

# Analysis of Adhesion and Self-Care in Patients Submitted to Lung Transplant in Outpatient Clinic Follow-Up

ORIGINAL

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## Abstract

**Introduction:** The lung transplant is the only option of survival of the patient affected by a deadly lung disease. The outpatient clinic follow-up requires the patient discipline and responsibility in the face of complex care suggested by the multidisciplinary team.

**Objectives:** Meet aspects related to adhesion to treatment and self-care of patients submitted to the lung transplant, accompanied, in outpatients, in a referral hospital in Fortaleza-Ceará-Brazil.

**Methods:** Exploratory research with qualitative approach, in a referral hospital in cardiovascular and pulmonary diseases in Fortaleza-Ceará, in the period September 2015 to January 2016. 10 patients transplanted lung were interviewed, after approval by the ethics committee of this institution. The Organization and analysis of the data was backed up on phenomenological and theoretical saturation used to meet the significant units.

**Results:** It was noticed the strong bond established by patients and professionals of the team that accompanies them. That bond is characterized by a relationship of trust between patient and professional, stimulating attendance and adhesion of the transplanted in outpatient visits. Outpatient consultations in lung transplant marked commitment, the accuracy of both periodical transplanted as part of some professional multidisciplinary team. On the other hand, it was observed the lack of autonomy of some categories.

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**Conclusion:** The treatment is complex and requires a commitment of both transplanted and the professionals who make up the lung transplant team. There was the patient's commitment in to adhere to consultations and interest in following the guidance of care. Is necessary joint participation and integral of all categories, in order to promote multiple interventions and educational practices in the singular therapeutic plan of transplanted.

**Keywords**

Lung Transplant; Adhesion;  
Self-Care.

## Introduction

The pulmonary diseases with bad prognosis are characterised by a heterogeneous group of diseases that have high lethality, despite the considerable progress in pharmacological treatments available [1]. The lung transplant is the only option of survival of the patient affected by a lung disease, in which have already been exhausted all existing medical therapy.

The first record of lung transplant in the world was on June 11, 1963, in the United States by James Hardy in Mississippi. After the unilateral transplantation of the left lung, the patient died on the 18th day after surgery by progressive renal failure and malnutrition [2,3]. In the 15 years following other lung transplant centers would arise around the world. Approximately, 40 cases of lung transplants were performed. However, the prognosis was bad. Most patients died in two weeks as a result of acute rejection, sepsis or primary graft dysfunction [3,4].

In 1986, in Toronto, one of the largest cities in Canada, was recorded the first case of bilateral lung transplant on a woman of 50 years. She survived for almost 15 years and died in 2001 by brain aneurysm, causes this not related to transplantation [4].

The first lung transplant, in Brazil, was carried out in 1989, at the Misericórdia's Saint House of Porto Alegre, by surgeon doctor José of Jesus Carmargo Peixoto. After the transplant, the patient lived for 13 years, died in 2002, by pulmonary tuberculosis [5, 6].

Currently, Brazil has four centers in activity: Saint House of Porto Alegre (Porto Alegre, RS), Heart Institute and Clinical Hospital of the Medical School of the University of São Paulo (São Paulo, SP), Federal University of Minas Gerais (Belo Horizonte, MG) and Messejana's Hospital Dr. Carlos Alberto Studart Gomes (Fortaleza, CE). However, this number is reduced when one considers the size of the country with a round of 200 million inhabitants [7].

On 14 June 2011 was held the first unilateral lung transplantation across the north and northeast of Brazil, in Fortaleza/Ceará, in the Hospital Dr. Carlos Alberto Studart Gomes, in a patient with pulmonary emphysema, getting a new left lung. The following year was the first bilateral lung transplant [8].

The survival of lung transplant in 1989, the expectation of being alive after five years operated was 40%. Until 2014, 60% of lung transplant patients survived until the fifth year, and 45% of them until the 10th grade [9].

