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The person with heart failure in the perspective of finitude: an understanding in the light of Martin Heidegger

A pessoa com insuficiência cardíaca em perspectiva de finitude: compreensão à luz de Martin Heidegger

La persona con insuficiencia cardíaca en la perspectiva de la finitud: una comprensión a la luz de Martin Heidegger

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ABSTRACT

Objective: To understand the experience of finitude from people with advanced-stage heart failure.

Method: Phenomenological study conducted in a tertiary referral hospital in cardiology, in Fortaleza - CE, from August to October 2022. The participants were 11 patients with advanced-stage heart failure. Data collection was conducted through semi-structured interviews, and the speeches were recorded and transcribed for analysis using Heideggerian hermeneutic circle.

Results: Of the 11 participants, eight were men; ages ranged from 43 to 82 years. The results were processed through the hermeneutic reduction process, which allowed the construction of two categories: (1) Being-with the other in heart illness and finitude, consisting of meanings related to the patients' physical conditions, their limitations and possibilities, and their interpersonal relationships, (2) The construction of being-toward-death, in which patients spoke about their fears, anxieties, perceptions, and concerns in the face of finitude.

Final considerations: The person with heart failure in the perspective of finitude experiences a phenomenon marked by the lack of information about the severity of the disease and the proximity of the end, which hinders the communication of their needs and conscious choices, resulting in an inauthentic existence.

Descriptors: End-of-Life Care; Heart Failure; Nursing; Fenomenology.

RESUMO

Objetivo: Compreender a experiência de finitude de pessoas com insuficiência cardíaca avançada.

Método: Estudo fenomenológico realizado em hospital terciário de referência em cardiologia, em Fortaleza - CE, de agosto a outubro de 2022. Os participantes foram 11 pacientes com insuficiência cardíaca em fase avançada. A coleta de dados deu-se mediante entrevista semiestruturada e os discursos foram gravados e transcritos para análise por meio do círculo hermenêutico heideggeriano.

Resultados: Dos 11 participantes, oito eram homens; a idade variou entre 43 e 82 anos. Os resultados foram trabalhados por meio do processo de redução hermenêutica, que permitiu a construção de duas categorias: (1) Ser-com o outro no adoecimento cardíaco e finitude, constituída pelos significados relacionados às condições físicas dos pacientes, suas limitações, possibilidades e relações interpessoais, (2) A construção do ser-para-a-morte, na qual os pacientes falam sobre seus medos, angústias, percepções e preocupações diante da finitude.

Considerações finais: A pessoa com insuficiência cardíaca em perspectiva da finitude vive um fenômeno marcado pela ausência de informação sobre a gravidade da doença e proximidade do fim, o que dificulta a comunicação de suas necessidades e escolhas conscientes, resultando em uma existência inautêntica.

Descritores: Cuidados de Fim de Vida; Insuficiência Cardíaca; Enfermagem; Fenomenologia.

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RESUMEN

Objetivo: Comprender la experiencia de finitud de las personas con insuficiencia cardíaca avanzada.

Método: Estudio fenomenológico realizado en un hospital terciario de referencia en cardiología, en Fortaleza - CE, de agosto a octubre de 2022. Los participantes fueron 11 pacientes con insuficiencia cardíaca en fase avanzada. La recolección de datos se realizó mediante entrevistas semiestructuradas, y los discursos fueron grabados y transcritos para su análisis mediante el círculo hermenéutico heideggeriano.

Resultados: De los 11 participantes, ocho eran hombres; las edades oscilaron entre 43 y 82 años. Los resultados se procesaron a través del proceso de reducción hermenéutica, lo que permitió la construcción de dos categorías: (1) Ser-con el otro en la enfermedad cardíaca y la finitud, constituida por los significados relacionados con las condiciones físicas de los pacientes, sus limitaciones y posibilidades, y sus relaciones interpersonales, (2) La construcción del ser-para-la-muerte, en la cual los pacientes hablaron sobre sus miedos, ansiedades, percepciones y preocupaciones frente a la finitud.

