Cogitare Enfermagem

ORIGINAL ARTICLE

Performance and patient safety metrics: a phenomenological approach in orthopedic wards

HIGHLIGHTS

1. Indicators facilitate the qualification of care in orthopedic wards.
2. Patient safety emerges from bodily and perceptual practice.
3. The nurse's intentionality guides prudent actions, avoiding additional damage.
4. Phenomenology reveals the lived meaning of daily safety practices.

Neidianna Martins Mendonça[1]
Rose Mary Costa Rosa Andrade Silva[1]
Eliane Ramos Pereira[1]

ABSTRACT

Objective: To understand how clinical nurses perceive and interpret the use of performance metrics in promoting patient safety in orthopedic wards. **Method:** A qualitative phenomenological study grounded in Merleau-Ponty's phenomenology and guided by Amedeo Giorgi. Thirteen nurses from the adult inpatient unit of a high-complexity federal hospital participated. Data were collected through phenomenological interviews and analyzed according to the four stages of the method, preserving the lived meaning of the experience. **Results:** Two essential categories emerged: the awakening of embodied safety and the operative intentionality of performance metrics within the inpatient unit setting. The findings reveal that patient safety is expressed in the nurse's embodied self, whose perception, habitual body, and sensitivity guide prudent actions beyond normative prescriptions. **Final Considerations:** When metrics are incorporated into the professional way of being, they facilitate safe practice by articulating indicators, lived experience, and clinical judgment to consolidate qualified care.

DESCRIPTORS: Quality Indicators, Health Care; Patient Safety; Nurses; Perception; Philosophy.

HOW TO REFERENCE THIS ARTICLE:
Mendonça NM, Silva RMCRA, Pereira ER. Performance and patient safety metrics: a phenomenological approach in orthopedic wards. Cogitare Enferm [Internet]. 2026 [cited "insert year, month and day"];31:e102933en. Available from: https://doi.org/10.1590/ce.v31i0.102933en

[1]Universidade Federal Fluminense, Escola de Enfermagem Aurora de Afonso Costa, Programa Acadêmico de Ciências do Cuidado em Saúde, Niterói, RJ, Brasil.

INTRODUCTION

The National Institute of Traumatology and Orthopedics (INTO) stands out as a national center of excellence in traumatology and orthopedics, as part of the Sentinel Network and contributing to the surveillance of adverse events within the Brazilian Unified Health System (SUS)[1]. The highly complex context and the need for systematic care monitoring make patient safety (PS) a cornerstone of professional practice, especially in orthopedic inpatient units, where clinical vulnerability is high.

Contemporary healthcare administration has established the use of performance indicators and metrics as fundamental tools for evaluating processes, structures, and outcomes[2-3]. Such metrics allow for a comprehensive understanding of care quality, integrating patient-centered care, practice effectiveness, and risk reduction[4]. In the Brazilian context, national regulations reinforce the integration of indicators into safety protocols, highlighting that measurement is strategic for clinical and managerial decisions[5-9].

However, studies indicate that, when disconnected from the concrete experience of healthcare professionals, these indicators can be reduced to bureaucratic tasks, becoming detached from the practices that define quality care[10-11]. This reveals an important gap: how does the nurse's embodied perception, as described by Merleau-Ponty, structure the meaning attributed to performance metrics in the promotion of PS? This question is particularly acute in orthopedic wards, where the complexity of care demands attentive and situated perception, clinical judgment, and continuous preventive actions.

Unlike cognitivist or normative approaches, Merleau-Pontian phenomenology[12] does not reduce PS to the rational compliance with protocols, but seeks to understand how care emerges from the nurse's perceptive and bodily experience in the lived world of care.

From this perspective, to address this gap, it is essential to recognize that, in this view, the nurse's body is not an instrument, but the very condition of possibility for care[12]. In this view, PS, is not limited to normative protocols; it manifests itself in sensory perception, in the habitual body, and in the operative intentionality that guides professional action[13].

