

# The Circularity of the Processes of Caring and Being Cared For in Shaping the Care for “the We”

A Circularidade dos Processos de Cuidar e Ser Cuidado na Conformação do Cuidado “do Nós”

La Circularidad de los Procesos de Atención y Cuidado en la Formación de la Atención de “Nos Otros”

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## Abstract

**Background:** The always intersubjective comprehension of the processes around human relationships requires awareness and openness to complex thought.

**Objectives:** To understand how nursing and health professionals experience and attach a meaning to the relationships in the process of caring for “the we”.

**Methodology:** Qualitative, descriptive and exploratory study. The Grounded Theory was the method and the Complex Thought was the theoretical framework used in this study. The sample was composed of 25 subjects, divided into 4 sample groups. Data were collected through semi-structured interviews, from March to July 2011.

**Results:** Represented by the following categories, referring to the consequences, according to the methodological framework: Understanding the meanings of care for “the we”/for us; caring and feeling cared for in its procedural circularity; how care is processed within family and friends; processing the care for “the we” through nursing.

**Conclusion:** The conformation of the care for “the we” occurs within the circularity of the processes of caring and being cared for by nursing and health professionals, by means of human relationships and interactions.

**Keywords:** Nursing; health professionals; interpersonal interaction

## Resumo

**Enquadramento:** A compreensão dos processos que envolvem relações entre os seres, sempre intersubjetiva, requer consciência e abertura para o pensar complexo.

**Objetivos:** Compreender como os profissionais de enfermagem e de saúde experienciam e significam as relações no processo de cuidado *do nós*.

**Metodologia:** Estudo qualitativo, descritivo, exploratório. A Teoria Fundamentada nos Dados foi o método do estudo e o Pensamento Complexo foi o referencial teórico. Participaram no estudo 25 sujeitos, distribuídos por 4 grupos amostrais. Os dados foram colhidos por meio de entrevistas semiestruturadas, no período de março a julho de 2011.

**Resultados:** Representados pelas seguintes categorias, que sinalizam as consequências, conforme o método do estudo: Entendendo os significados do cuidado do nós/de nós; Cuidando e sentindo o cuidado na sua circularidade processual; Sentindo o cuidado processar junto da família e de amigos; Processando o cuidado do nós pela enfermagem.

**Conclusão:** Na circularidade dos processos de cuidar e ser cuidado dos profissionais de enfermagem e de saúde, através das relações e interações humanas, acontece a conformação do cuidado do nós.

**Palavras-chave:** Enfermagem; profissionais de saúde; interação interpessoal

## Resumen

**Marco contextual:** La comprensión de los procesos que implican relaciones entre los seres, siempre intersubjetiva, requiere conciencia y la apertura al pensamiento complejo.

**Objetivos:** Comprender cómo los profesionales de enfermería y la experiencia de la salud y la media de las relaciones en el proceso de atención de nosotros.

**Metodología:** Estudio qualitativo, descriptivo y exploratorio. La Teoría Fundamentada fue el método de estudio y el pensamiento complejo fue el marco teórico. En el estudio participaron 25 sujetos, divididos en 4 grupos de la muestra. Los datos fueron recolectados a través de entrevistas semiestructuradas, de marzo a julio de 2011.

**Resultados:** Representados por las siguientes categorías, que señalan las consecuencias, ya que el método de estudio: Entender el significado del cuidado nosotros / nosotros; El cuidado y sensibilidad en la redondez de atención, sensación de procedimiento del proceso de atención a familiares y amigos, cuidado de procesamiento de nosotros en la enfermería.

**Conclusión:** La circularidad de los procesos de atención ya ser cuidado por los profesionales de enfermería y de salud, a partir de las relaciones e interacciones humanas, sucede la conformación de nosotros importaba.