International records indicate high survival rates in the first year of life, between 75 and 85%. Aspects related to increase of donors, improves functional performance, more effective diagnostic of infections of the immediate and late surgery, and management of the complications related to chronic rejection [10].

According to the Brazilian Organ Transplant Association (ABTO), the pulmonary transplantation in Brazil, from 2011 to 2013 has been increased, but

decreased 16.2% in the year 2014. And in the year 2015, grew 10% over the previous year. From January 1997 until March 2016 were registered in Brazil 949 lung transplants. As for survival, is currently 51% after six years of transplant [11-13].

The systematic monitoring of transplant patients, in general, both in the preoperative or postoperative may reduce the complications after transplantation, increasing survival.

Increasing survival rates are due to the following parameters: establishment of criteria for selection of candidates and the most appropriate procedure; perioperative management qualification (donor and receiver) and finally, the implementation of late postoperative follow-up routines, with early recognition and effective treatment of the complications that may appear (especially cytomegalovirus infections and chronic rejection) [10].

The increased survival of transplanted depends not only of the consultation and follow-up with the qualified health professionals, but also the determination and valuation of self-care, from the moment it enters the program, and is applying to enter the list of your new organ.

The successful transplant depends on the participation of the patient in the process of self-care, that is, the engagement to your continuous treatment [14]. Therefore, the survival rates of transplanted has direct influence with your self-care. And it is routinely discussed in the whole trajectory of the transplanted from the initial moment when applying to queue. In outpatient consultations, the health team uses techniques of encouragement, continuously, with the patient for the sake of adaptation to the new lifestyle that must be purchased.

Against the above, the objective of this research was to know aspects related to adhesion to treatment and self-care of patients submitted to lung transplant, outpatient follow-up in a reference hospital in Fortaleza-Ceará, Brazil.

The development of this study is justified by professional practice of one of the researchers to assist the patient pulmonary chronic submitted to

transplant. Taking into account that such a patient needs strengthening in the increment of strategies for better driving in your life with new organ, reducing the rejection and, consequently, morbidity and mortality.

## Methods

The development and implementation of research were based on an exploratory qualitative approach, whereas the subjective data are not quantifiable, in order to understand and meet the problem of research.

It was performed at the Messejana's Hospital Dr. Carlos Alberto Studart Gomes, in Fortaleza-Ceará, Brazil.

The hospital is configured as a tertiary unit specialized in the diagnosis and treatment of cardiac and pulmonary diseases, featuring high-complexity procedures in these areas and especially in the heart transplant of adults and children and a pioneer in the northeast in artificial heart implant and lung transplantation [15].

The survey was conducted during the period from September 2015 to January 2016, after the approval of the committee of ethics in research in humans of this hospital researched.

As scenario, the research used the outpatient service of the lung transplant, whose activities began in the middle of the month of May 2011, with completion of the first transplant in June of that same year.

The lung transplant team consists of nurses, pulmonologists, Thoracic Surgeons, pharmacists, psychologists, nutritionists, physiotherapists, dentists, social worker, occupational therapists and infectologist.

Have already been 33 cases of pulmonary transplantation in Ceara (Northeast of Brazil), in the Messejana's Hospital Dr. Carlos Alberto Studart Gomes, with the last three transplants occurred after the completion of the research. Account with 20 patients alive, who are outpatients follow-up.

The study population was composed by all the adult lung transplant patients who perform follow-up in Lung Transplant Unit. However, the sample of this study was defined by the theoretical saturation criterion, in which data processing is interrupted, when it is found that not find anything that field of observation [16, 17].

Thus, 10 patients were interviewed, of both genders, who consented to participate in the study and signed the Written Informed Consent Form (TCLE).

It was applied a semi-structured interview, all were recorded on audio and analysed by the researcher. Were not used the names of patients, while respecting the principles of confidentiality of the research. Therefore, these patients were identified by the letter "E" followed by the ordinal number corresponding to the interview order (E1, E2...).