It is therefore necessary to distinguish the body-object (a purely organic and functional view of an object predominant in traditional clinical practice) from the body-subject. For Merleau-Ponty, the latter is not an object of study, but the medium through which the world exists for the individual, structuring the meaning of all perception[12].

In Merleau-Ponty, operative intentionality refers to the pre-reflective mode by which the body orients itself in the world before conscious rational elaboration.

> This is why Husserl distinguishes between the intentionality of act, which is that of our judgments and our voluntary stances—the only one discussed in the Critique of Pure Reason , and operative intentionality (fungierende Intentionalität), that which forms the natural, pre-predicative unity of the world and our life, which appears in our desires, our evaluations, our landscape, more clearly than in objective knowledge, and provides the text of which our knowledge seeks to be the translation into precise language[12:16].

Care is not an isolated act, but an existential expression that is intertwined with the caregiver's way of life. In light of Maurice Merleau-Ponty's phenomenology of corporeality, it is understood that care is experienced through one's own body, that

is, a body that perceives, acts, and intentionally relates to the world. Thus, indicators cease to be merely numbers or abstract protocols and become embodied practices that guide the way in which the nurse inhabits the care setting and engages with the patient[14].

In line with this philosophy, a Brazilian article demonstrated that Nursing and Health Sciences draw on Merleau-Ponty's framework to reveal lived experience, transcending the biological dimension of care. From this perspective, care is seen as an intertwining of the bodies of those who care and those who are cared for, revealing, through intersubjectivity, its contribution to humanized care, understood here through its repercussions on the subject's existence, thus ceasing to be a strictly physiological event and instead constituting a restructuring of the way the individual inhabits the world[15]. Thus, conceiving safety as a lived phenomenon allows us to go beyond formal prescriptions and reach how it is embodied in the daily routine of work[16].

In this process, the metric is naturally absorbed into daily life until the indicators become ingrained habits, at which point the pursuit of excellence ceases to be an external imposition and becomes part of the professional's very being. According to Merleau-Ponty, the professional does not consider safety to be a given; rather, they experience it as a sensory perception of the environment. The indicator thus becomes the visible reflection of a body that cares in a pre-reflective and habitual manner, consolidating a culture in which safety is the very way of being in the world of care[17].

Therefore, investigating nurses' perceptions of these metrics is essential for improving care management and strengthening the Safety Culture (SC), understood here as a construct of health management that, from this perspective, is redefined based on the professional's phenomenological experience.

Based on the scientific relevance of the relationship between lived experience, care management, and PS, as well as on the institutional potential to improve risk surveillance and mitigation strategies from the perspective of direct care, this study aims to understand how clinical nurses perceive and interpret the use of performance metrics in promoting patient safety in orthopedic wards.

METHOD

This is a qualitative phenomenological study of a descriptive nature, grounded in the phenomenology of Maurice Merleau-Ponty12 and implemented using Amedeo Giorgi's descriptive phenomenological method18. The phenomenon investigated was nurses' perceptions of the use of performance metrics in promoting patient safety in orthopedic wards.

Phenomenology, in this context, seeks to describe experience as it manifests itself to consciousness, prioritizing lived meaning over causal explanations19. From a Merleau-Ponty perspective, the body-subject is the perceptual center from which the nurse interprets and responds to the lived world of care12. Thus, this study was guided by a rigorous search for the meanings that emerge from daily practice, conceiving patient safety as an embodied experience17.

The study was conducted in the Adult Inpatient Unit (UIN) of the National Institute of Traumatology and Orthopedics (INTO), which comprises seven nursing stations distributed across the 6th and 8th floors. The institute operates with 181 of its 232 potential beds, constrained by limited human resources. This organizational context

defined the environment experienced by the participants, influencing their perceptions of safety indicators and practices.

The sample consisted of 13 nursing staff (on-call and daily staff). The eligibility criterion was working directly in the adult UIN; professionals on vacation or leave were excluded. The number of participants was determined according to the phenomenological principle of saturation by meaning, which occurred in the 12th interview and was confirmed in the 13th, ensuring stability of units of meaning and depth in the understanding of the phenomenon20-21.

