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Abstract

Concern with humanization in hospitals has been an increasingly common feature in debates related to healthcare, public policies and hospital management. However, in most Brazilian hospitals, humanization has not gone beyond the stage of 'politically correct' discourse and has not resulted in substantive changes in organizational behaviour. These changes mean a greater challenge especially in hospital organizations, as these are renowned for their complexity, pluralism and knowledge-based work. From an ethnographic experience guided by intervention in the implementation of a humanization programme at a hospital, we analyzed the resulting cultural change, highlighting the obstacles that were encountered and the main actions taken to overcome them. The results of this initiative reveals important lessons: (i) it represents an organizational commitment to the continuous improvement of health services by focusing on one of the most critical elements: human beings; (ii) to implement the initiative, it was necessary to develop social actions such as relationships with the government, market and society; (iii) it was necessary to hold a scientific, albeit incipient, debate concerning the role and relevance of clinical psychology in hospitals. Results were grouped as individual, social and organizational dimensions reflecting substantive aspects of the change process in complex setting.

Keywords

Cultural change process, complex systems, hospitals, healthcare, humanization

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Introduction

Healthcare services are deservedly attracting the attention of scholars due to their complexity and significance in society today. One area that is increasingly in the spotlight is the humanization of services. Humanizing increasingly requires procedural changes in complex organizations, especially where powerful professionals and stakeholders coexist. Furthermore, hospitals show signs of 'cultures of safety' that refer to practices required to provide optimum care (Weick & Sutcliffe, 2003).

Hospital administrators are virtually overwhelmed by the humanization process, which requires structural and, especially, cultural and behavioural changes on the part of multiple stakeholders who coexist in a complex, professional and pluralistic institution (Perrow, 1986). Hospitals can be characterized by the nature of their mission as humane organizations. In a hospital, major policies and actions have to focus on human beings and their healthcare. One of the challenges facing hospital management is to integrate family members who are concerned with the health of their relatives, but unprepared to play a different role, and healthcare professionals concerned with medical care. The result is a demand for major behavioural and cultural changes along with changes in the managerial procedures of the hospital (Schein, 1992; Smircich, 1983). On the other hand, the new humanizing policy brings a new meaning to the healthcare professional/patient relationship, triggering significant benefits for individuals, groups and organizations.

With renewed interest in dignity in health services, the humanization of treatment in Brazilian hospitals has become a national policy for the healthcare system. It has also been a legal obligation since the passing of the National Plan for Humanization in 2003. Although several years have passed since the legislation was enacted, we have perceived that humanization practices have not passed beyond the elementary stage in most Brazilian hospitals.

An ethnographic experience at one of the largest children's hospitals in Brazil served as the basis for this study. As the humanization of services in an organization that is characterized by complexity, plurality and knowledge-based work (Etzioni, 1964; Perrow, 1986) requires a cultural change process, we ask the following question: *How can humanization be promoted in a children's hospital as a complex and pluralistic organization?*

The main category for guiding the study was the management of cultural change that had guided the relationship between patients and health professionals in an organization characterized by diverse professional groups with autonomy and diversified, different or even pluralistic interests. The study looks at the change process and, particularly, the actions taken to integrate counter-cultures and multiple team perspectives in order to implement an innovative humanization model (Gioia, 1986; Smircich & Morgan, 1982). To this end, an attempt was made to identify the different actions to be taken by psychologists and managers and which actions were necessary for the humanization of services provided by the hospital, especially between 1990 and 2003. In this experiment, we focus on the sense-making, learning and improvisation (Gioia, 1986; Hatch & Yanow, 2011; Weick, 1979) required of the hospital's managers for working in a complex system (Jarzabkowski & Fenton, 2006; Perrow, 1986).

The study is structured to include, for of all, the theories on which the analyses are based. In this case, we highlight a hospital organization as professional, pluralistic, complex and humane, and also consider the implications of these characteristics on the development of a cultural change process. In the next section, we highlight the methodological procedures that were adopted. This is followed by the experience and the main results of the Participating Family Program (PFP) through which humanization was introduced at the Hospital Pequeno Príncipe (HPP). In the following section, we present the reflections and learning that stemmed from the research in the light of experience that was gained and the theoretical framework that was used. We then turn to the final considerations and contributions to future studies.

Change in Hospital Organizations

Hospitals are complex and pluralistic organizations in which characteristics such as diffused power, diverging interests and knowledge-based work have a heavy influence on their management and especially on change processes in this context (Denis, Langley & Rouleau, 2007; Jarzabkowski & Fenton, 2006; Meyer, Pascuci & Murphy, 2012; Perrow, 1986). In these organizations, plurality, diversified interests and technical authority overlap with hierarchical authority. This means that management and decisions, in particular, are essentially political processes, and making and maintaining changes becomes a challenge.

As social institutions, hospitals are constantly under pressure to provide quality services while operating with scarce resources (Porter & Teinsberg, 2006). The functionalist orientation of the market has influenced these organizations and encouraged them to incorporate managerial techniques that are mostly inadequate for their specific needs. This 'managerialism' has resulted in internal competition regarding performance goals that ends up giving more priority to the *instrumental* (based on purely economic criteria) than to the *substantive* (based on the individual's own system of values and convictions) (Ramos, 1984).

The activities developed by the hospital organization hinder the adoption of a managerial model based solely on functionalist premises. The fact that the main product of a hospital is *life* means that a different management model is required. In other words, it would have to be sustainable but at the same time would focus on human beings (Moore, 2000).

Hospitals are essentially organizations that exist to provide healthcare for human beings. To speak of humanization in a hospital may sound like a euphemism, but it is a strategic initiative for these organizations because it has to do with the fulfilment of their social mission. Concern over hospital humanization as a way of preserving dignity and citizenship and transforming hospital management has increasingly been the subject of debates regarding medicine, public policy and hospital management. However, each of these instances has a baggage of beliefs and specific interests where this topic is concerned and they are not always in agreement. Consequently, in many hospitals, humanization has come to be seen as little more than a form of 'politically correct' discourse.