The questions that guided the interview were: What are the cares that you happened to have held after the lung transplant? How are consultations and treatment after the transplantation? How you conduct yourself in relation to the guidance received in the consultations?

The organization and analysis of the speeches made themselves through the phenomenological foundations of Martins and Bicudo. It is characterized by searching for a particular understanding of what was understood, centering on specific, in the peculiar, in the individual, always seeking the understanding experienced by the subject [18].

Through the recording of interviews of 10 patients, were found 146 dialogues clippings with expressions and ideas, separated into three meaningful units (adhesion and self-care, outpatient follow-up and changes after transplantation).

The research was based in accordance with the guidelines and regulatory norms for research involving humans, based on Resolution 466/2012 of the National Commission of Ethics in Research (CONEP) of the National Health Council [19].

## Results

The monitoring of lung transplantation in the outpatient clinic occurs before and after the surgical event, and is characterized by one of the routines that this need to have for effective conduct and guidance with the new organ.

This follow-up consists of consultation by professionals from different areas that make up the multidisciplinary team of transplant outpatient clinic.

According to research carried out in the transplant program of a Ceará state hospital, which is a reference in cardiopulmonary transplantation in Brazil, the monitoring post-transplant should occur weekly until complete a month. After this period, the patient will return biweekly. After two months, the consultations will be monthly. Completed a year of transplant this patient should return on a quarterly. However, in any unfavorable clinical condition this patient should be attended to promptly, scheduling interleaved queries in a short time [20].

One of the aspects mentioned by the participants of the survey were the descriptions of how the initial monitoring in post-grafted. As can be seen in the following statements:

*(...) It was weekly, then became fortnightly. Then it became monthly. Then quarterly.*

E10.

*Initially it was every week, but now I come from month to month. And I've never missed.*

E3.

*Come all consultations and not miss any.*

E1.

*Of 3 in 3 months, always have exams and the return. And I always get better. I'm happy. I've never missed any consultation. I'm always just right and present.*

E5.

The statements above are consistent with patients that adapt, positively, to the routine outpatient consultations, incorporating them into their daily.

It was observed the assiduity and adhesion are shared by more than one interviewed. Considering that it is in the frequency of their presence in the consultations that the patient gets guidances that facilitates a good follow-up with your new organ.

In these consultations, the patient is evaluated rigorously by the lung transplant team. The clinic consultations analyze from biological aspects to the social parameters. It is in this date patient-professional meeting that are raised any doubts, difficulties and adaptations, in addition to being offered guidance and promoted health education.

It is notorious the periodic rigor of consultations of the multidisciplinary team with the attendance of the patients, because the responsibility of both parties will make the transplant has good driving, with reduction of opportunistic infections and decreases of rejection of the new graft.

About the multidisciplinary team and the consultation period, it is noteworthy that the nurses and the physicians, with a clinical expertise in pulmonology, meet lung transplanted with more rigorous periodic consultations.

The other statements following perceives ambulatory continuous segment in the pre-transplant and post-transplant ambulatory:

*I mark and always come. Have physician and nurse always.*

E7.

*I've never missed any. Not before transplantation or post-transplantation.*

E8.

*I've had consultations before the transplant. I always came (...).*

E9.

The speeches of patients above express the emphasis they give to the commitment to attend the scheduled consultations. That demarcates adhesion and positive attitude to bring to him the responsibility to do this, ensuring the continuity of the follow-up.

Are these consultations that professionals of medicine and nursing plan and request the consultation with other categories of the multidisciplinary team (nutrition, psychology, pharmacists, social workers, physiotherapy, dentistry).