The data were collected between August and September 2025 through semi-structured phenomenological interviews conducted by the researcher in a private room at the institution itself. The interviews were guided by three central questions: understanding the use of metrics; perceptions regarding their applicability; and their relationship to patient safety. The interviews were recorded on an MP4 device and subsequently transcribed in full. Participants were identified by the letter E followed by Arabic numerals (E1, E2...).

First, a sociodemographic and professional questionnaire was administered to characterize the nurses. The objective data were organized into tables and analyzed using simple descriptive statistics, complementing the phenomenological understanding of the context.

The phenomenological analysis of the data was conducted in strict accordance with the methodological approach proposed by Giorgi18. This framework was structured into four systematic and sequential stages: first, the reports were read in their entirety to grasp the overall meaning; next, Units of Meaning (UMs) were identified. The third stage involved translating these units into scientific language and, finally, synthesizing the essential structure of the investigated phenomenon, as illustrated in Figure 1.

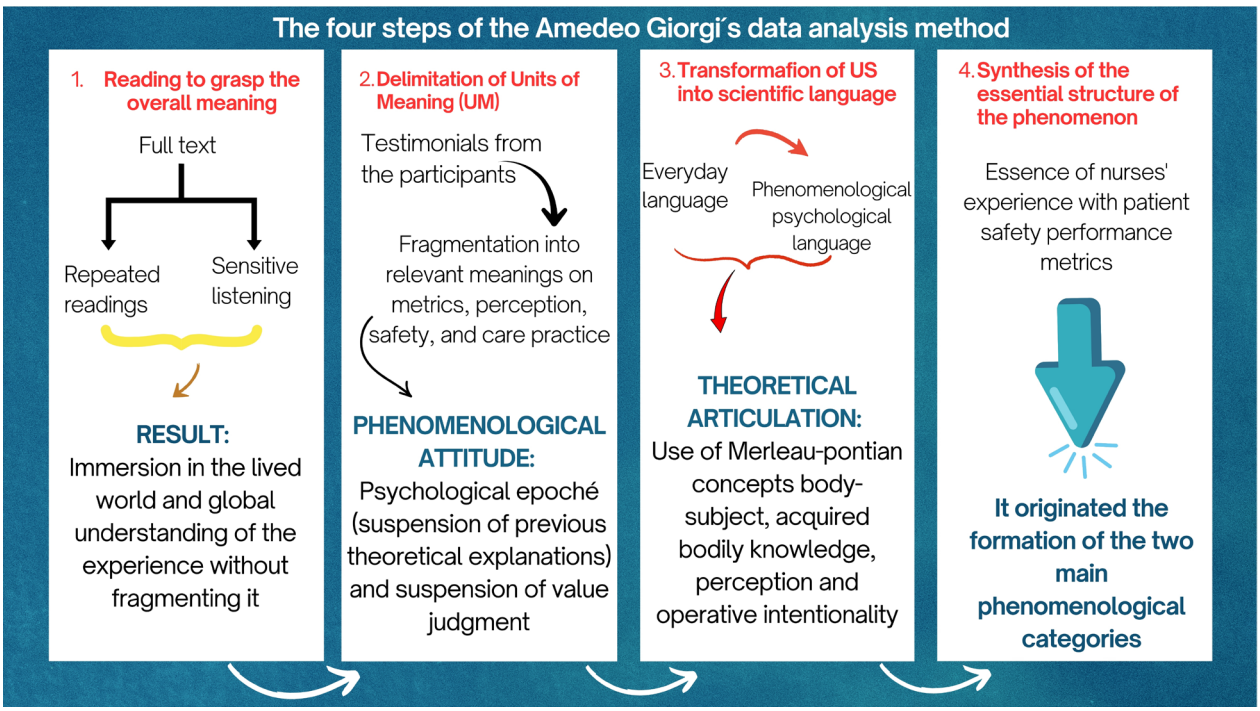

Figure 1. Didactic scheme of Amedeo Giorgi's phenomenological analysis, representing the path taken for the processing of empirical data from lived experience to the essential structure of the phenomenon. Niterói, RJ, Brazil, 2025

Source: The authors (2025).