Consideraciones finales: La persona con insuficiencia cardíaca en la perspectiva de la finitud vive un fenómeno marcado por la falta de información sobre la gravedad de la enfermedad y la proximidad del final, lo que dificulta la comunicación de sus necesidades y elecciones conscientes, resultando en una existencia inauténtica.

Descriptores: Cuidados al Final de la Vida; Insuficiencia Cardíaca; Enfermería; Fenomenología.

INTRODUCTION

Cardiovascular diseases are the leading cause of death worldwide and nationally. It is estimated that by 2040, there will be a 250% increase in these events in Brazil[1]. Heart failure (HF) requires large public expenditures and causes multiple losses to patients and their families[2]. Patients who progress to advanced-stage HF often face the exhaustion of disease-modifying therapies, physical limitations, loss of autonomy, exacerbation of symptoms, and approaching finitude[3].

Patients with heart failure often require palliative care (PC), an approach that promotes the quality of life of patients and their families when faced with problems associated with life-threatening diseases; that prevents and alleviates suffering through early identification, proper assessment, and treatment of pain and other physical, psychosocial, and spiritual problems[4]. However, access to palliative care for patients with HF remains a challenge[5].

There is a significant gap in knowledge about end-of-life care for patients with heart failure, with barriers related to recognizing terminality and late integration of palliative care, especially when compared to other chronic conditions, such as cancer[6].

Many healthcare professionals are reluctant to discuss prognosis and end-of-life care with patients with heart failure, and may not feel comfortable addressing these topics, which can delay the implementation of palliative care[7]. The transition of patients with HF to palliative care is still complicated, and there is a difficulty in addressing this topic in the early stages of the disease, in addition to the lack of integration between curative and palliative care[8].

The experience of people with advanced-stage heart failure involves a difficult prognosis, and nurses

need to identify the specific needs of this population. Understanding the experience of people with HF from a finite perspective can allow the development of interventions that promote person-centered care, humanized assistance, and respect for patient autonomy, valuing shared decision-making and contributing to the consolidation of palliative care for patients with heart disease. Thus, the guiding question of this study was: "How does the person with heart failure in the perspective of finitude experience it?".

Thus, the study aimed to understand the experience of finitude of people with advanced-stage heart failure.

METHOD

Study design

This is a qualitative phenomenological study based on the theoretical and philosophical assumptions of Martin Heidegger, according to his work *Being and Time*[9]. Phenomenological research seeks the essence of the phenomenon through the experience report of the being studied. The researcher approaches the being and seeks to look at the phenomenon as it shows

itself in its own experience, seeking to understand the phenomenon that presents itself to consciousness[10]. In this way, the Heideggerian framework allows the researcher to immerse himself in the experience of the person with HF from a perspective of finitude, bringing them closer to its essence and meaning through the discourse of Being-there.

To ensure the quality of the study, the Consolidated Criteria for Reporting Qualitative Review (COREQ) guide was used, a 32 item checklist distributed in three domains (Research team and reflexivity; Study concept; Analysis and results) for interviews and focus groups, adapted to Brazilian Portuguese[11].

Study location and setting

The research was conducted in a tertiary public hospital, a reference in cardiopulmonary care, from August to October 2022. The study settings were the hospital wards with patients with advanced-stage heart failure. The institution was chosen since it offers all the high-complexity procedures and serves patients from the 184 municipalities of Ceará and the North and Northeast regions of the country.

Participant selection criteria

The study included hospitalized patients over 18 years of age and who met criteria for advanced-stage heart disease according to the Supportive and Palliative Care Indicators Tool (Brazilian version) SPICT - BR, functional class III/IV of the New York Heart Association (NYHA), heart failure or extensive and untreatable coronary disease, as well as refractory symptoms despite optimized therapy[12]. It is important to note that, despite meeting the SPICT - BR criteria, the patients were not being monitored by a palliative care team, even though the institution has such service.