**Palabras clave:** Enfermería; personal de salud; interacción interpersonal

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## Introduction

The current historical moment is marked by the hegemony of certain disciplines/professions, the advances in the sciences, the multiplicity of specialisations, the fragmentations of knowledge, and, even, the fragmentation of human relationships, of human beings themselves, of care for ourselves, for the other and for others, care for nature, the world, the universe. Therefore, global care/collective care/care for “the we” may be compromised by relationships marked by individual interests and by an increasingly high competitiveness by and between human beings. In the nursing and health field, it is possible to find studies addressing care in its multiple dimensions, as well as the care of the self (self-care), of the professional as an individual caring for oneself and as an individual caring for others, either patients/clients, family members or colleagues/professionals (Beneri, Santos, & Lunardi, 2001; Bub et al., 2006; Jesus, Freitas, Carneiro, & Soares, 2001; Silva et al., 2009). However, the care for the we as multiple relationships is still an emerging theme, whose research studies are recent and require development. These relationships correspond to the complexity inherent in human interactions, characterised by subjectivity, plurality and singularity, which are features intrinsic to human experience. In this sense, the Complex Thought theory (Morin, 2011a, 2011b, 2011c) challenges us to redirect our focus to a broad and multidimensional type of care, based on the very own relational beings in the nursing and health fields. Supported by the theoretical framework of complexity, this study aims to understand how nursing and health professionals experience and attach a meaning to the relationships in the process of caring for the we.

## Background

The always intersubjective comprehension of the processes around human relationships requires awareness and openness to complex thought. According to complex thought, nursing and health professionals, because they are human beings, are, in essence, complex beings who are, at the same time, singular and multiple, biological and socio-cultural, individuals with essentially common characteristics

while having their own singularities: Mental, cerebral, psychological, spiritual, emotional and intellectual. They are free and autonomous, capable of making choices and decisions. Within the complexity of human relationships and interactions, human beings are not only actors, but authors of their own stories; they experience love, tenderness, affection, pain, anger, and hate; they maintain and extend solidarity, but also competitiveness; they rely on the biological, physical and cosmic nature, but also on culture, which allows them to create ethical, religious, cultural, social and rational identities (Morin, 2011a, 2011b; 2011c).

The comprehension between human beings requires awareness of the human complexity, the comprehension of human unity in all its diversity, and its diversity within its unity in order to recognise that the human being is a multiple being, and that this multiplicity is unique. This always intersubjective comprehension requires openness and cannot be understood without its constituent elements, the comprehension of individual autonomies, of the human interactions with society and culture, which act upon these individuals to transform them into social beings. According to the complexity perspective, society is perceived as a mechanism of confrontation/cooperation between the we and “the Self”, where the individual provides unity and invariance to a diversity of subjects of interaction, qualities, and possibilities in a given social space, due to the intersubjective nature of human interactions (Morin, 2011b, 2011c).

The relationships/interactions occurring in the process of caring/care are recognised through the specificities inherent to the subjectivity of nursing and health professionals as human beings, the multiplicity of possible interpretations by the human mind, as well as the motivations and sensations involved in the process of caring/caring/care within the local context, without disregarding the global context. These acknowledgements demand a multidimensional focus and openness to what is new in order to understand similar and different events and phenomena that occur in an given setting, that permeate relationships/interactions, and that reveal the human unity and the diversity of the process of caring/care (Lanzoni et al., 2011; Morin, 2011a).

## Research question

How nursing and health professionals experience and attach a meaning to the relationships within the process of caring for the we? Based on this research question, this study aims to understand how nursing and health professionals experience and attach a meaning to the relationships in the process of caring for the we. The article describes the category that identifies the circularity of the processes of caring and being cared for to shape the care for the we which, according to the paradigmatic model of the Grounded Theory (Baggio & Erdmann, 2011), the methodology applied to this study, represents the consequences of the phenomenon of the thesis entitled: *Acontecendo o cuidado “do nós” nos movimentos e ondulações dos processos interativos no ambiente hospitalar* (“The care “of us” takes place in the movements and fluctuations of interactive processes within the hospital environment”), presented within the scope of the Postgraduate Program in Nursing of the Federal University of Santa Catarina, Brazil.