The psychological epoché proposed by Giorgi[18] differs from Husserl's transcendental reduction[16], as it seeks to suspend theoretical assumptions without abandoning the empirical plane of lived experience.

The approach proposed in this study does not constitute eclecticism, but rather epistemological coherence: while Giorgi's method[18] provides for the systematization of data, the Merleau-Ponty framework[12] illuminates existential interpretation, deepening our understanding of the phenomenon from an embodied and situated perspective.

Rigor was ensured by the criteria of credibility, transferability, dependability, and confirmability[22]. Credibility was strengthened by prolonged immersion in the field and by repeated re-listening to the interviews. Transferability was achieved through a dense description of the context and the participants, allowing for evaluation by other researchers. Reliability and confirmability were ensured by detailed documentation of the stages, the auditability of the process, and the researcher's constant reflection on her preconceptions, thereby reducing interpretive biases.

The study was approved by the INTO Research Ethics Committee (Opinion No. 7,432,273) and complied with national and international ethical guidelines for research involving human subjects.

RESULTS

The sociodemographic profile of the participants in this study showed that, of the 13 (100%) nurses interviewed, seven (54%) were between 50 and 59 years old, with women constituting the majority, comprising 11 (85%) of the professionals, as shown in Table 1.

Table 1. Demographic characteristics of the adult UIN nurses interviewed. Niterói, RJ, Brazil, 2025

Demographic characteristics	n	%
Age		
30-39 years	1	8
40-49 years	5	38
50-59 years	7	54
Gender		
Female	11	85
Male	2	15
Marital status		
Married (stable union)	9	69
Single	2	15
Divorced	2	15

Source: The authors (2025).

Regarding the professional profile of the study group, it was found that 12 (92%) nurses were engaged in direct patient care on an on-call basis; seven (54%) nurses had been working in the setting under study for more than 15 years, and eight (62%) reported having no prior experience in managing quality indicators (Table 2).

Table 2. Professional characteristics of nurses in the adult UIN. Niterói, RJ, Brazil, 2025

Professional Features	n	%
Work regime		
On-call staff	12	92
Routine diarist	1	8
Other employment relationship		
Yes	8	62
No	5	38
Education level		
Specialization completed	10	77
Specialization in progress	2	15
Completed doctorate	1	8
Time to complete the nursing degree		
Over 15 years	11	85
Between 11 and 15 years	2	15
Length of professional experience at UIN		
Over 15 years	7	54
Between 11 and 15 years	3	23
Between 6 and 10 years	1	8
Less than 5 years	2	15
Experience in quality indicator management		
Yes	5	38
No	8	62

Source: The authors (2025).

From the interviews with nurses in the adult UIN, six significant themes emerged that describe the essence of the phenomenon. These themes include: social responsibility, humanized care, empathy, professional satisfaction with the organizational structure, and performance metrics as facilitators of quality care and SC.

Next, the structuring of categories emerged as an essential procedure for understanding the implications of these investigated professionals for the described phenomenon. To fulfill this purpose, two categories were formulated: the awakening of embodied safety and the operative intentionality of performance metrics in the UIN world.

The Awakening of Embodied Security

Day-to-day care in the UIN reveals that PS is not limited to the bureaucratic fulfillment of goals, but is grounded in the sensitivity of the caring body. Upon first entering the hospital setting, the body-world relationship is established when the nurse perceives the institutional atmosphere through bodily attention focused on the continuity and thoroughness of care.

On my first shift, I saw a lot of concern among the federal staff here about ensuring continuity. I saw a lot of concern regarding dressing changes, dressing dates, access points, and, in general, the quality of care. (E1).

This immersion in the hospital environment is mediated and facilitated by the quality of the objects surrounding the healthcare professional. Technique and technology are not merely isolated tools, but extensions of the nurse's own capacity to act. The reported feeling of 'peace of mind' points to a body that feels secure in its ability to act. A practical embodiment occurs here, in which high-quality equipment ceases to be foreign objects and becomes integrated into the professional's body schema, allowing their movements to flow toward the patient with precision and without the weight of imminent risk.