Patients who were unconscious or disoriented were excluded due to their inability to respond to the questions. The focus of phenomenological research is on the described phenomenon and the understanding of the experience, therefore, data saturation was used as the criterion for concluding the interviews. Data saturation is a dynamic phenomenon that emerges from the recurrence and density of the collected information, ensuring the robustness and consistency of the qualitative findings, and it is a continuous process that involves the reflective judgment of the researcher during data analysis[13]. The sufficiency of the material was demonstrated through the repetition of the themes in the participants' statements.

Thus, according to the inclusion and exclusion criteria, 11 patients with heart failure in the context of finitude participated in the study.

Data collection – The phenomenological encounter

Entering the world of the Being in heart illness at the end of life requires personal preparation from the phenomenological researcher to establish an approach favorable to the opening of the Being-there. It is important to note that the researcher approached the participant in an empathetic manner, to express reception and acceptance; the interviewee was informed about the study's objective and the voluntary nature of participation, so that the report of their experiences and perceptions would be as authentic as possible. The interviews were conducted by a female doctoral student with extensive experience in qualitative research.

In this context, the interviews were grounded on the following guiding question: "What is your understanding of your heart illness?", which aimed to unveil the condition of being cast into a serious heart disease with no prospect of clinical change. The statements were recorded for later transcription and analysis. Some participants had access to the transcribed material (they provided feedback on the results), while others did not due to the impossibility of contact after data collection period. Family members and companions were kept distant at the time of the interview to preserve the participant's privacy. Each participant was interviewed once, and each meeting lasted an average of 40 minutes.

Data analysis and treatment

The narratives were understood and interpreted through the Heideggerian hermeneutic circle, which is composed of the previous position, previous vision and previous conception. The previous position comprises the initial stage, indicating that the interpretation already has a position that allows the horizon of the

articulations; the second moment, called the previous vision, is the perspective from which the set of articulations is viewed and approached; and the previous conception, the third moment, consists of the understanding of the set of previous positions and visions[7].

The care of the phenomenon followed this circle in search of the meaning behind the hidden phenomenon, or the truth as *aletheia*, a Greek term that means unveiled and was revisited by Heidegger in his work *Being and Time*[9]. The hermeneutic circle consists of interconnected stages that allow a continuous movement enabling the understanding of the whole from its parts so that the researcher can grasp the meaning behind the statements, getting closer to the true presentation of the experiences[10].

Heidegger[9] highlights that the rational concept of truth consists of the agreement or adequacy of knowledge to its object; in his thinking, truth is the Being and the uncovered Being by the entity itself, it is what allows itself to be seen from within itself, that is, what is unveiled; truth is a presentation of things, and not a representation.

To proceed with this unveiling, it is necessary to consider that Being can only be understood if revealed in its existential horizon, which here occurred through the existential plot that involves each study participant, understanding their experiences in the time and space of cardiac illness.

In this way, the participants' statements were fully transcribed and read repeatedly, seeking to immerse in the participants' experience, to grasp the content and to recognize the themes addressed. Subsequently, the statements were divided into meaningful segments, respecting the pauses and the thematic changes in the statements.

The segments extracted from the interviews were analyzed in search of latent meaning and, subsequently, these units of meaning were grouped by similarities and proximity of themes and experiences, giving rise to thematic categories.

The interpretative analysis of the categories occurred in a circular movement between the empirical data and the Heideggerian theoretical framework, which allowed the phenomenon to be understood in its existential depth, revealing the meanings underlying the experience of Being in the context of cardiac illness from the perspective of finitude.

The participants' statements were coded with numbers and only the researcher had access to the interviewees' names to guarantee anonymity; this data management was done using Excel. However, no software was used for data analysis and categorization.

Ethical aspects

All ethical and legal precepts of research involving human beings were respected, and the project was approved by the institution's research ethics committee, Opinion No. 4.975.015/2021 and all who agreed to participate signed the Informed Consent Form (ICF).