In addition to operational change, humanization in a hospital implies a change in values, beliefs, stances and behaviours. This would pose a challenge in any organization, but even more so in hospital organizations because in hospitals it is common to find counter cultures and subcultures that arise because of the different interests and perspectives of professional groups and the autonomy they enjoy.

Culture can turn out to be a hero or a villain when it comes to promoting organizational change. It is not by chance that major organizational changes initially focus on internal culture (Schein, 1992). Organizations are made up of different social groups, which can lead to different beliefs and interpretations of organizational reality. This is why it is particularly important for leaders to have the ability to encourage a good relationship between culture and organization, minimizing conflict and resistance and, above all, managing meanings (Smircich & Morgan, 1982).

Meaning helps us to understand how thoughts, actions and how we use language help us to *create* the organization in which we believe. People, both individually and in groups, can construct and reconstruct contexts from elements such as sense-making, meanings, values and symbols (Geertz, 1973; Gioia, 1986; Schein, 1992; Weick, 1979). Organizational culture, in its turn, is a receptacle for symbols and artefacts produced by its members, which can be the result of collective sense-making or of a context in which meaning is continually defined and redefined (Hatch & Yanow, 2011; Weick, 1979).

The way in which thought and behaviour construct and reconstruct reality is explained by Weick (1979) through the term 'enactment'. Thus, the description of how the world is constructed pervades

the identification of how people define *what* will be considered information, *how* they collect and analyze data and *how* they use data to decide and act. In other words, as the process of social (re) construction has continuity, sense-making and enactment generate stability, promoting changes which only occur when the altered meaning is symbolized, communicated and accepted by others. This process normally operates involuntarily, but it can also occur intentionally and even be politically motivated. Hatch (1993), from the concepts proposed by Weick (1979) and Schein (1992), pointed out that interpretation and symbolization are processes that form underlying meanings of the culture of an organization.

Context and Place of the Study

We looked at an innovative experience of implanting and consolidating a humanization programme at a Brazilian children's hospital that has been considered an example to the nation due to the good results that have been achieved. Traditionally, humanization has always been one of the guiding principles of the Pequeno Príncipe Hospital (HPP), but it was only in 1986 that it was officially instated with the inauguration of the Psychology Department. The good results achieved through the humanization implemented by the psychology team led, in 1990, to the creation of the Participating Mother Program (PMP). When the scope of this programme was broadened, in 1991, it was formally renamed as Participating Family Program (PFP). However, this initiative was only consolidated in 2003 (e.g., Figure 1).

However, the psychology professionals had actually been systematically involved in humanization at the HPP since 1982. In 1983, one of their first acts was to have children accompanied by a family member or guardian during their stay in the hospital. In those days, the Child and Teenager Statute, which guaranteed a child's right to a companion in hospital, had not yet come into force. This initiative by the HPP was born after the psychologists noted that being away from their families caused or aggravated the children's problems and led to more suffering and longer stays in hospital, in addition to increased stress for the medical team.

> No matter how good the medical treatment or the technology used to provide it, we were not providing integral treatment in human terms. The psychologists noticed that the children were crying all day long and that the medical professionals were irritated by this crying. No matter how well fed, clean and well treated they were, the children were missing their families, and to them family meant security. In those days, families could only visit the children twice a week for half an hour. At the time, the average period of internment in the hospital was seventeen days. (Forte & Sato, 2006, p. 33)

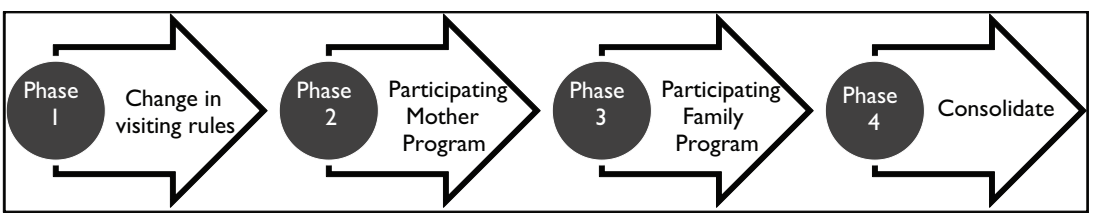

Figure 1. Phases of the Change Process

Source: Research.

In the 1980s, universities and research centres were seeking to adapt traditional clinical psychology to the hospital environment. In addition to the practical reality, the concern of the team of psychologists (one of whom is a researcher contributing to this article) had a scientific aspect thanks to a partnership formed between the HPP and a renowned local university. As a result of the work conducted by psychologists, professors and interns from the Psychology course, the HPP team began to interact with other hospitals. They also began to attend and promote scientific events on the role of psychologists and the therapeutic approach of these professionals in the hospital context.

Without a specific technical and theoretical framework as yet, the psychologists and interns at the Psychology Department of the HPP initiated a gradual process of change by having family members closer to the children while they were hospitalized. The earliest initiatives included increasing the frequency and length of visits (Forte & Sato, 2006). These initiatives, which met with strong internal resistance and led to behavioural and organizational changes, made the HPP a forerunner of a public national policy by granting its patients a right that would later be guaranteed by the Child and Teenager Statute, which was only passed in 1990 by the National Congress.

The Child and Teenager Statute ensured that children had the right to be accompanied by a family member during a stay in hospital. In 1991, the HPP was already allowing children full-time companionship by a family member or guardian. Since that time, humanization has become a serious goal of the hospital and part of its institutional framework. In addition to reducing stress and cases of depression among patients, the initiative broke with tradition, requiring almost 20 years of work and cultural, behavioural and organizational changes to be implemented.

Although humanization in hospitals has brought many benefits to health services, these initiatives are still rare in the reality of Brazilian hospitals. In order to promote changes in the health service model and the management model of the public health system in Brazil, in 2003 the Ministry of Health set up the National Humanization Policy by launching a programme known as 'Humaniza SUS'. The main aim of this programme was to humanize the Brazilian National Health Service, known as SUS,[1] at every level, with strategies involving managers, workers and users of the health system around the country.