In addition to having the physical structure, the equipment is of good quality and up-to-date; this certainly brings greater peace of mind to practice nursing in a way that poses no risk to the patient, safely, with the aim of providing better treatment and better care to the patient. (E2).

However, the harmony of this body-world relationship is often strained by organizational demands. The quest to ensure PS frequently requires nurses to push themselves beyond their biological and professional limits to fill gaps in the system.

In general, I see it as an institution that has the best protocols and practices regarding PS. Today, what puts the patient at risk does not depend on nursing. For us to ensure PS, we end up taking on roles that are not ours. But we can't always handle everything. (E7).

Despite these tensions, as protocols and indicators are internalized over time, they cease to be external rules and instead become an integral part of the professional's very identity. Safety becomes a driving and cognitive habit that is ingrained in the nurse and emerges spontaneously in their speech, demonstrating that the culture of safety has transformed the way this professional engages with the world of nursing.

Here at INTO, I consider the balance to be positive, especially because, looking back over the years, there has been a significant improvement regarding falls, phlebitis, pressure injuries, and deep puncture site infections. So, you're seeing all of this right on the tip of my tongue; it's because we have this practice, we have this culture. (E13).

The operative intentionality of performance metrics in the world of the inpatient unit (uin).

The body-world relationship is revealed through attention to the minutiae of space. Checking these elements is part of an embodied routine, in which the eye and the hand act almost symbiotically with the environment to protect one another.

It's the care with the PS, how am I going to say, it's having in our routine the checking of the bars and if the bathroom floor is slippery. Another thing we have to keep an eye on to make sure it's in good shape, that it's intact, is that little rubber pad that supports the crutches; that makes a difference too. (E8).

I don't give up a complete label. Just the first name and maybe it doesn't even have the name of the medication, it doesn't have the day, it doesn't have the time. I charge and I look. (E1).

Nursing practice in the UIN is thus a continuous effort to mitigate harm. The nurse deals with a body that is already vulnerable due to surgical trauma and acts in such a way that the hospital environment does not intensify this suffering. The body-world relationship here is therapeutic and preventive; touch and technical handling are guided by perceptual sensitivity, triggering a pre-reflective substitution action to protect the patient's biological boundaries against infection.

The patient already has some damage here that is expected from the surgery itself, from the hospitalization itself, but we try not to cause further damage. If the access site is compromised, we try to change it right away, and by doing so, we are already addressing the risk of infection. It also involves care in handling the PICC, in handling a deep vein, and in contact precautions. (E5).

The indicator is integrated into the team's workflow as a tool that broadens the perspective on care. It is not a static piece of data, but rather a compass that guides the collective understanding of where and how physical care should be prioritized.

It is clear that the indicator acts as a facilitating tool; by equipping the team, it enhances care. (E2).

It's something you see in the courses they offer: there's always someone talking about PS, in identification, when you note that the patient is going into surgery and needs the fasting sign, or when the patient is under contact precautions and needs the sign posted on the ward door, or other protocols. (E11).

The testimonies also revealed tensions and limitations in the use of performance metrics, especially in the face of work overload and insufficient human resources, which highlights that PS is shaped by a field of possibilities and constraints that nurses experience firsthand.

There are days when we know what we need to do, we know the indicator, we know the protocol, but the number of patients and the lack of staff mean we have to prioritize what's essential so as not to cause further harm. (E9).

DISCUSSION

For nursing practice, understanding PS as an embodied phenomenon implies recognizing that protocols and metrics only produce effects when incorporated into the nurse's habitual way of acting in direct care[14]. Thus, Merleau-Ponty's phenomenology helps to highlight that the effectiveness of indicators lies not only in their measurement but also in their practical assimilation into the workplace.

The perceptions of the participating nurses demonstrated alignment with PS guidelines. As postulated in the literature, PS comprises various organized activities aimed at structuring cultures, processes, and behaviors that seek to consistently reduce risks and mitigate harm to patients[23].