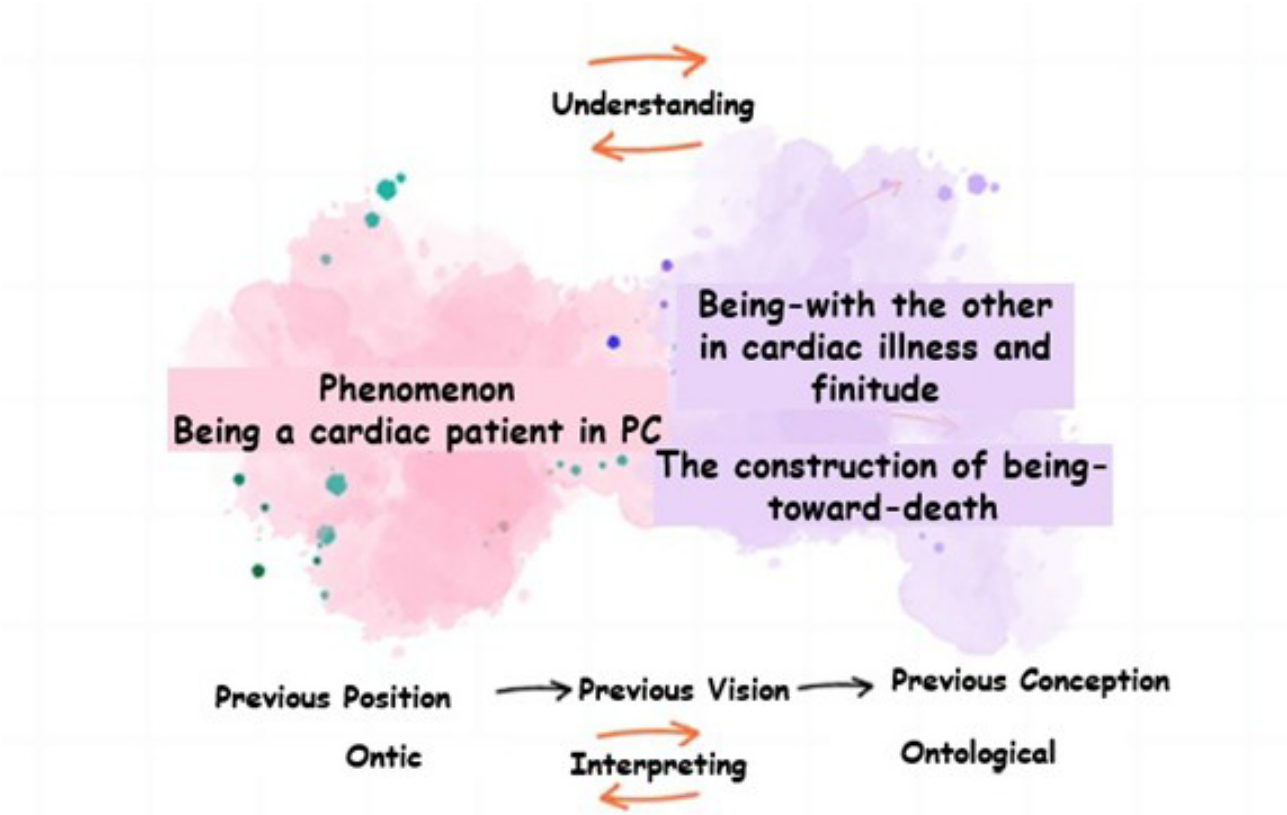
RESULTS

Of the 11 participants, 8 were men; ages ranged from 43 to 82 years old, 8 were Catholic, 2 were Evangelical and 1 practiced Umbanda. All had been hospitalized for more than 15 days; the longest hospitalization among the patients was 60 days; 9 had previously been hospitalized due to heart disease and only 2 were in their first hospitalization. The patients' income ranged from no income to 3 minimum wages, with an income of 1 minimum wage predominating. Only 2 patients were unaccompanied in the hospital and among those with companions, wives and daughters were the most common companions.