According to The Toronto Lung Transplant Program, world reference in lung transplant, the outpatient consultations, both the physician as the nurse fully evaluate the patient transplanted. This constant evaluation shall review the patient's vital signs, cardiac function, lung function (spirometry) and respiratory muscle strength (walk test), sputum culture, chest x-ray, bronchoscopy with or without biopsy (to evaluate the graft), laboratory tests as serology and blood gas analysis (evaluating various functions of the organs in general and possible infections, dosages of immunosuppressant). In addition, the patient is always evaluated as to their psychological health, ideal weight, social factors, drug adherence, oral health and above this it is requested the opinion of other professionals that make up the transplant team [21].

In other speeches is perceived the commitment to adhere to the guidance's prescribed by the team:

*I try to adapt to that they say. If you have to take, make some treatment, have to do it and wait for the result.*

E4.

*I can get along with all the guidances. To try to hear well everything doctors talk. Pay much attention at the time that the doctor's consulting, talking about medicines. Because if I'm okay, want is even better.*

E5.

*All suggestions of care prescribed by the team, I'm obeying.*

E8.

*At the same time it's boring, you see the doctor's care with you. They discuss, disapprove of some things, but you realize that it is careful. That's you to have really.*

E2.

The expressions mentioned, is emphasized the interest in adapting interventions suggested by the professionals who make up the multidisciplinary team. Given this commitment, is expected to be positive results in clinical outcome.

However, it is also observed through the first dialogue, the E4 and E8 speeches, that the patients follow the guidances is not always by understanding that it means, There is absence of reflection turns out to accept a form of imposition of the health professional.

The adaptation for adherence in the clinical management of transplanted shown as a key tool to reduce the risk of recurrent infections, readmissions and graft rejection.

In the last discourse reported, the E2 speech points that even if the guidances are complicated to join, and that health's professional insist that adherence, the patient tries to sensitize and commit because it knows there's a zeal for their health, in order to minimize the risks.

About routine of multidisciplinary consultation, a late lung transplanted patient reports the importance of other professional categories also to have a fixed period of outpatient follow-up:

*Today I had consultations with the pharmacist and nutritionist. It's once in a while. It should be always. If to include food and medicine, then you should be go through them, 3 in 3 months too.*

E2.

The process of understanding of speech described anteriorly, it is noticeable the expression of the need for the patient to be attended by other professionals in the multidisciplinary team. And this need is not just a demand outlined by physician or nurses, but by the needs experienced by the patient.

Note the importance that the patient reports on periodic rigour that the rest of the multidisciplinary team of lung transplant should have.

Has been observed is that the nurse and the physician, due to the need of each case, make the request of consultation with the other professional category. Either because the patient is overweight, or has the desire to feed with other options, or questions on how to ingest medications.

Some situations analyzed in the outpatient clinic, the patient, in consultation with the physician and/or nurse reports it needs to be consulted by another category.

On the analysis done at the outpatient clinic about the performance of the various health professionals, it is observed that all the categories that make up the multidisciplinary team of lung transplantation have autonomy to follow the rigour of periodic consultations. Both the nursing, as the medical follow with great regularity this criterion and encourage other categories to adopt the same profile. The fact is that most of the other categories is awaiting some notification of medical team and nursing, or even in the appearance of complaints of patients.

It is of great notoriety the work of each professional group on lung transplant team. The individual contribution of categories adds care and total interventions to be applied to the needs of patients. These professionals must work together, intervened in different outbreaks through a common goal, which is to assist the patient in the conduct of their new organ.

Remembering that the best driving in reducing the risks of rejection with the new graft must start care ranging from the times and types of drugs

that the patient must ingest, to nutritional restrictions. Therefore, it is necessary the presence of the consultations of all the professionals who make up the team.

Multiple interventions with a multidisciplinary approach are effective in conducting the transplant. For in addition to medical care, consultation with other health professionals, such as pharmacists, nutritionists, psychologists, social workers and nurses, contributes to the success of the adaptation therapy with new graft, reduction of complications, and increase quality of life [22].