This policy has been limited by several factors. As well as the challenge of systematizing changes in hospitals because they are complex, professional and pluralistic organizations, interference in cognitive, behavioural and organizational elements leads to serious obstacles that hinder hospital managers. It is a common understanding among hospital managers that humanization is a burden on hospitals and competes with technological requirements, which are viewed as essential for ensuring the quality of the services provided by hospital organizations (Porter & Teinsberg, 2006). The organizational culture is another limiting factor when introducing changes into an organizational environment in which there are professionals with a wide range of interests and where power is diffused (Denis et al., 2007). These challenges mean that in many Brazilian hospitals humanization is nothing more than discourse or, at most, the provision of chairs for companions to sit on while waiting in line.

Design and Approach

The initiatives and efforts that resulted in the implementation of the hospital's humanization programme were conducted as a strategy that combined ethnography and action research, with projects, experiments, reflections and redefinitions, in a gradually unfolding multi-stage process. Ethnography is generally viewed as a search for a report on a culture, and this is carried out by pointing out what characterizes a culture in terms of artefacts, beliefs, values, symbols, myths and history. But ethnography can also study the creation, maintenance and reworking of shared meanings in organizational

social processes. Knowing, describing and understanding organizational social processes can be seen as a form of participating in them, in monitoring their birth and existence (Geertz, 1973), but can also mean asserting their birth and existence.

There are several possible orientations for ethnography (Barab, Thomas, Dodge, Squire & Newell, 2004; Brewer, 2005; Reason, 2004; Sykes & Treleaven, 2009; Van Maanen, 2006, 2011a, 2011b), but for the situation in question, ethnography was based on investigation and intervention or the actions that were taken. In an organizational context, it is said to provide useful information for consideration, planning and organizational actions similar to those professed by Chambers (2003) and Argyris (1985)—(Lewis & Russel, 2011; Noblit, 1984; Sykes & Treleaven, 2009). Therefore, ethnography focuses on cultural negotiation processes, including those that help to define and give meaning to the past, the emergent and the ideal, and which rebuilds social reality retrospectively and prospectively, interpreted as history and opportunities and desired objectives and values (Bourne & Jenkins, 2013).

Therefore, ethnology analyzes how a group or organization knows, constructs and makes changes in terms of value and behaviour. Rather than understanding culture as a characteristic or quality that people possess, it diverts interest towards studying how ideals and meanings are—or were—negotiated and altered in organizational social processes, principally those concerning the creation and pursuit of goals and the definition and solution of problems.

From this perspective, ethnography is not restricted to the purpose outlined above but can also resort to active interaction with the study object or even go so far as to intervene. It can be combined with action research and clinical research, and encourage participants to tests their own 'theories-in-use' and analyze how these participants relate them to certain problems or social situations. It encourages them to educate and train participants to use ethnographic strategies to see and better and deeper understanding of their own cultural reality and analyze how it influences or impacts those who do not directly participate in it (Argyris, 1990; Chambers, 2003; Reason, 2004).

Ethnography seeks knowledge that describes and provides a meaning for and explains a given social space and social processes. But it can go beyond this by adding the purpose by which this knowledge is useful to those who occupy the space. The resulting interpretations of ethnographic work can be collated with explanatory schema, generating recognition, reflection, learning and action. In this study, these factors resulted in reworking which, although based on considerations that were important enough to warrant these changes, proved at the same time to be partial and transitory. The data collection and ethnographic interpretations characterize and conceptualize the everyday experience that makes it interesting and makes the scientific research understandable and relevant to all the participants. It helps to reconnect theory and practice, analogously to the debate of Eden and Huxham (1996).

This dynamic provides the participants (both researchers and non-researchers) with knowledge concerning themselves, in terms of organizational experience, which can alter existing conditions to the point that the change is favoured in terms of interpreting the world and themselves in their practices and culture. The research process is collaborative because the researcher becomes a participant in the organization and the members of the organization become assets as they take part in the research. While the former becomes involved in and contributes to the organization and its practices, the latter contribute directly to the research in order to obtain scientific results (Eden & Huxham, 1996).

Therefore, we understand that a research process combined with action, using multiple methods, can be a more effective means of achieving the purposes of the research and intervention (Barab et al., 2004; Reason, 2004; Sykes & Treleaven, 2009). The integration of data and the analyses obtained through these different methods can take the form of an ongoing organizational process. Observation, inquiry, analysis, experience and reflection succeed one another in an ethnographic strategy for change and in the knowledge of an organization and a context in transition (Hugentobler, Israel & Schuman, 1992). In this

sense, we conceive that this methodology would correspond to a double loop learning process catalyzed by a programme of cultural change (Argyris, 1985).

Action research has the potential to develop a theory that could be relevant to the practices of the organization, considering that every intervention is an opportunity to review theory. Reflection can generate an evaluation of the means adopted to obtain knowledge, develop theory and intervene in the social reality (Huxham & Vangen, 2003). This study sought to complement these methods. For this, we used ethnographic action research as recommended by Tacchi, Slater and Hearn (2003). In this case, ethnography guides the research process and action research connects the study of activities to the planning of the project for change. The analytical observation of practices generates knowledge, while the analytical reflection based on these observations provides new looks and new experiences, that is, a changing culture.

Furthermore, the definition of the methodology took into account the specificities of formal organizations in comparison with social organizations from the community and society (Eberle & Maeder, 2011; Neiland, 2008; Rosen, 1991; Sykes & Treleaven, 2009). This explains organizational ethnography, as the methodology considers that there are differences between studying culture in organizations and culture in communities and societies. On the one hand, the situation or social space is a base for the significance of these referentials and on the other hand, these referentials measured the meaning of the situation and the social space.

The implementation of the humanization programme at the HPP was guided by organizational ethnography combined with action research (Holloway, 2005; Hugentobler et al., 1992; McNiff, 1988; McTaggart, 1991). The present study was based on registers and results achieved from a retrospective analysis approach. There are several explanations for the use of a retrospective approach. The first has to do with the intention of the researchers to gain a better understanding of the process of change that took place in the hospital as 'an inquiry with people, rather than research on people' (Eriksson & Kovalainen, 2008, p. 196). In this type of approach, it is also essential for the information produced to be useful *to the group of people/organization* and not only *to the researcher or group of researchers*. The second reason is based on the recommendation of Kleiner and Roth (1997), for whom the retrospective approach is justified when 'it is used as an intervening learning in the organizations and will eventually lead to "re-education", changing patterns of thinking and action' (Eriksson & Kovalainen, 2008, p. 220), as is the case of this study.