The process of hermeneutic reduction gave rise to two categories: Being-with the other in cardiac illness and finitude and The construction of being-toward-death (Figure 1).

The category Being-with the other in cardiac illness and finitude was composed by the meanings related to the physical conditions of the patients, their limitations and possibilities, and their interpersonal relationships, whether with family members, professionals, or other patients. The following statements refer to the limitations experienced by the patients.

Figure 1. Illustration of the hermeneutic reduction movement. Fortaleza, CE, Brazil, 2024.



Source: The authors.

If you get ill and can no longer do your things, it becomes a burden and you suffer, it's really bad. (Participant 04)

Not being able to work properly, not being able to go for a walk because if I walk 50 meters, I get tired. That's it, not having the freedom to do what I want, I have to be restricted, and I'll be even more restricted. (Participant 08)

In addition to the limitations described, the patients also talk about their relationships with other people, whether professionals, family members, or other patients. Some of these statements point to loneliness, as sometimes these patients do not have the opportunity to talk, which corroborates the silence and misinformation about their health condition.

I have two children, but that's the least of it. They live their lives, and I live mine. (Participant 08)

I think you are a person of God. Who comes to talk to the patient. There are patients here who don't get a visit from a nurse, they just give them a pill and that's it. (Participant 04)

I need help with the pumps. Bathing, I do it by myself. But sometimes I want to go early in the morning, and that lady there is sleeping [the patient's companion next to me], so I won't wake her up. (Participant 05)

In the second category, The construction of the being-toward-death, it is possible to perceive the process experienced in search of the construction of the being-toward-death.

The medicines are good and I ask God to give me peace of mind until the day I leave this Earth, because He is the Father. (Participant 01)

I prefer it to be like this, when the day comes when I go (die) and He wants to take me, that is how it is too, because I don't want to depend on others or on medication [...] people say: 'oh why are you going to keep taking medicine for the rest of your life? I won't' [...] I have faith in my Father that soon, soon He will put an end to it. (Participant 06)

He died all at once (the patient's mother), it wasn't a burden. It was too beautiful (death). It was good because it wasn't a burden. (Participant 04)

In the following excerpts, the patients talk about their fears, anxieties, perceptions and concerns regarding the finitude and limitations related to cardiac illness and the consequences of this condition in their lives.

I was very sad when I found out about this disease, because I thought it was all over, right, because the doctor said I couldn't do this, couldn't do that, I couldn't... then it was sad. (Participant 03)

Disgusted because I still have a lot to live for, many years ahead. (Participant 05)

I'm afraid of being dependent on others, right?! (Participant 06)

I'm not afraid. If God takes me, I don't care either, I'm not afraid at all. (Participant 09)

The interviewees also express their regrets and frustrations, as well as their perceptions of the life they've lived.

I used to work a lot and now I'm seeing that I didn't need to. Whenever I had work, I would work all day. I regret some efforts that I shouldn't have made. I'm going to work less and free myself more. (Participant 08)

My life never had a good period. (Participant 03)

I was killing myself over things that weren't worth it. (Participant 10)

Participants also discussed the lack of knowledge about their health condition, often referring to concerns and anguish in the face of events that unfold and cover up the phenomenon experienced.

They [the team] are very complicated. One day I have one illness, another day another, then another, then another. And my head is confused, not knowing what I have. (Participant 03)

I have to keep coming to the doctor, I have been doing it all the time, I am being treated, and it had only been a month since I went to the doctor, but he saw these problems and didn't say anything. So, I am tired. (Participant 07)

Based on these findings, in the light of Heideggerian phenomenology, the phenomenon in question begins to be unveiled in search of a more elaborate whole, whose understanding and interpretation guide us toward the meaning of this phenomenon, which is described in the discussion.