## Methodology

The research consists of a qualitative, descriptive, exploratory study, which adopted the Grounded Theory (Baggio & Erdmann, 2011) as methodological framework and the Theory of Complexity (Morin, 2011a, 2011b, 2011c) as theoretical framework. Following inclusion criteria, the research subjects were nursing and health professionals from a university hospital located in the South region of Brazil. The project was approved by the Ethics Committee for Research with Human Subjects of the Federal University of Santa Catarina (UFSC), under No. 860/2010. The ethical aspects of research involving human beings were observed in all steps of the study, as provided for in Resolution 466/12 by the National Health Council (Ministério da Saúde, Conselho Nacional de Saúde, 2013).

The process of data collection and analysis included four sample groups, with a total of 25 participants. Initially, we sought to understand the study object by establishing the first sample group, composed by six nursing professionals from one open care unit (surgical unit), including nurses and nursing technicians. Then, we sought to understand the study object through

the accounts of health professionals (psychologist, physician, nurse, pharmacist, and nutritionist) from the same unit, who constituted the second sample group. Subsequently, for the comparison of data and confirmation of the hypotheses emerging from the first two sample groups, consisting of nursing and health professionals from an open care unit, the third group included 11 nursing and health professionals (nurses, nursing technicians, physicians, psychologist, speech therapist, and social worker) from a closed care unit (intensive care unit). Finally, in order to obtain the data saturation, we compared the phenomena and the confirmed hypotheses with a fourth sample group, composed of three hospital directors (general, nursing, and social welfare directors).

The participants' anonymity was guaranteed through the identification of the participants with the letter P followed by the ordinal number corresponding to the order of the interviews (P1, P2, P3...).

Data were collected from March to July 2011, through semi-structured individual interviews, which were audio recorded. The interviews were performed to the participants after they were informed about the research objective by the researcher, and after signing the free and informed consent form. The research began, using the following opening question: Could you please talk to me about the meaning of the care for the we based on your experience? Based on the answers to the opening question, a semi-structured script was applied to all respondents. However, based on the answers and hypotheses from previous interviews, other questions were drawn up to achieve in-depth interviews.

The analytical process was structured according to the paradigmatic perspective, consisting of five components (context, cause, intervening condition, strategies and consequences) that explain the phenomenon. The context represents a particular group of conditions that enable action/interaction strategies. The conditions assigned to the cause are represented by a set of events and incidents that lead to the occurrence of the phenomenon. The phenomenon is characterised as the central idea, where relationships and interactions are interrelated. The intervening conditions are the structural foundations that are sustained by the strategies integrating the phenomenon. The strategies consist of the resources used to respond to the phenomenon. Finally, the consequences are the results of the

actions and interactions of the study participants. Data here presented and discussed pertain to the consequences of the paradigmatic model, represented by four subcategories arising from the theoretical connections performed, which result from an explanatory analytical process of the experiences and relationships within the care for the we from the perspective of nursing and health professionals. This process is represented by the phenomenon known as: The care “of us” takes place in the movements and fluctuations of interactive processes within the hospital environment.

The participants agreed to participate in the research after being explained the research objectives and after signing the Free and Informed Consent Term, which guarantees data anonymity and confidentiality, as well as the principles of autonomy, beneficence, non-maleficence, justice and equity.

## Results

### Understanding the meanings of care for us/ the we

The care for the we is a new subject, which is somehow controversial, ambiguous, uncertain and contradictory. According to the respondents, the care for the we refers to a group of individuals/professionals who interact in the same work unit. In a broader sense, the care for the we refers to caring for the whole, for all individuals/professionals belonging to an institution, including patients and accompanying persons/family members, and also other people outside their own working relations. The scope of this care extends even further, and points towards the care for the universe, the environment, and other organisational and societal structures.