At one point of the research, one of the participants expressed concern regarding the caregiver accompanying, suggesting that the team during the consultations could have this observation:

*I think it's very important to know the caregiver. The caregiver is also there, together, feeling everything. The caregiver gets sick and needs to be worked on the psychological.*

E2.

Therefore, the understanding of speech above is suggested that the caregiver can also have participation within the guidance and care plan prescribed by the multidisciplinary team of lung transplantation.

The patient emphasizes its concern to show how subject participant of its consultation process, including the caregiver as primary tool of their treatment.

The care for caregivers is an intervention that must exist in the care plans in team, to the task of caring for the patient to be effective and the clinical evolution of the patient is positive. Understand that if the caregiver is able to care for themselves, have a better condition to drive patient care, practicing the self-knowledge and self-care [23].

The care dispensed by the health team members needs to reach beyond the patients, their families and caregivers, to ensure effective care. And for

this it is necessary that the caregiver is in physical, mental and emotional appropriate [24].

So that there is reduced risk of opportunistic infections, longer survival and life quality in the post-graft it is necessary for the patient to acquire knowledge and has sensibility in to adhere the care prescribed by the team. In addition, both the transplanted as the multidisciplinary team need to acquire commitment to follow with periodic rigour outpatient consultation, in order to driving safely the grafted organ.

Therefore, adhesion is a fundamental instrument importance in obtaining the desired quality of life after transplant. However, it is in ambulatory attendance that the pre-transplant that the patient receives care in health education in order to provide knowledge on adherence to prescribed care, post-grafting, associating the changes and risks inherent in transplanted itself.

Continuing the analysis of the discourses of the patients interviewed, will be the daily routine of the person submitted to the transplant, addressing the limitations existing in the patient with advanced lung disease (candidate for lung transplantation), and the changes experienced by the post-grafting, in addition to the inherent risks to patient immune suppressed that can increase in patients with characteristics of difficult adherence to the continuous treatment.

## Discussion

Throughout understanding observed the experience of patients undergoing lung transplant, it was noticed the strong bond established by them and the team that accompanies them.

That bond is characterized by a relationship of trust between patient and professional, stimulating attendance and adherence of the transplanted patient consultations.

Study in Bahia, Brazil, analyzed the use of the technologies of care in people with chronic diseases,

it was concluded that the presence of the professional-patient bond promotes adherence, maintenance of health and reduction of injuries, for creating a relationship of trust, through the use of reception, listening and integrated dialogue. Is this bond that is shared the experiences, knowledge, hopes, feelings, autonomy, relevant in building individualized care to each patient [25].

In this research, it was noticeable to observe that the outpatient consultations in lung transplantation marked a commitment, in the periodic rigor, both by the transplant patients and by some components that make up the multidisciplinary team. This commitment creates a relationship of credibility and security on both sides, promoting dialogue and observation of the needs of each patient. In addition, it facilitates the practice of care in order to better preserve the grafted organ, reducing the risks of complications, readmissions and the probability of rejection.

Another study carried out in a Brazilian hepatic transplantation center in the city of Fortaleza, with 20 patients signaled by the multidisciplinary team of the hospital as people non-adherent to the treatments, it was observed that the transplant patient needs to have continuous medical follow-up, besides making use of immunosuppressive medications prescribed, in order to reduce the risk of rejection. In addition, the patient's adherence to the consultations of the multidisciplinary team is of paramount importance, so that the adaptation and follow-up with the new organ is the most adequate. This team is characterized by the presence of physicians (thoracic surgeons and pulmonologists), nurses, physiotherapists, pharmacists, nutritionists, psychologists, dentists, social workers, and speech therapists, if necessary, acting in an interdisciplinary capacity [26].

A study carried out with 65 cardiac transplants, accompanied in a transplant outpatient clinic of a Brazilian hospital, located in the city of Fortaleza, found that the existence of a continuous assistan-

ce in the immediate and late postoperative period, with the performance of a multidisciplinary team focused on the patient and the family, have contributed to the adaptation of the new organ, in reducing the rejection, and increasing survival rate through a process of health education in incorporating new habits of life [20].