From this perspective, the notion of care as a way of life, explored in a Brazilian study, provides the phenomenological framework for understanding the integration of performance metrics into clinical practice[14]. When care is internalized and lived as a way of life, numerical indicators cease to be bureaucratic impositions and come to be recognized as reflections of the nurse's active intent[14]. From this perspective, the safety indicator is not merely a target to be met, but the visible expression of a way of being and perceiving the nursing ward, where the metric is incorporated into daily life as a constitutive element of excellence in care, rather than as an end in itself.

Furthermore, in the orthopedic context where musculoskeletal impairment imposes a high dependence on nursing care, it is also observed how this condition of reduced mobility causes a disruption in the patient's operational intentionality. When the habitual body fails, the role of the nursing team is to mediate the reconstruction of a new horizon of perception and adaptation for that modified body-subject[24]. PS thus emerges as

a bodily and intersubjective practice, constructed through the continuous interaction between professionals, patients, protocols, and the institutional environment.

It is in this context that the incorporation of performance metrics is linked to the development of an institutional culture of safety, as it becomes a habit or a collective way of being, which manifests itself and is transmitted through the practice of embodied care.

It is the way nurses' bodies move together, how errors are avoided or corrected through communication that is, first and foremost, bodily and gestural, and how skilled care becomes the way of life in that unit. Furthermore, it is safe know-how, lived and expressed in the shared field of intercorporeality[25].

Corporeality is also expressed in the professional's relationship with the objects, equipment, and structures of the hospital environment. E2's account reveals the process by which equipment transcends its status as a body-object to become integrated into the nurse's space of action. In light of Merleau-Ponty's analogy regarding the blind man's cane (which ceases to be an external object to become an extension of touch), the technological devices in the orthopedic unit appear not merely as technical objects, but as practical extensions of the nurse's body, integrating into their perceptual mode of confident action in care[13].

However, the discourses also reveal tensions and limitations in the application of these metrics when the lived world (*Lebenswelt*) undergoes a rupture, transforming the care setting from a field of possibilities into a field of material constraints. In this context, corporeality is not merely a potential for action, but also an expression of fatigue, overload, and institutional limitations. Thus, quality indicators cannot be understood in isolation from the actual conditions in which care takes place[26].

The practical implications of this study lie, therefore, in redefining risk management, shifting PS from a purely normative dimension to a phenomenological and care-oriented perspective. By revealing that safety is embodied in the practice of orthopedic nurses, the findings suggest that the effectiveness of performance metrics depends on their assimilation as tools that facilitate perception, rather than mere mechanisms of bureaucratic control.

Thus, the study contributes to innovation in care by proposing that strengthening PS in inpatient units involves valuing perception and subjectivity, essential elements for the consolidation of a reflective, humanized practice critically situated within the hospital lifeworld[23].

Regarding the limitations of this study, we note that the interviews were conducted solely within the hospital wards. These data, therefore, do not reflect the perceptions of nursing professionals at the institution as a whole regarding SC and care management.

FINAL CONSIDERATIONS

This study reveals that, in the orthopedic ward, the nurse's body serves as the mediator between metrics and care, translating technical standards into intentional acts of care. The central contribution is the humanization of risk management by validating clinical judgment and sensitivity as pillars of patient safety. It is recommended that managers integrate this human dimension into institutional strategies, recognizing that the protection of life requires a balance between protocol and the professional's subjective readiness.

REFERENCES

1. Instituto Nacional de Traumatologia e Ortopedia Jamil Haddad. História [Internet]. Rio de Janeiro: INTO; [cited 2025 Nov 18].História;[about 3 screens]. Available from: https://www.into.saude.gov.br/institucional/apresentacao/historia

2. Migoto MT, de Oliveira RP, Freire MHS. Validation of indicators for monitoring the quality of prenatal care. Esc Anna Nery [Internet]. 2022 [cited 2025 Jul 29];26:e20210262. Available from: https://doi.org/10.1590/2177-9465-EAN-2021-0262