However, as highlighted by some respondents, we cannot forget that the care for the we includes the self in the we, in a way that the self is active part in the care process, leading to think and question how we care for ourselves as professionals/workers/individuals, how we care for others and how we care for ourselves as a work group/team. Here, care can also be understood as a caring for us, which relates to how we care for ourselves as well as how we care for a group of equals, a specific work team, a group of friends or family members. The care for us gives the idea of a more inclusive care within a micro-space,

within more subtle relationships, of greater intimacy, greater proximity, both in the workplace, and in family and personal life. In turn, care for the we is more extensive and refers to a macro-space, a larger universe of care relationships and interactions.

In this sense, the care for the we/us refers to the care of ourselves (the self) as individuals, which involves both the individual care (caring for oneself) and the collective care, associated to the care of the self that ensues from the professionals' relationships outside the work environment, with their friends and family, and also to the care for/between the professionals themselves. The care for the we/us means being aware of ourselves, caring for ourselves (the self) before caring for others, referring to the ability or condition to look at ourselves also as caregivers, and being aware of our mental and physical care, which will allow us to continue caring for the other. Thus, by caring for ourselves (the self), we will be in a better position to care for the other and the others, so that the care of the we occurs within the movements and fluctuations of interactive processes.

As such, the care for us and the care for the we are intrinsic and interconnected. The care for the we includes caring for a whole world, and, because we belong to it, by caring for the world, we are caring for us, for ourselves, and for each other. Thus, when the care for the we occurs, the care of us also occurs. The individual feels included both in the care for the we and in the care for us; both involve a collective, a group, a set of individuals, of human beings. The care for us is part of the care for the we and of the interpersonal relationships, and the care for the we is mainly the care of the multiple relationships, which are based on objective and pragmatic questions, but which are also mediated by each individual's subjectivity, as observed in the statements: “Care for ‘the we’ . . . is a new subject, a somewhat controversial subject . . .” P21 (2011); “The care for ‘the we’ . . . transcends the professional, the patient, and the patient’s family . . . it also involves the professionals’ relationships outside of the work environment.” P18 (2011); “The care of us is a smaller thing, it happens here, it refers to us, to my team, to where I am; and the care for ‘the we’ would be a broader thing, everyone, the care of this entire institution . . .” P19 (2011); “The care for ‘the we’ . . . I think that it integrates ourselves, beyond our role as caregivers, it means to be aware of ourselves, to perceive care as, besides caring for

others, caring for ourselves . . . The care for 'the we' is part of the care of us . . ." P17 (2011).

### **Caring and feeling cared for in its procedural circularity**

Caring for the other, for others, previously implies the performance of the care of the self by the professional. Caring for the other and for others, through the exchanges arising from the interactions established with these others, refers to professionals' caring for themselves as beings of care. This confirms the value and importance of self-care by professionals before and while caring for the other and for others, whose care needs to be continuous/constant/uninterrupted. While caring for themselves, for the other and for others, professionals feel the care that results from the multiple interactions formed in the work and care space/environment, with these several others, whether they are the patients, family members, their peers or other professionals who integrate and circulate in the same space/environment. Thus, while providing care, they also receive it, feeling cared for within the procedural circularity of caring for the self, for the other and for others.

In order to care for the self and, consequently, care for the other and for others, proper sleep and rest are vital, as well as an adequate hydration and diet, leisure and physical activities, spiritual practice, a correct body posture during the execution of labour activities, socialisation and spending time with friends and family. Furthermore, we should also avoid stress and work overload, respect our own limits, organise and reconcile personal and professional commitments, take some time for ourselves, among other things.

When professionals feel cared for, they care for the other, for others, by helping, listening, valuing, respecting, welcoming, praising, being available and tolerant, showing warmth, zeal, affection and empathy, being concerned with and meeting the needs of the(se) other(s). These conditions generate satisfaction when the professionals perceive themselves as facilitators of the well-being of the(se) other(s). However, there are days when the professionals receive more care than they provide, and there are days when they provide more care than they receive, being important the circularity of care, so that one feels cared for while caring for the other; and, therefore, so that the care of the self, of others and of the other occurs in the circularity of the processes of

caring and being cared for. The statements confirm this: "There are several types of care . . . the care for the patients, which is professional; the care for the patients' accompanying persons; the patients' care for us, . . . among the professionals . . . it is a care relationship . . ." P11 (2011); "A starting point is to care for oneself in order to be able to better care for the other. Thinking that way . . . it is very important to care for 'the we'" P3 (2011).

