, listening and giving meaning to the discourse revelations will allow us to avoid providing care with characteristics of domination. We believe that this is one of the genuine expressions of solicitude, since the nurse recognizes the possibility that the patients can take responsibility for their own destiny and find themselves in an existential pathway, authentically capable of caring for themselves. If we assume this professional stance, we *release the patient* to be the caregivers of their own bodies and commit themselves to the human pathway.

After delimiting the units of meaning with the manifested needs, the immediate procedure is to talk about them with the patient, including the probable care routines that could be used to meet them, using the priority reference requested by the patient (Annex – topic 3.2 – Care prescription). It is inevitable that the choices and range of actions in each situation will depend on the emotional state, the level of consciousness, the mental and physical deficit and other impeditive dependencies presented by the patient. In these cases and any other approach, the family caregiver's participation in decision making will be guaranteed, along with the professional.

Given the specificity of the proposal herein and considering the fact that the nurse is in a continuous existential relationship with the patient in the therapeutic experience, we chose the interpretation of the units of meaning as a group, differently from what is usually suggested for phenomenological research analyses.

When we decide on this new meeting with the patient to build the therapeutic interaction, we are actually allowing for another opening that will facilitate possible adjustments of the perceptions of significant structures, their priorities, in addition to being able to add something that was not said or acknowledged in the discourse. It is also the moment to undo any mistakes made by interpreting non-verbal messages and arguments. When we assume this existential interpretation, we intend to promote meetings to revisit the units of meaning and, by means of the nurse-patient intersubjectivity, make sure that we are weaving actions that produce sense. With this attitude, interventions with professional responsibility will only start after the patient and/or the family caregiver knows all the prescribed care and agrees to the elaborated plan of action.

## RELATIONSHIPS WITHOUT DISTANCING: COMPREHENSION IS NEVER EXHAUSTED

As mentioned, one should not think that the apprehension of existence occurs entirely through a single look at the meanings that are present in a first narration. Since existence is understood as temporality, here and now, it does not exhaust itself. It is always showing and hiding from interpretation. The experience of the existential body is not completed by a limited inspection, neither is it a single verbal report that will provide full knowledge about the experience of the being-in-a-disease-situation. Its comprehension needs to be faced as a flow of individual events. The being is an open existence in the process of coming-into-being. *I always am, at every instant, more than the group of predicates a survey done by me – or by any other – about me could focus on*[11].

As such, the nurse has to frequently access the meanings given to the personal events during the time in which she will be working with the patient. The individual comprehension of how each person experiences the disease will only occur in the daily intersubjectivity present between caregiver-professional and being-patient. Comprehension according to this perspective has a continuous character and can only be reached by the identification of the requests, either verbal or not, in the daily dialogue that is held with the patient.

*Being-able-to-be* demands one to be *ahead of oneself* in time, creating an opening that will permit understanding and finding oneself on one's existential pathway.

For this reason, it is expected that care itself be p*lausible of being revisited, retaken, according to another appeal, and therefore possible to be taken care of: we also take care of our care of being*[5]. As our way of being, our personal and collective history never escapes when it opens itself to knowledge. Its interpretation is only possible through insistence, communication and the observation that occurs in daily coexistence. In the case of the patient, this will occur through the periodic evaluation of his evolution, resulting from the prescribed care or whenever there are possible events that will affect him, bringing other meanings.

## SHARED ASSESSMENT

In order to share the assessment, we once more need to retake the phenomenological attitude by listening and taking note of the patient's perceptions regarding the response of the existential body to the healthcare actions. The future narrations of the daily routine require other healthcare actions (Annex – Topic 4 – Shared assessment)

In the proposed methodology, it is fundamental to comprehend that the actions need to be shared. Every time a new type of care is prescribed, the being-patient and the being-professional should be reevaluated concomitantly, as co-participants in the therapeutic practice.