For the purposes of this study, we considered the four-stage cycle process: planning, acting, observing and reflecting. In practice, the process took on the shape of a spiral as complementary and corrective actions were identified with each new need, leading to new cycles of new planning, which in turn generated new actions, and so forth.

Insersion, Data and Participants

One of the researchers of the present study conducted a field research. She is identified in this text as Mary. She became involved at the HPP in 1982 when an agreement was made between the hospital and a local university. However, the present study covers the years from 1990 to 2003, when Mary worked with a team of psychologists at the HPP to plan, create and develop the *PFP,* which resulted in the consolidation of humanization as a practice in the hospital services provided at the HPP.

Her working in the field was facilitated by her previous involvement with the research team and her experience at the hospital. The everyday tensions and conflicts as a result of patients being separated from their families led Mary and the team to seek solutions by adapting traditional clinical psychology to the hospital context. This humanization in the hospital, in turn, meant a radical cultural change,

especially among the autonomous professional groups. To understand *how to promote humanization in a children's hospital organization,* in 1990, Mary and the team of psychologists prepared a project that was approved by the Top Management Team (TMT) for intervention and resulting actions in the organization. The initial question led to other questions, such as What needs to be changed and why? Which dimensions would be affected by the change process? Which strategies would be adopted? Which sectors would be involved? What resources would be necessary to support the change process? What types of resistance should be expected?

During this process, data were collected from several sources, ranging from the more traditional, such as observation, questionnaires, documents, interviews and reports, to interaction, formal and informal meetings, photographs, videos and conversations in the corridors and over coffee with the different publics involved. The interviews, interaction and reports involved dozens of health professionals, administrative staff, hospitalized children and their family members. During the whole period under study, Mary coordinated and participated on a daily basis in the decisions and actions directly related to the implantation of the PFP and the resulting gradual cultural change. Examples of the activities that were developed include seeing patients and their families, attending meetings, preparing proposals, interacting with the top management, opinion makers and teams of professionals, reviewing internal processes, analyzing data and presenting results.

In addition to data collection, eight interviews were conducted between 2010 and 2013 with Bob and Joanna (members of the TMT), Julia and Bill (psychologists), Ana and Karen (nurses) and Joseph and Patrick (physicians), all of whom were directly or indirectly involved in the development and/or implantation of the PFP. The real names of the interviewees have not been used to protect their anonymity. The purpose of these interviews was to gauge the perception of the organizational agents directly involved in the change process concerning the implantation of the PFP and its implications for the process regarding aspects of a cultural nature resulting from this initiative within the organization. The interviews were recorded and transcribed to ensure the accuracy of the information. The actions that took place during the period in question were recorded by Mary in field diaries. Another source of data was a book published in 2006 on the humanization experience at the HPP, entitled *The Participating Family Program at the Pequeno Príncipe Hospital.*

Ethnography and action research requires knowledge, skill and sensitivity for handling the organizational dynamic (Brewer, 2005; Coughlan & Coghlan, 2002; Sykes & Treleaven, 2009). The fact that Mary was a member of the team of psychologists and coordinated the implantation of the PFP allowed her to be an active participant deeply involved with the problem in question, the alternative solutions, the practices that were developed, the obstacles and how they were overcome, and the knowledge and learning gained from the experience. This knowledge and learning enabled Mary to identify how the system would recognize the need for change, articulate the desired change and, especially, plan and develop actions to achieve these changes. Besides empowerment to promote changes, other special skills required of the team of psychologists included political negotiation to resolve conflicts and decision making to convince the different groups involved of the relevance and benefits to be gained from the proposed changes. This was necessary because most of the professionals at the organization in question enjoy autonomy, and power is shared between them and the top management.

To maintain the reliability of the research, the initial questions and resulting assumptions were tested at each cycle involving the whole team of psychologists in order to share impressions, meanings and the direction of the research. People from outside the psychology team were also involved in the validation of actions in order to ensure impartiality in the interpretations and decisions regarding future referrals.

Clearing the Path for Change

One significant characteristic of the experience was the transformation that the humanization process brought upon the organizational culture, leading agents to rethink their values, stances and internal policies. Under the circumstances, the main challenge was to seek these changes in the right way. In a context of deep learning, Mary and the team reviewed the actions that were planned as a result of difficulties that arose and we discovered that actions that were improvised during the group's interaction, in most cases, had greater effects than the planned actions.

The drive to create conditions for the effective humanization of hospitals was begun in the 1980s by the psychologists at the HPP, with internal and external repercussions (Forte & Sato, 2006). Within the HPP, the support of the psychology staff in intervening with patients and family members in critical situations, such as amputation and death, allowed an initial approximation and showed the health professionals how important psychology can be in a hospital.

The implantation process began in 1983 with a gradual increase in the number of visiting days and the amount of time that family members could spend with a patient. This process required changes beyond typical changes in process. It required cultural and behavioural change in the hospital context. It was not only a matter of allowing the presence of family members in the hospital, but mainly to create conditions for family members and health teams to become active participants in the health process of patients combining behaviour and process.

Thus, Mary and the psychologists at the HPP devoted the rest of the 1980s to the development of a theoretical framework and the methodological bases that were essential for interacting with the directors and the clinical staff of the hospital in an attempt to change visiting rules. The goal was to present proposals for questions, such as, what, for whom, where and how. to sustain hospital psychology at the Hospital. They soon perceived the need for *multidisciplinary action* to provide integral treatment to the children and also *interdisciplinary action* involving and promoting a change in the mindset of the health professionals.

The experience at the HPP began to have external repercussions leading Mary and the Psychologists team to begin to organize national events on the subject and hospital psychology training, training courses and other courses at local and regional hospitals and universities. For the first time, doctors, nurses, social workers, physiotherapists and psychologists met to discuss the health of the children, teenagers and family members and the practice of hospital psychology in the state.