DISCUSSION

From the phenomenological reduction, the comprehensive and interpretative action of the phenomenon begins, which remains concealed and, therefore, demanding to be unveiled. Entering the hermeneutic circle requires the researcher's attentive gaze, stripped of previous judgments and personal inferences. The phenomenon conceals and (un)conceals in the provocative action of allowing itself to be grasped.

Category I: Being-with the other in cardiac illness and finitude

For Heidegger[9], the analysis of Being involves the understanding of several constitutions, among them Being-in-the-world, which consists of the appropriate starting point for the analysis and interpretation of the ways of being of Being-there. The philosopher

emphasizes that the expression Being-in-the-world must be understood as a unity, which cannot be dissolved. However, despite the non-dissolution, it has a multiplicity of structural moments, since to understand it, it is necessary to visualize three expressions: in-a-world; entity and being-in[9].

In-a-world refers to the ontological structure of the world and the idea of worldliness, that is, it is not only about geographic space, but an experiential world marked by historicity[9]. The being-in-the-world, in the context of this study, is the Being-there who experiences the phenomenon of being a person with heart failure from a perspective of finitude. The world of the Being-there is represented here by this phenomenon and its consequences, such as hospitalizations, limitations, proximity to death. The Being-there lives and shares these situations, shares this geographical, historical and experiential world.

It is perceived that, despite the cultural, religious and personal differences of each Being-there, the world is the same, since everyone experiences the same phenomenon, so that the statements show us how close the Being-there establishes itself with other Beings-there, this is due to the sharing of the world of symptoms and limitations.

In category I, it was observed that the Being-there is dissatisfaction due to not being able to carry out their daily activities independently, as they need help with tasks in which they were previously self-sufficient. Studies that seek to understand the experience of the Being with cardiac illness and who receives palliative care demonstrate that the limitation of carrying out daily activities significantly interferes with the quality of life of these individuals, since they long to resume their daily and work tasks, ensuring autonomy and self-care[14].

The statements lead to reflection on the limitations and interpersonal relationships of the Being-there, now dependent on help for basic daily activities. This help often comes from family members, but it can also come from people whom the Being-there does not even know, such as the healthcare team, companions of other patients and others who share the same phenomenon.

Heidegger[9] states that care is inherent to Being, is part of its identity structure and can alternate between modes; we can care through concern or occupation. Care as concern is shown when the patient receives care in a participatory, authentic way, when this manifests itself in the form of being-with-the-other. However, often, care as occupation becomes predominant, in which case the patient becomes the object of actions, treated as a tool or instrument, merely receiving medications and procedures without truly participating in those actions.

According to the participants' statements, some professionals do not talk to the patients, they just 'deliver the medicines'. The Being-there is cared for in the mode of occupation, or rather, it is an instrument that the professional handles, a receptacle for their actions. It was also noted that the Being-there is distressed by needing care from people they have just met, after all, it is difficult to put oneself in the position of being cared for.

Communication permeates the care offered to the patient as a strategy to promote comfort. When it is not carried out effectively, feelings of fear and concern are evidenced due to the lack of knowledge about the current chronic condition and the type of assistance provided, resulting in a certain level of rejection and resistance[11]. The study participants had no formal referral to the palliative care team, and they did not receive clear information about their prognosis. Kept within this conspiracy of silence, the anguish becomes acute, and the possibility of care and authentic living are limited.

Although discussions about death and finitude bring about feelings of fear, anguish and uncertainty, finitude and the process of dying are topics that need to be discussed between the patient, the family and the healthcare team through effective communication that ensures that all involved understand the phenomenon, establishing strategies that promote comfort[15].

The conspiracy of silence needs to be gradually dissolved; the team needs to be available, needs to communicate honestly and empathetically, to listen actively and strengthen the bond with both the patient and the family. Furthermore, referral to a palliative care team at the beginning of the illness process can help prevent the conspiracy of silence[16].

The limitations imposed by illness make the Being-there face their fragility and the need to be cared for. This generates distress, but it can also be essential for the development of authentic relationships that support care; it is in the need for care that the Being-there perceives themselves as being-with-the-other.