This activity demands that professionals do not only master technical-scientific knowledge about diseases and treatments, but especially have skills to understand the existential flow of the being in view of the reality of the dis-

ease, in order to identify the significant experiences and delimit the care actions. This will happen when the professional uses, overall, the certainty that the patient is a being of possibilities, capable of helping him to choose the care that will allow the situation that he experiences to evolve into a different *being-able-to-be* in the search for welfare. At this stage, as before, the voice of the being is the starting point for any decision.

It should not be forgotten that the attitude of care towards another, in the disease situation, should be reconsidered in terms of purpose. If caring in phenomenology leads us to the meaning of solicitude, zeal, attention and other attitudes concerning the existential dimension of the being, the final commitment of care also requires another type of comprehension.

To know that, it is equally necessary to give new meanings to the objectives of the therapeutic actions, i.e. to incorporate the meaning of humanity in the way health and cure are faced as the conclusive result of the professional activity. The comprehension of the whole health, the inexistence of disease, is a false assumption. Being healthy does not mean simply getting rid of the physical problem, but

> It is to know how to face the disease and the health healthily. Being healthy means to heave a sense of life in the many situations where health, disease, suffering, recovery, aging and a quiet path towards death occur [...] Health is not the absence of damage. Health is the strength to live with this damage. Health is to welcome and love life as it is presented, limited and open to the unlimited scope that comes after death[1].

By retaking the assessment pathways, after taking note of the essential references for their construction, new units of meaning will be sought, other types of care will be prescribed and, if necessary, the analysis of the priorities and responsibilities will be redone, with the purpose of readjusting the plan of actions (or not). The frequency of assessments, as in all existing healthcare methodologies, will be performed according to the conditions of each patient and the nurse's common sense.

The described methodological pathway can be resumed at any of its stages, whenever it is considered prudent to promote the purposes of *inter-action* and intervention in self-care until patients are able to manage, without any help from the professional, their existential task of caring for themselves.

## FINAL CONSIDERATIONS: A PATHWAY TO BE CONCLUDED

This reflective study does not allow for a conclusive synthesis. Our intention was to share, with nurses and other healthcare professionals, ideas of an essay about healthcare practice based on some of the principles of phenomenology. Our next commitment is to apply the described proposal, assessing its feasibility as a nursing care methodology. Thus, we hope to give new meanings to the actions, incorporating the sense of humanity in the way of perceiving beings who are healthy or in situations of disease.

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**ANNEX** - NURSING CARE IN THE PHENOMENOLOGICAL APPROACH*

**IDENTIFICATION OF THE PERSON IN A SITUATION OF DISEASE**

Name:_____ Age: _____ Gender: _____

Hometown:_____ Marital Status:_____ Color:_____ Occupation:_____

Hospital:_____ Clinic:_____ Bed: _____

Date of admission: _____ Data do Relato:_____

**1 - PATIENT'S REPORT**: Comprehensive opening during the conversation; express the availability to listen to the patient– "I am here to listen and help you in any possible way, sir/madam."
**Guiding question:** How are you feeling, sir/madam? Tell me about your life today."

**2 - BODY EXAMINATION** (Consists of three moments)

**2.1** Moment when the nurse, using all senses, describes her perception about the body of the patient and his considerations during the exam.

**2.2** Questions to survey expectations regarding the patient's self-care capacity and the nurse's help with a view to shared care.

- About the care you need, which types are you capable of doing by yourself?
- What can I do to help you?

**2.3** Complements with important information for the nurse: contained in the medical records, reports by the nursing team, other professionals and the family (diagnosis, prognosis, evolution, exams, etc).

**3 - CONSTRUINDO JUNTOS O CUIDADO** (Comentar com o paciente as prescrições).

| | **3.1 Units of meaning for care** | **3.2 Prescription of care** |
|---|---|---|
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**4 - SHARED ASSESSMENT** (Evolution)

- How are you feeling today (or now), sir/madam?
- What would you like to tell me so that I can help you?

**Signature**

* This instrument was elaborated by Professors Geralda Fortina dos Santos and Elizabeth Mendes das Graças to apply the nursing care methodology in the phenomenological approach.

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