3. Seiffert LS, Wolff LDG, Ferreira MMF, Cruz EDA, Silvestre AL. Indicators of effectiveness of nursing care in the dimension of patient safety. Rev Bras Enferm [Internet]. 2020 [cited 2025 Nov 18];73(3):e20180833. Available from: http://dx.doi.org/10.1590/0034-7167-2018-0833

4. de Oliveira NPG, Fassarella CS, Gallasch CH, Camerini FG, Henrique DM, Pinto SMO. Ocorrência de eventos adversos associados às práticas de enfermagem: revisão integrativa. Enferm Bras [Internet]. 2023 [cited 2026 May 18];22(1):103-117. Available from: https://doi.org/10.33233/eb.v22i1.5143

5. Ministério da Saúde (BR). Agência Nacional de Vigilância Sanitária. Resolução RDC n° 63, de 25 de novembro de 2011. Dispõe sobre os Requisitos de Boas Práticas de Funcionamento para Serviços de Saúde [Internet]. Brasília, DF: Ministério da Saúde; 2011 [cited 2025 Dec 28]. Available from: https://bvsms.saude.gov.br/bvs/saudelegis/anvisa/2011/rdc0063_25_11_2011.html

6. Brasil. Ministério da Saúde. Portaria n° 529, de 1° de abril de 2013. Institui o Programa Nacional de Segurança do Paciente (PNSP) [Internet]. Brasília, DF: Ministério da Saúde; 2013 [cited 2025 Nov 18]. Available from: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2013/prt0529_01_04_2013.html

7. Brasil. Ministério da Saúde. Portaria n° 1.377, de 9 de julho de 2013. Aprova os Protocolos de Segurança do Paciente [Internet]. Brasília, DF: Ministério da Saúde; 2013 [cited 2025 Nov 18]. Available from: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2013/prt1377_09_07_2013.html

8. Brasil. Ministério da Saúde. Portaria n° 2.095, de 24 de setembro de 2013. Aprova os Protocolos Básicos de Segurança do Paciente [Internet]. Brasília, DF: Ministério da Saúde; 2013 [cited 2025 Nov 18]. Available from: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2013/prt2095_24_09_2013.html

9. Brasil. Ministério da Saúde. Agência Nacional de Vigilância Sanitária. Resolução RDC n° 36, de 25 de julho de 2013. Institui ações para a segurança do paciente em serviços de saúde e dá outras providências [Internet]. Brasília, DF: Ministério da Saúde; 2013 [cited 2025 Nov 18]. Available from: https://bvsms.saude.gov.br/bvs/saudelegis/anvisa/2013/rdc0036_25_07_2013.html

10. Chourabi LF, de Souza VR, da Silva LG, Costa SM, Balonecker AFC, Figueira SHS, et al. Indicadores na assistência cirúrgica de um hospital universitário: o que pensam os gestores? Rev Enferm Atual In Derme [Internet]. 2024 [cited 2025 Sep 10];98(1):e024263. Available from: https://mail.revistaenfermagematual.com.br/revista/article/view/2080

11. Paz DD, de Souza LM, Brinati LM, Coutinho JSL, de Souza SM, Correia MDL, et al. Analysis of quality indicators in an adult Intensive Care Unit: a descriptive study. Online Braz J Nurs [Internet]. 2023 [cited 2025 Dec 28];22:e20236665. Available from: https://doi.org/10.17665/1676-4285.20236663
12 Merleau-Ponty M. Fenomenologia da percepção. 5a ed. Moura CAR, tradutor. São Paulo: WMF Martins Fontes; 2018. 662 p.