The Beginning of Change

In 1990, Mary and the Psychology Department submitted a systematized proposal to the TMT seeking the implantation of the humanization programme and allowing children hospitalized by the SUS to be accompanied around the clock by a family member. The programme had initially been called 'Participating Mother'. The proposal was broadly accepted by the Administrative Directors, but came up against a great deal of resistance from the Clinical Directors. The clinical staff who opposed the programme would agree to it only after considerable negotiations.

> In their daily lives within the organization, the professionals needed to be made aware of the situation with security and kind words, with an institutional directive. We could not enter an institution and simply change everyone's routine. We had to prepare the institution for this change. (Excerpt from interview with Julia)

Mary and the team of psychologists also identified resistance stemming from paradigms that had to be broken. Among these, it is worth mentioning the child being *hospitalized on its own* (lone hospitalization) rather than *hospitalization with a companion, lone intervention* versus *joint intervention* and the paradigm of *sickness* versus *health*. In most cases, the origin of the identified paradigms lay in the mindset of the healthcare professionals, a professional culture and the impersonal practices that were the norm between doctor and patient.

The training of healthcare professionals, by nature, encourages cold and autonomous behaviour and the use of language that is too technical for patients and their families to understand. It may appear to be something simple to handle, but this hinders the humanization process because this behaviour had been learned and consolidated throughout the careers of these professionals and, for this reason, it was difficult to change.

As was the case with raising the awareness of the professionals, here too the team chose to act gradually. However, there was still a great deal of resistance because changes bring discomfort. While the doctors did not wish to become involved with patients' families, the nurses were afraid of losing their jobs if the mothers began to take care of their children. This context required a revision of the initial planning process by Mary and her team. Thus they to prepare a pilot project instead. The resistance from professionals was faced carefully while trust was strengthened among the group of nurses. The decision made by the team of psychologists was to implant the programme in two specialties whose professionals were willing to begin the process, and the implementation was monitored. The team intervened in all new situations. However, before this happened, Mary and the team held numerous meetings with internal groups reviewing processes and preparing a training manual for the family member. The team described activities and roles and implemented humanizing measures, presenting proposals for adapting to the infrastructure and involving all the collaborators in this process.

> Our strategy was to receive the request to implement the program, once the resistance had died down a little, through active and passive observation. They [the doctors] did not observe only passively. They would ask if the mother was causing any problems or getting in the way. Our strategy was to reduce resistance, allowing the professionals to observe both actively and passively and then accept their request and implement it immediately. (Report from Mary's Field Journal)

Many difficulties and reviews of the plan later, Mary and some psychologists decided, with the support of the TMT, to hold meetings with the clinical staff for the purpose of reducing their resistance to the process. In the opinion of the healthcare professionals, the presence of a family member would 'hinder' procedures, increase the likelihood of secondary infections and have an impact on costs, especially in a hospital that works with public resources. On this occasion, the surgical team threatened to abandon the hospital if the mothers were allowed in and the top management's stance was that the mothers would enter the hospital irrespective of internal resistance. Because all the professional groups had very close ties with the institution, none of the surgeons left and the mothers were allowed to enter.

Clashes like these are not uncommon when changes of this nature are made, especially in complex settings such as hospitals. In this case, the team of psychologists perceived that the support from the leadership played a fundamental role in the implementation of the humanization programme. In addition to verbally voicing their support, members of the board at the HPP linked the necessary changes to organizational values in their discourse, accepted the challenge of handling long-term change and continuously encouraged changes in behaviour. However, there were times when they needed to be adopting a tougher position to show that the changes were necessary and that they would indeed be implemented.

> Implementation took place step by step. Family members would arrive at the hospital and be sent to the psychology service. The psychologist told the family members of their rights and their duties and situations involving the clinical team and that these situations should be dealt with readily. For instance, if there were an emergency situation in the ward, the mothers would be asked to wait in the corridor to allow the nurses to provide the patient with the proper attention. We did this 'training' not to train people to be a mother but to teach them or how to behave in a hospital, which is like a microcosm, with many families not knowing how it functions and the medical teams not knowing what to do with so many people around. We had to prepare the families for these situations. When families finished their training and went to the wards, we would go with them and observe everything. (Report from Mary's Field Journal)

Many meetings with managers were required as the process unfolded. The purpose was to work on the meaning of humanization and strengthen the idea of opening up the hospital to family members because, once they had accepted it, other sectors would follow suit. With the healthcare teams, the psychologists held numerous meetings with each professional category and, in addition to defining the meaning of humanization, they worked on raising awareness regarding respect and children's rights. By adopting a non-confrontational strategy to handle resistance and supporting open communication, Mary and the psychologists saw fear diminish and the unknown become safe.

From that moment on, the programme had good results, triggering requests by other professional areas to participate in the humanization programme. At this time, even though the team could have expanded the programme, they created a 'grace period' to ensure that the interest raised by the benefits of the programme was accompanied by a change in beliefs and behaviour, which were a requirement for the good functioning of the programme. During this process, Mary and the team noticed that they need to create a culture focusing on *health* rather than on *sickness*. This challenge meant breaking another paradigm that required years of work because of a set of meanings rooted in the qualification of professionals in the field of healthcare and also in the evolution of hospital services.

> Every institution has its rules and our intention has always been to look at the rules but also verify to what extent these rules were in favor of health rather than only in favor of sickness. This was the major question: an institution that focused on healthcare that was provoking emotional sickness during hospitalization. In four months, we managed to get family members to stay with the children all afternoon, with the help and monitoring from the psychologists. We monitored in the sense of being at the units along with the nurses and doctors, working as intermediaries between them and the family members and the children. (Excerpt from the interview with Joanna)

In 1993, the Participating Mother Program was renamed the Participating Family Program. The team of psychologists found that the name needed to be altered because it was not always the mother who came to the hospital to stay with the child. They also noted that working parents could not stay with their children at the hospital and internal rules were modified to allow them to visit at night.