### **Feeling how care is processed within family and friends**

The family occupies a prominent place in the care process of health and nursing professionals, whose values (learned within the family) are brought to the relationships established with other people. The family is the structure that strengthens the professionals to face the challenges that arise in life, both at the personal and professional level.

Within the circularity of the processes of caring and being cared for, the family receives and provides care. Focusing on the care of the family, the professionals try to prevent the hospital work from interfering in their relationships with their spouse and children. It is difficult task, because it is not always possible to avoid the influence of the work environment in the domestic environment; these can only be, perhaps, minimised.

It is especially important to do simple leisure activities, such as spending time with friends, and, above all, with the family, in order to allow the professional to feel that the care for the we is being processed. The care for the we occurs in multiple dimensions, but the dimension that interrelates family and friends, by involving people with strong emotional bonds, stands out, as identified in the following statements: "The husband and daughters are our life support . . ." P12 (2011); "The WEs of a more personal relationship, outside the work environment, the family, friends . . ." P17 (2011).

### **Processing the care for the we through nursing**

Likewise, nursing and health professionals were questioned about the care for the we. In the statements, no differences were found in the perspectives about the meanings of care for the we among professionals. However, the accounts show that nursing is the profession in the health area which



is more capable of performing the care for the we than other professions, as nurses are in the health care unit full-time, are directly responsible for the patient and provide, together with other health professionals, care to the patients. Having a comprehensive understanding of the whole and the complexity that permeates the environment and the individuals is a characteristic inherent to the professional who cares for the we, a characteristic which is attributed to the Nurse/nursing professional.

The health professionals' responses show that nurses are the professionals who connect the patients to other health professionals who circulate in the care setting; they are the ones who try to maximise the multi-professional space in order to make it interdisciplinary, and that makes contacts with the professionals from different areas and services so that patients and family members have proper access to services. Thus, according to these respondents, nurses are the mediators, facilitators, organisers, and managers of nursing and health care in the triad user-professional-institution, besides being responsible for themselves and for their work team.

On the one hand, health professionals state that they value the nurses' knowledge and skills because they are important contributions to the training of health students and resident nurses. On the other hand, a group of nurses says that they seek recognition through their commitment, the changes and improvements in the care process and the new care technologies implemented through studies and surveys in the researched institution. This group seeks differentiated qualification, both at the level of intervention and care, while also seeking their professional qualification depending on the competitiveness currently existing in the profession. Furthermore, concerning the nurses' skills, health professionals consider the nursing professional's intervention, in caring for patients at the hospital and in the patients' homes, as an activity that represents beneficence and altruism in the care of multiple people. Finally, the care for the we, as processed within the researched context, is understood as being connected and interrelated to the actions, skills, knowledge, competencies and characteristics of the profession and of the nursing professional, as seen in the following statements: "Within the institution . . . they are one of the professionals who take more care of us. Maybe because they spend most time

there . . . because they are responsible for keeping that environment running" P3 (2011); "Nursing is the profession that is, perhaps, I don't know, more prepared, closer to the care for the we . . . than the other professions . . . care is the essence of nursing" P5 (2011).

## Discussion

In order to care for the other, for others, as nurses do in their daily practice, they first need to have the conditions to care for the self, being aware of the limits of their own practice and acknowledging the(se) other(s) as distinct individual(s). Similarly, the debate on the forms of care should not address only the way in which nursing professionals have cared for the other, but how they have cared for themselves (Lunardi, Lunardi Filho, Silveira, Soares, & Lipinski, 2004).