13. Cruz RAO, de Almeida FCA, Bastos RAA, Costa MML. Skin aging: interlocutions between nursing care and corporeity in Merleau-Ponty. Rev Enferm UERJ [Internet]. 2023 [cited 2025 Dec 14];31:e69466. Available from: http://dx.doi.org/10.12957/reuerj.2023.69466

14. Waldow VR. Enfermagem: a prática do cuidado sob uma perspectiva filosófica.
Investig Enferm Imagen Desarro [Internet]. 2014 [cited 2025 Dec 28];17(1):13-25. Available from: https://doi.org/10.11144/Javeriana.IE17-1.epdc

15. Cruz RAO, de Almeida FCA, Bastos RAA, Costa MML. Skin aging: interlocutions between nursing care and corporeity in Merleau-Ponty. Rev Enferm UERJ [Internet]. 2023 [cited 2026 Jun 2];31:e69466. Available from: http://dx.doi.org/10.12957/reuerj.2023.69466

16. Cerbone DR. Fenomenologia. Tradução de Caesar Souza. 3ª ed. Petrópolis: Vozes; 2014. 296 p

17. Henriques CMG, Botelho MAR, Catarino HCP. Phenomenology as a method applied to nursing science: research study. Cienc Saude Colet [Internet]. 2021 [cited 2025 Dec 6];26(2):511-9. Available from: https://doi.org/10.1590/1413-81232021262.41042020

18. de Castro A. Introduction to Giorgi's existential phenomenological research method. Rev Pesq Qual [Internet]. 2018 [cited 2026 May 14];6(11):136-144. Available from: https://doi.org/10.33361/RPQ.2018.v.6.n.11.228

19. Gomes WB. A entrevista fenomenológica e o estudo da experiência consciente. Psicol USP [Internet]. 1997 [cited 2025 Nov 18];8(2):305-36. Available from: https://doi.org/10.1590/S0103-65641997000200015

20. Andrade CC, Holanda AF. Apontamentos sobre pesquisa qualitativa e pesquisa empírico-fenomenológica. Estud Psicol (Campinas) [Internet]. 2010 [cited 2025 Dec 28];27(2):259-68. Available from: https://doi.org/10.1590/S0103-166X2010000200013

21. Branco PCC. Diálogo entre análise de conteúdo e método fenomenológico empírico: percursos históricos e metodológicos. Rev Abordagem Gestalt [Internet]. 2014 [cited 2025 Dec 14];20(2):189-97. Available from: https://doi.org/10.18065/RAG.2014v20n2.5

22. Moreira H. Critérios e estratégias para garantir o rigor na pesquisa qualitativa. Rev Bras Ensino Cienc Tecnol [Internet]. 2018 [cited 2025 Dec 28];11(1):153-82. Available from: http://dx.doi.org/10.3895/rbect.v11n1.6977

23. Sátiro LSP, Rodrigues CCFM, Tibúrcio MP, Oliveira PMS, Salvador PTCO. Perceptions of professionals working in a university hospital about the patient safety culture. Cogitare Enferm [Internet]. 2024 [cited 2025 Dec 28];29:e92456. Available from: https://doi.org/10.1590/ce.v29i0.95250

24. Carel H. Phenomenology and its application in medicine. J Med Philos [Internet]. 2011 [cited 2026 May 14];37:96-113. Available from: http://dx.doi.org/10.1007/s11017-010-9161-x

25. Dupond P. Vocabulário de Merleau-Ponty. 1ª ed. São Paulo: WMF Martins Fontes; 2010. 84 p.

26. Santos VAA, Sousa RS. A fenomenologia da percepção de Merleau-Ponty a partir do corpo e a educação (em ciências). Rev Contexto Educ [Internet]. 2024 [cited 2025 Nov 18];39(121):e14366. Available from: https://doi.org/10.21527/2179-1309.2024.121.14366

Received: 07/01/2026
Approved: 17/05/2026
Associate editor: Dra. Luciana de Alcantara Nogueira

Corresponding author:
Neidianna Martins Mendonça
Universidade Federal Fluminense
Rua Doutor Celestino, 74, Centro, Niterói, RJ. CEP:24020-091
E-mail: neidiannamm@id.uff.br

Role of Authors:
Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work - **Mendonça NM, Silva RMCRA, Pereira ER.** Drafting the work or revising it critically for important intellectual content - **Mendonça NM, Silva RMCRA, Pereira ER.** Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved - **Mendonça NM, Silva RMCRA.** All authors approved the final version of the text.

Conflicts of interest:
The authors have no conflicts of interest to declare.

Data availability:
The authors declare that all data are fully available within the article.

ISSN 2176-9133