> When we implemented the program in the entire hospital, there was a widespread strike in the health and nursing sector with almost 100 per cent of the professionals taking part. At that time, mothers, fathers, grandparents, uncles, aunts and godparents were coming to the hospital. We saw one father take care of eight babies in a unit with another two mothers. From that day, we perceived that the program welcomes the whole family and as a result we decided to change the name from Participating Mother to Participating Family. So is the mother the one who stays? No, it's whatever family member who is available that stays. It may be the mother, the father, the grandmother, the aunt, the godmother. Sometimes it is a neighbor who has already looked after the child that comes to the hospital. (Excerpt from interview with Joanna)

The programme continued to grow with the incorporation and validation of the internal and external community. The perceived acceptance of the programme encouraged Mary and the team to go further

and allow overnight stays in 1995. As expected, fear of sexuality led to new resistance as a pretext for the initiative not to be implemented. However, nocturnal emergencies proved not to be significant and the hospital soon adapted to overnight visits.

In 1996, the programme had already been consolidated in the whole hospital except in the Intensive Care Unit (ICU). The ICU is an environment in which everyone is under a great deal of pressure and this pressure should not be heightened further. Thus, Mary and the psychologists held numerous meetings with medical teams, directors and family members in order to define specific procedures for a family member to remain at the ICU. To everyone's surprise, there have never been any major problems and the concerns and doubts were clarified at that time. Two reports, given below, show the change in posture and behaviour that took place following the introduction of family members to the ICU.

> We thought that we were the ones that had to do the caring, and we didn't prepare the family for the ICU [...]. They had to be taken care of by us because we were the ones with the technical knowledge. But a lot of things aren't technical. Deep down, we underestimated the capacity of the family members. We were forgetting that families have a whole learning process: they know how to touch the child; they know how to take care of it. What we at first thought was an absurd idea turned out to be quite natural and the changes caused by the program led to new learning processes and new relationships between everyone at the HPP to take care of children and teenagers with quality treatment, dignity and respect. (Excerpt from interview with Nurse Karen)

> If you want something done in this [hospital], environment, you have to talk to people, not boss them around. (Excerpt from interview with Dr. Patrick)

The change process put an end to deeply rooted concepts, making the hospital administration more democratic and technically efficient. The psychology team also needed to demystify concerns regarding resources, especially the additional costs resulting from the implementation of the programme. Initially, the HPP had support from donors to meet the resulting extra cost of feeding and accommodating family members at the hospital. Over time, costs were reduced because patients came to spend less time in hospital, and this was proof that the programme was working. The family members themselves spread the benefits of the programme and in addition to its own investments, the HPP has received support from society to finance the infrastructure necessary for family members to remain at the hospital.

> At first, the mothers would stay at the hospital in the morning and afternoon. Later they also began to spend the night. We had no other place for them to stay except a bench to sit on. We couldn't feed them either. We had to think of the financial side because how can we put people into a hospital and not feed them? [...] We are a hospital with 75 per cent public health service patients and we had no funding for the program. We went in search of support from the community. The donations began to pour in and increase and this also encouraged other specialists at the hospital to ask us to implement the program in their units. (Excerpt from interview with Bill, the psychologist)

> Today we have a room with lavatories, showers, hygiene kits and sleeping kits for family members. In the wards, we have a reclining chair for each family member and they also receive four meals a day, free of charge. (Excerpt from interview with Bob, the director)

Results Achieved and their Dimensions

The benefits of the humanization programme were felt all over, from the quality of the medical treatment to the management indicators. The qualitative results of the PFP also included lower rates of child depression and other manifestations of psychic suffering, in addition to quicker and more positive

reactions to treatment. In 1991, the average stay in the hospital was 18 days. This number fell to 4.38 days in 2005 for accompanied children. At the same time, the HPP registered an average stay of 8.25 days for unaccompanied children (Forte & Sato, 2006).

Contrary to the initial fears of the healthcare professionals, the rate of secondary infections fell by 20 per cent between 1992 and 2005 (Forte & Sato, 2006). This was due to a change in the behaviour of healthcare professionals as a result of the presence of family members. As the families had to wash their hands regularly, they also began to demand that the professionals do likewise. In the beginning, the mothers were required to put up their hair, but this rule did not apply to the other women who were visiting or working at the hospital. Noticing this difference, the families questioned this rule and this led to it becoming a general practice.

With hindsight, we noticed that the range of actions developed throughout the implementation of the PFP incurred changes in different dimensions. What began as a *social* concern led to significant changes at the *individual* and *organizational* levels.

The humanization process led to the emergence of a new sense of internal identity, breaking with the old paradigms and giving birth to new values and strengthening the existing values. More than an action or obligation, humanization took on the meaning of rebuilding relationships, broadening the perception of everything and especially, rebuilding *being* and *doing* by reviewing stances, attitudes and behaviour. The sharing of meanings helped to review *individual* and *collective beliefs*, resulting in a questioning of values and promoting changing behaviour and a transformation of organizational culture. Indeed, the internal change began only when the new meaning of humanization was spread and, more specifically, accepted by the agents involved (Bourne & Jenkins, 2013; Schein, 1992; Weick, 1979).

From an *organizational viewpoint*, we saw that the hospitals are organizations characterized by pluralism and the diversity of interests of a number of groups, diffused power and work that centres around professional knowledge. In this environment, the countercultures have largely been overcome or minimized through dialogue, informal interaction and the individualized treatment afforded each group. In this sense, one of the most significant results of the PFP was the democratization of information, the implantation of participative management and, especially, the emphasis on multidisciplinary teamwork. There was also a reduction in stress, greater dialogue and the understanding of agents regarding the importance of humanization and solidarity in all health services provide in the hospital.

Furthermore in the organizational dimension, we identified numerous positive results of the humanization programme. Among them, it is worth highlighting the strengthening of the institutional mission, improved indicators for the quality of services, the potential for partnerships that enabled the infrastructure to support the programme and the economic impact due to the optimization of resources and reduced costs. In parallel with the PFP, several other correlated services and programmes have been developed in recent years and have contributed towards the expansion and improvement of humanization operations at the hospital (Forte & Sato, 2006).