It is important to consider that care is not exclusive to human beings or a given profession, nor the care of the self is specific to nursing professionals, but it is seen as an intrinsic feature of the human being. In order to be able to care for the other, for others, health professionals must first care for themselves (Silva et al., 2009; Fernandes et al., 2011), taking into account their physical, psychological, cognitive and spiritual health, to achieve a healthy lifestyle and, consequently, better quality of life (Hiitt et al., 2012).

From the perspective of complexity (Morin, 2011a, 2011b, 2011c), in any context where care is processed, health professionals, as caregivers, must, above all, and before caring for the(se) other(s), care for themselves in their own systematicity/totality, seeking to integrate the multiple care dimensions in order to achieve a relative harmony between the care of the self and the care for the other, while caring and feeling cared for by themselves and by the other (Baggio, Monticelli, & Erdmann, 2009).

By understanding the care interactions in environments of professional relationships, the care of the self, for the other and for others, when interrelated and motivated by the circularity of the processes of caring, being cared and feeling cared for produce a greater care, the care for the we (Baggio et al., 2009), i.e., the care for the we is the product of care interactions between human beings, produced within the circularity of the processes of caring and being cared for.

The care for the we is an emerging subject, still in development, which demanded from all participants an in-depth reflection in order to understand the care relationships established and formed within the care for the we. However, this comprehension, arising from the uninterrupted movement of care among human beings, and between human beings and the micro and/or macro environments of relationships, needs to be continuously explored and developed (Baggio & Erdmann, 2010), requiring further studies on this topic.

The care for the we covers other subjects besides the self, which, within the established interactions, change and cause changes to the existing relationship networks. First, and simultaneously, the relationships within the care for the we involve the relationships of caring for the self, for the other and for others, combining the multiple dimensions of caring for human beings that, within their specificities, determine the type of relationships established with oneself, the(se) other(s) and with the “we”, in the broad and collective sense (Baggio & Erdmann, 2010).

The “we” encompasses several relational beings who, by being integrated, form a team, a group, a set, a gathering of people, a community of individuals who, interrelated within an institutional space, for example, process the care for the we, particularly through the exchanges arising from the relationships between those individuals, by meeting the individual and/or collective expectations (Baggio & Erdmann, 2010).

In view of the above, in this study, the respondents also speak of the care for us in a sense that is, at the same time, complementary and contradictory, requiring a complex way of thinking, which both distinguishes and unites the same thought, allowing, through dialogic, to assume the inseparability of contradictory notions to perceive the same phenomenon, a characteristic of the open thinking system of complexity (Morin, 2011c).

The care for the we, in a broader perspective than the previously exposed, refers to the care for the universe, the environment, the organisational structures, and the societies, which, according to the Complex Thought paradigm (Morin, 2011c), goes beyond the local perspective of care, of a close group of people, enabling a global view of the individuals, the environment, the collective, and society as a whole.

When the professionals care for themselves, for the

other, and for others, they feel that the care for the we is being processed, which arises from the multiple care interactions established in the work space/environment. The care for the self, for the other, for others, and for the we are interconnected and take place in circularity, in a movement that strengthens the ties of relationships, allowing the caregiver to be and feel cared for while caring, in a relationship of mutual exchange (Baggio et al., 2009).

Complexity is understood as involving the interactions created in daily life, within the multiple environments where human beings perform their various roles, for example, at the workplace, at home with their families or in social spaces with friends. The human being is autonomous and, at the same time, dependent, therefore relying on the relationships established in multiple dimensions. Within these relationships, the family, the parents, and the children are placed at the centre of the world, together with the self, considering that we, as individuals, place ourselves at the centre and, next to us, our affections (Morin, 2011a).