In our study, it was understood the dissatisfaction on the part of the transplanted person about reduced periodic outpatient consultation rigor for other professionals of the lung transplant team, with the exception of the nursing and medical categories.

The work of all the professionals who contemplate the transplant team is of great importance, because each one will work with specific needs, differentiated, multiple and individual needs, which will total complex care, encouraging patients to practice self-care practices holistically.

Recent studies in the field of hepatic and pulmonary transplantation report that post-transplant treatment has the characteristics of a patient with chronic conditions, requiring continuous specialized follow-up. This implies uninterrupted treatment with complex therapeutic regimen prescribed by a multidisciplinary team in different areas, such as: nutritional restrictions, mealtime limitations, abstinence from alcohol and smoking, safe sex and abstinence from sexual until the first month after surgery, drug therapy adequate, permanent periodic examinations, and restrictions on socialization. And over time it is noticeable that some patients lose the motivation to follow the rigid rules necessary to maintain the graft [26-27].

In the present survey, the interviewees expressed an interest in adhering and adapt to the guidelines suggested by the multidisciplinary team, during the consultations scheduled. This reflection of desire in adherence and commitment with the recommended interventions is justified by the fear of the risks and complications that exist of non-adherence to the new lifestyle.



Throughout the course of the ambulatory follow-up before and after the transplantation, the patient is assisted by a multidisciplinary team whose purpose is to explain the entire surgical procedure, with a view to sensitize him to the adherence and self-care measures that should be taken to reduce graft rejections and increase survival. In other words, patients should have the understanding that to have the relief of disabling symptoms of the underlying lung disease with the option to apply for the transplant and to survive with the graft, it will be necessary to have discipline with the prescriptions suggested by the team.

The multidisciplinary team has the objective of to pass all the necessary information for the patient to apply for transplant, besides highlighting a set of care actions that the patient should adhere to after surgery. And so, the adherence behavior gains great connotation and importance when it complements the sense of self-care.

The commitment in the self-care happens when the patient sees himself active in your health-disease process, that is, when there is the empowerment of the subject in your lifestyle through knowledge/wisdom about their disease situation and search for health.

According to the World Health Organization (WHO), adherence to treatment means the expansion of a person's behavior facing the proposed treatment, corresponding to the recommendations drawn by health professionals. Are five related factors to adherence that influence in the self-management of care: those related to the patient, drug therapies and non-pharmacological available, the socioeconomic order, multidisciplinary team and disease characteristics [28].

The meaning of adherence is something particular, own of each patient, which presupposes the free right of the patient to choose to adopt or not specific medical recommendation. Therefore, all the multidisciplinary team, that attends the transplant, need to know the singularity of each

client, consider the history of the subject, the personality and patient's vision in wanting to join a new lifestyle.

A systematic review study on the effectiveness of interventions to manage adherence to treatment in adult heart transplant patients pointed out that various circumstances may prevent the satisfactory evolution of transplants, such as: poor socioeconomic conditions, communicable diseases, neoplasms, alcoholism, as well as the lack of adherence to treatment. In addition, it was reported that lack of treatment engagement, after the transplant, is considered a relevant health problem, since it contributes to increased morbidity and mortality, reduces quality of life, and increases the costs and utilization of health services of patients [29].

The patient subjected to lung transplant just over time, losing motivation in continued adherence, and this non-compliance cannot be understood as disobedience. The relationship between health professionals, family members and patients should achieve cohesion. And this can be achieved through training at the team's ability to communicate, resulting in significantly higher adherence rates [27].

The lung transplantation outpatient clinic has an important role in maintaining the health process of the adaptation and reducing the risk of rejection of this transplanted, promoting uninterrupted follow-up. Other situations may make the patient abandon the treatment, due to adverse effects of medication, inadequate instructions, lack of trust between patient and professional, poor cognition, and patients who do not understand the importance and need for treatment [29].