In a *social* environment, the contributions of the PFP have reached far beyond that which was expected by the researcher and team, and also by the top management of the hospital. Families have seen their rights as citizens to stay with their children guaranteed and they can maintain their care and affective bond with their children. The ongoing raising of awareness of the clinical staff has made them replicators of the programme in other local and national hospitals, broadening the scope of their results to locations outside of the HPP in other cities and states in the country. The effectiveness of the programme has also resulted in the hospital being awarded prizes, which has helped to spread the word about this experience to hospitals all over Brazil and overseas.

Reflection and Learning in Light of the Experience and Theory

An analysis of the research results indicated that our initial theoretical argument that the presence of family members at the hospital would be beneficial to child patients was valid. However, the response to how humanization should be promoted in a paediatric hospital organization led us to new theoretical questions that had to be considered for the purposes of this study. We are referring especially to the implications of the complex characteristic of the hospital organization (Perrow, 1986; Stacey, 1996) and how this affects the change process, in addition to the cultural aspect of changes (Cook & Yanow, 1993; Schein, 1992) at the HPP.

We characterize the experience as a motive for learning, both for Mary, the team of psychologists, and the organization as a whole. The learning was perceived as a dynamic process involving not only the incorporation of practices or routines that lead to a dynamic and systematic process of learning, but also mainly as part of the connections resulting from sociopolitical relationships (Antonacopoulou, 2009). Joint learning was also perceived as a characteristic of the learning process (Miner, Bassot & Moorman, 2001) due to a break with paradigms between sectors (Antonacopoulou, 2009), because of a lack of knowledge regarding how to do things differently. Consequently, all the teams involved made an effort to integrate group interests with institutional interests. For this, they gave way and reviewed their old paradigms. The importance of organizational learning can also be seen in the promotion of changes concerning the capacity of agents to identify errors, learn from them and take action to correct and prevent them (Tucker & Edmondson, 2003). It seems to us appropriate to state that one characteristic of the organizational and psychological dynamic of the hospital was that errors either go unnoticed or were minimized, and this hindered or generated difficulties along the change process (e.g., Figure 2).

When we compared the practical experience with the theoretical framework that guided this study, we identified *three main sources of learning*. The *first* was the implantation of the humanization process not as a managerial and essentially instrumental process but rather as a cultural change. The *second* has to do with the peculiar characteristic that the conducting of a change process assumes in a complex system with diversified interests, such as a hospital. The *third* has to do with the different dimensions that the change process ended up including and their influence on the achieved results. These sources of learning are presented and discussed below.

The humanization of hospital services was only possible once the initiative came to be seen by the diverse groups not only as a managerial process but as a cultural change. The focus on the individual was fundamental as the practice of humanization is a way for individuals to think, interpret and prepare to act before they become a group. We noticed that we could help to define and explain the meaning of humanization, but we could not force people to agree with us or to put this idea into practice. In this way, we perceived the importance of paying special attention to the *human* dimension, including professional training, which helped to shape the mindset, beliefs, view of the world and values of the healthcare professionals and, therefore, their behaviour as individuals.

We also found that the process of building meaning is essentially dynamic. The actions that had an effect resulted much more from the sense-making and improvisation skills (McDaniel, 2007) developed by the team during individual interactions than from the rationally worked and reworked plans that had been made. With the passing of time, humanization came to be seen as something that makes sense in a hospital organization that does good work to benefit patients, comfort their families and create a more pleasant working environment that produces learning by integrating professional teams. In short, humanizing helps to create an environment that results in general satisfaction for individuals and society.

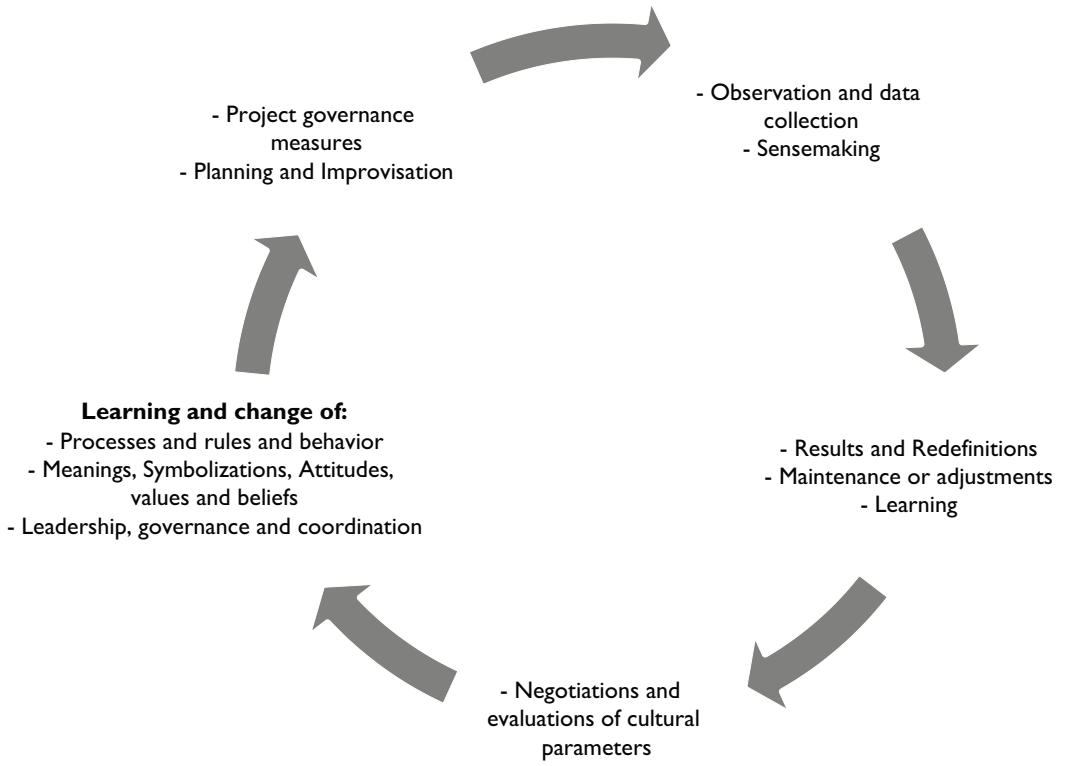

Figure 2. Cycle of the Learning Process

Source: Research.