The interaction with the family is considered important and vital to human beings (Fernandes et al., 2011), being built through the complexity of interpersonal relationships and fed back into the everyday situations (Oliveira, Nitschke, Silva, Gomes, & Busanello, 2009). A good relationship with family members and other people promotes social support, confirming its relevance (Fernandes et al., 2011). The family's presence and interaction is also important when facing the challenges of everyday life in the care for the we as individuals who share emotional bonds. Modern life tends to create tensions that are reflected at home, within the family. Family relationships represent a support and encouragement system of its members, designed to control and overcome difficult situations, guiding and helping to identify external stress factors, bringing the family members closer in order to face the required challenges, and this is strengthened by the intimacy within intra-familial relationships (Pi Osoria & Cobián Mena, 2009).

It is the parents, relatives and friends who primarily contribute to the development of human virtues, in this case interaction, respect and tolerance (Fernandes et al., 2011). It is the family that teaches one of the most important aspects for a healthy development, i.e. the ability to create bonds and learn how to establish social relationships (Oliveira et al., 2009). It is also within the social relationships and

interactions with other people, in multiple spaces and environments of daily interaction, that we learn to live with the differences for building individual and collective healthy relationships and care processes, within the procedural circularity necessary to care for the we.

In the hospital space/environment, health professionals consider that nurses are more capable of caring for the we than other professionals. This condition relates to the fact that nurses provide attention and care to patients, the patients' relatives, and also to other personnel and health professionals who socialise and interact in this social setting, although some nurses associate this characteristic to an instrumental work feature (Yamamoto, Oliveira, Viera, & Collet, 2009). However, because caring requires concern, knowledge, dedication to others and to oneself, among all the professionals who participate in the caring relationships, nursing professionals are the ones who are in a better position to provide/encourage/facilitate a care environment that integrates and interrelates human beings (Baggio et al., 2009).

In this sense, nursing professionals have the necessary conditions to understand the patients' more specific needs and offer them integral care, creating a closer relationship with patients and establishing trust in the development of the therapeutic relationship. However, the therapeutic relationship is threatened when the professionals are unable to stay in close proximity to the patients (Schluter, Seaton, & Chaboyer, 2011).

Nurses also have a professional role in fostering learning in the workplace. Particularly within the provision of direct care, these professionals share knowledge, facilitate and encourage the learning of others (Henderson, Eaton, & Burmeister, 2012), whether from the nursing field or from other health areas, who rely on the interrelationships with other professionals of the clinical practice to improve and consolidate their knowledge and skills.

In the health field, work is divided and specialised into disciplines according to its scientific area, naturally tending to disciplinary autonomy. However, under the light of complexity, interdisciplinarity interrelates the multiple disciplines, favouring relationships of exchange, cooperation, collaboration and interaction of knowledge/skills between professionals from different fields who, by considering the uni- and

multi-dimensional, achieve the necessary openness to unite the knowledge/skills, in order to care for the patients, resulting in a care that is provided by one and by all (Morin, 2011c). In this study, nurses interrelate components/professionals/disciplines to contemplate the multiple care dimensions with a view to caring for the we.

## Conclusion

The study reached the proposed objective, by identifying that the care for the we occurs within human relationships and interactions, within the circularity of the processes of caring and being cared for by nursing and health professionals.

The care for the we is processed in the relationships and interactions that involve multiple individuals, with their own singularities, pluralities and life stories, that promote the movements within the processes of caring and being cared for, involving care relationships that integrate the professionals, the patients and their families, the professionals' relatives and friends, as well as other relationships created outside the organisational environment, with other people, other organisational structures, the society, the environment, the universe.

Caring for the other, and for others, implies that the professionals must care for themselves first. Caring for the other, and for others, through the exchanges arising from the interactions established with the(se) other(s), refers to the, to the professionals as beings of care. Thus, while caring for themselves, for the other, and for others, professionals feel the care that derives from the multiple interactions established in the work and care space/environment, receiving and providing care, caring and feeling cared for within the procedural circularity of care of the self, for the other, and for others, shaping the care for the we by nursing and health professionals, without distinction of profession and/or professional category.

It is necessary to perform further research studies in order to explore in more depth the results of this study, whether by adding to or refuting these data, or presenting unusual ways of care shaped by human relationships.

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