From this perspective, the Being-there recognizes their own humanity and may have the opportunity to understand their existence as life and death. The Being-there needs to understand another way of being, because in addition to being-in-the-world, the Being-there is not alone, they share this world.

The other Beings-there are those people who share the world and experiences with the Being-there and can be represented by other patients, family members, companions and healthcare professionals. The relationship between the Beings-there can allow for approximation to the phenomenon; there are those who experience these relationships in a close and cooperative manner, and others in a more distant manner. Thus, one cannot go through the phenomenon alone, because it is impossible to detach from the other Beings-there and from the experience of one's own finitude.

The other Beings-there are related to the concept of social support, which refers to interpersonal exchanges that involve affection, affirmation and help. This relationship focuses on recognizing the other and legitimizing their actions[11]. Social and family support is crucial to improving patients' quality of life, helping them to face their finitude with greater well-being, which helps to dispel the feeling of loneliness, promoting a more dignified and comfortable experience during palliative care, accompanying the person's finitude trajectory[17].

The way of relating can follow different paths; some allow themselves to establish relationships and others remain impersonal. For Heidegger[9], the impersonal belongs to others; it is the neutral, it is the way of being that we all are in our daily lives. The Being-there, existing in an impersonal and caring way, often in the mode of occupation, is cast into idle talk or chatter. What is said in chatter drags with it increasingly wider circles, assuming an authoritarian character; things are the way they are, because that is how they are spoken about (impersonally).

The Being-there, surrounded by chatter, is unaware of their health condition and the implications of this condition for their existence; the chatter covers up the true meaning of the phenomenon of 'being a person with HF' from the perspective of finitude and, consequently, continues impersonally passing through existence in an inauthentic way.

It is noted that Being-there can remain in impersonality, ignoring its prognosis instead of confronting the phenomenon presented. Being-there, whose life has always been immersed in impersonality, whose dreams and desires were never fulfilled, is the one who finds the most difficulty in embracing the phenomenon into which it was thrown, as it does not develop authentic relationships; they distance both from the phenomenon and from other Beings-there, living in the superficiality of relationships. However, by distancing from impersonality, the Being-there can find possibilities in the shared world to establish authentic relationships with other patients, with companions, with their families and, mainly, with themselves.

Para Heidegger[9] authenticity and inauthenticity are ways of being of the Being-there, we can shift between the two modes and there is no value judgment regarding this. Authenticity consists of breaking the barrier of the ontic and reaching the ontological, leaving the impersonal and taking responsibility for its existence; Those who remain in an inauthentic mode follow an ontic, unreflective existence, surrounded by concealed phenomena.

The Being of the person living with heart failure, in the perspective of finitude, can choose to live authentically or inauthentically, and may also alternate between both. However, by experiencing the phenomenon authentically, the Being-there comes closer to recognizing the being-toward-death, as described in the following category.

Category II: The construction of the being-toward-death

The patients' statements show their reactions and desires not only for death, but for the time they have still have to live. It was observed that the Being-there is distressed by the possibility of suffering, sometimes referring to the death of family members as quick, painless and without suffering as something desirable for themselves. The proximity of this end brings out spirituality. The discourses mention death, God, faith, reflections on flaws and virtues. Therefore, attention is drawn to the way in which these spiritual issues can be addressed with these people.

The Being-there's narrative is permeated by memories, by recollections of significant events, whether happy or sad. The Being-there seeks, in his memories, elements that help him experience the approaching phenomenon, because of this, death cannot be taken away from the other; each Being must, in their own time, assume their own death[9].

The personal and non-transferable nature of ending, as dying, awakens fear in the Being-there, as noted in the statements. There is an obscure ontological link between the phenomena of fear and anguish, but both are, most of the time, inseparable, being confused. Both phenomena are a withdrawal, but not every withdrawal is an escape; one withdraws when something threatening is identified, that is, fear is triggered and that which one is afraid of is always an intramundane entity. Anguish is always an escape, an escape from oneself; what causes anguish is not an intramundane entity, but something undetermined, which in this case is death[9].