The interviewees showed feel welcomed and encouraged by the professionals who make up the multidisciplinary team of lung transplant outpatient clinic, that is, the professional-patient relationship is positive and productive, encouraging them to keep mindful of the proposals for the well-being and quality of life. And this aspect is crucial parameter for effective and effective adherence.

In addition, it was noticed the interest of these patients in complying the rigor of outpatient consultations following the guidances prescribed by the health team.

However, that was analyzed in the research is that the way of patients follow the guidances are not always by understanding what it means, perceive the absence of reflection and end up accepting by a way of imposition of the health professional. That is, the majority of patients do not understand the importance and necessity of the treatment, perhaps because cognition deficit or by way of language approached by the professional, demarcated by great scientific theories.

Thus, there is hierarchical connotation between the patient-professional relationship within the ambulatory follow-up of lung transplantation, in which the patient accepts the recommendations by imposition and obedience.

In view of this, it is necessary to work the reflection, wisdom and the uniqueness of these lung transplants, in order to promote cognitive ability in adherence to the care of the patient undergoing transplantation. The multidisciplinary team need to create health education strategies in order to recognize this client as an active and voluntary subject of their ongoing health care plan.

For the success of the transplant, it is necessary the patient's understanding of the practice of self-care, and that takes responsibility and recognizes the importance of their participation in the process of care.

## Conclusion

The development of this study offered the opportunity to approach the universe of the patient who performs the lung transplantation. Intermediated by their speeches was possible the recognition and understanding of the motivations, overruns and hopes of those who choose this procedure as an alternative only in search of a normal life.

The treatment is complex and requires the commitment of both, transplanted and the professionals, who make up the lung transplant team. It is notorious that there is the patient's commitment to self-care. For this, health professionals, during the consultations, need to have ability to assist patients in a singular way, highlighting the needs and peculiarities of each one, and from there to create individualized strategies and plans of care.

The goal of lung transplant team is to keep these patients at a satisfactory level of self-care and adherence to treatment, reducing unwanted episodes.

The role of the team is to establish measures that favor the achievement of this goal based on the complaints and difficulties that exist in each transplant.

Many times, the resources used to achieve this objective are imposed in a non-educational, failing to collaborate in the reflection and criticality of these patients.

Many of these professionals are formatted according to a protocol that does not focus on the individual and in the peculiarities inherent to each patient.

The technicality and procedures in the area of health cause a relative distance of professionals in the aspects inherent in our condition of humanity. It is necessary to resize the practices and interventions in health practices and interventions through the adoption of subjective and sociocultural aspects of individuals assisted.

The techniques and decisions should not be imposed by the team, in which the health professional becomes dominant in the relationship, and the patient listens and accepts, without reflect and opine. It is in the face of the discussion and dialogue between professional-patient in a horizontal dimension, that the learning is reached. It is necessary to know the uniqueness and the characteristics and difficulties of each person in joining the complex treatment of transplant. Thinking in this way, the

patient will be the subject and will have an active role in the creation of your plan of care.

The horizontal dialogue between patients and health professionals promotes the link, the creation of individualized care plans and educational practices of adherence and self-care. This care should be delineated by multiple interventions, through multidisciplinary and interdisciplinary work, towards a common goal. The outpatient clinic of pulmonary transplant requires the participation of all categories that make up the professional team, not just a one-time participation, so that a holistic view can be added in the therapeutic plan of the transplant.

For that reason, it is necessary the humanization of the lung transplant team to observe the uniqueness and the conflicts existing behaviors in patients, working on listening, horizontal dialogue, the exchange of ideas and strategies of reflection on the understanding of risks and complications that exist in the daily life of the transplanted.

The suggestions permeate the practices of light technologies, with educational practices in order to achieve the main objective of the multidisciplinary team of transplant, in a satisfactory and humanized way for the clientele.

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