The Being-there is frightened by the phenomenon of being a person with heart failure in the perspective of finitude from the beginning of the diagnosis, as heart disease is associated with severity, suffering and death. They speak about how frightening it is to know about the disease and how much they still hope to live and achieve things, however, this desire is faced with imminent finitude, which, although not mentioned, can be felt by the Being-there who experiences their functional decline every day.

The statements refer to God and faith as positive aspects, as they believe that only God knows the moment their existence will cease and driven by faith, they trust that this moment should be accepted and respected. The Being-there removes from themselves the responsibility of thinking about their own death, leaves the decision to God, and believes that God or a higher power, with all its wisdom, will decide for them.

There are also reports of desires for the time they believe they have left, and statements about working less and seeking new experiences emerge. When armed with memories they are proud of and have experiences that were built based on their desires, the Being-there refers to finitude in a less anguished way. In other words, those who have had an authentic life show themselves open to the possibility of the final outcome.

Following this thread, the Being-there declines and finds themselves thrown into a condition they did not choose, at least not consciously. Decay is nothing more than an existential mode of movement. Decay is a movement of existence itself. The Being-there, while decadent, has already fallen from itself as a factual being-in-the-world, the same world to which it belongs and had already been thrown[9].

The decay established in the experience of the Being-there with HF in the perspective of finitude, brings the possibility of constructing the being-for-death, as this construction occurs in authentic living. When faced with the imminence of death, that is, the annihilation of its being, not only physical, but also historical and temporal, the Being-there finds itself faced with its (im)possibilities, the main one being the impossibility of accessing its Being in totality. With death, the Being-there reaches its biological end, but also its ontological-existential end.

In this scenario, the nurse emerges as a central figure in the construction of authentic care, with a fundamental role in the mediation between the Being with heart failure in the perspective of finitude and the knowledge necessary to fully experience this phenomenon.

When a nurse tries to understand the world of an individual they care for and their family members, as well as their subjectivities, and effectively succeeds, the path is paved for the establishment of empathy between the professional, the patient and family. This enhances a relationship of mutual understanding, leading to a more effective detection of existing needs, a correct definition of priorities and interventions to be implemented[18].

The nurse's role must transcend physical care, encompassing the patient's existential dimension by providing information for the possibility of clear and accessible communication, the construction of spaces in which care is established in an authentic way. Furthermore, the nurse faces the challenge of breaking the impersonal and establishing a relationship that respects the singularity of the Being-there, fostering

an authentic living that allows the patient to construct the being-toward-death consciously and with dignity.

The study contributes by clarifying the experience of these patients, which in turn can serve as a foundation for interventions aimed at improving care for this population, whose needs are often neglected during the finitude process. One limitation of the study is the non-inclusion of patients in intensive care and emergency settings, which may significantly interfere with the experience described, since these settings have different dynamics from the hospital ward, requiring further research to include participants from these spaces.

FINAL CONSIDERATIONS

After unveiling the phenomenon, it is perceived that the Being with heart failure in the perspective of finitude goes through a process of construction of the being-toward-death, which is dynamic and continuous, conditioned by existence itself: I live, therefore I will die.

The Being-there is faced with numerous possibilities to experience finitude, being able to relate authentically with other Beings-there and with their process of finitude, thus establishing a guiding thread that helps them understand and prepare for the outcome. However, inauthentic relationships and the established impersonal mode lead the Being toward a becoming that remains concealed by the other that surrounds them, in such a way that misinformation consolidates a distancing from the inevitable.

The phenomenon studied is marked by this lack of information about the severity of the illness and the proximity of death, which hinders patients' communication about their essential needs and excludes the possibility of conscious choices, consolidating an inauthentic existence at the end of life.

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Data and material availability

Access to the dataset can be obtained upon request to the corresponding author.

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