In this way, the cultural transformation resulted in a gradual change process both in terms of thinking and behaviour that can be characterized as an enactment (Smircich & Stubbart, 1985; Weick, 1988). This implies that the recreated meaning of humanization had to be symbolized following its acceptance to be included in the routine of every organizational agent promoting cultural changes.

The leadership played a relevant role in this process (Smircich & Morgan, 1982), not only in conducting the process but especially by quelling internal resistance. Even though the change was intentional, it was a sociopolitical process that required careful handling regarding the wide range of internal conflicting interests, especially when a new form of management was being gradually introduced. For this reason, many conversations and intense negotiations took place in order to convince, involve and integrate the many sub-cultures that existed at the time. This occurred because humanization either had to be practiced to help both patients and professional teams or the humanization of services would never become a reality.

Other lessons learned had to do with the management of change in an organization with the complex and pluralistic characteristics of a hospital. The three characteristics highlighted by Denis et al. (2007) that have a heavy influence on the management of change (diffuse power, divergent objectives and knowledge-based work) were identified and had to be worked on throughout the process. Given these characteristics, processes that require changes in hospitals take on an essentially political character.

Thus, we learned to transform *resistance* into *strategies of action*, paying attention to the specificities of each public involved. The autonomy of the healthcare professionals guarantees them power that often overlaps with bureaucratic authority, meaning that changes in behaviour and procedures can only be achieved through dialogue, conversation, awareness, negotiations and a presentation of results.

Although the initial planning and reviews helped to reveal the scope of the initiative, the experience of the process suggests that in hospital organizations actions are more likely to be accepted when they occur incrementally (Quinn, 1978). Despite the fact that unsatisfactory use of managerial methodologies in organizations has been highlighted in the literature (Meyer et al., 2012), these types of approach continue to be a common practice in hospitals. At the HPP, the rational and systematic plan that gave birth to the process was substituted by micro-actions, which were gradually identified and adjusted to each situation. The resulting changes were therefore characterized as *small wins* (Weick, 1984).

Another lesson that was learned has to do with the internal development of the humanization programme at the hospital and the actions that were taken for this purpose. In hindsight, we perceived that we essentially acted in three dimensions: *individual, organizational and social*.

The *individual dimension* was represented by our understanding that the provision of a humanized service implies cognitive changes in individuals, such as beliefs, values and attitudes. It is only when the change makes sense to the agent that its meaning is shared with other agents in a broader social context and in its turn influences the behaviour and performance of others, eventually leading to the breaking of a paradigm and cultural change.

The *organizational* actions had to do with the major challenge of implementing humanization at the hospital. The main focus of these actions was cultural change, the creation of mechanisms for healthcare professionals to live in harmony with the families of patients, reducing conflicts and internal resistance, reviewing processes and the management of the additional costs of the initiative. We also concluded that cultural change was triggered by the dynamic of the cultural negotiation focus on the mutual creation of compatible and shared meanings (Cook & Yanow, 1993; Yanow, 2000).

To implement the initiative, it was necessary to develop *social* actions. This involved relationships with the government, market and society. Because of the implementation of the PFP, it was necessary to hold a scientific, albeit incipient, debate concerning the role and relevance of clinical psychology in hospitals. Interaction with society included the establishment of partnerships with external stakeholders to make the initial costs of the programme feasible and the sharing of good practices with hospitals, universities and research centres. Alongside these actions, representatives of the HPP had to work publicly in a drive for support and to enable the social and legal changes required to ensure the rights of the children and teenagers at the hospital.

The implementation of the PFP was an important achievement for the hospital as it resulted in significant improvements in its services and raised the aggregate *social* value of its services (Moore, 2000). At the same time, the programme strengthened the institutional image and prestige of the hospital and helped the improvement of its social role as a community hospital as well as the fulfilment of its social mission, which is to improve the health of human beings.

Concluding Remarks

The experience of the humanization programme carried out by Pequeno Principe Hospital reveals important lessons triggered by the introduction of substantive changes in a complex setting, such as a hospital. First, it represents an organizational commitment to the continuous improvement of health services by focusing on one of the most critical and sensitive elements: human beings.

Usually, changes within the context of hospitals essentially focus on either technology or processes, seeking to reduce costs and increase efficiency by adopting new managerial approaches such as strategic planning, cost containment and the achievement of ISO certification. All these initiatives are mostly based on the best interest of the organization and its operational objectives rather than on the best interests of human beings as users of the health services.

The humanization programme at HPP as a children's hospital can be seen as an example of a change process with a two-pronged effect. First, there is the promotion of patients' health by focusing on a critical factor: **individual dimension**—the presence of the parents as a psychological and emotional element in the recovery of their children. Second, the humanization programme brought about visible improvements in the quality of both patients' care and recovery as direct benefits while some contributions to the organizational side were also observed. This was based on the development of an *interdisciplinary group* of health professionals *challenging old paradigms* embedded in the organizational culture and *changing this culture* by improving services through integrated efforts, reinforcing the importance of the **social dimension** in the change process.

Third, the significant reduction of the average number of days that patients are hospitalized has resulted in financial advantages, allowing more patients access to specialized services. Furthermore, due to the level of commitment of children's parents as participants in the programme, some of them have become volunteers in fund raising campaigns. All of these aspects are directly related to the **organizational dimension**.

Fourth, an important contribution of the study is related to the approaches taken by the group in charge of the development of the programme to overcome expected and unexpected obstacles. The humanization process can be better represented as a sociopolitical, interactive and incremental one characterized by trial and error in which every achievement was celebrated as a 'minor victory' as the process progressed. It can also be represented as a learning process for all those from a variety of professional fields involved in different stages either as leaders, change initiators, decision makers or action generators. All the accumulated experience in different areas was retrospectively interpreted based on sense-making, with the pivotal factors and elements grouped as *individual*, *social* and *organizational dimensions* reflecting substantive aspects of the change process in such a complex and pluralistic setting.

Finally, the humanization programme brought about achievements and benefits which were only possible because of a culture of change that was developed and disseminated as the process advanced, supported by the leadership, trust and the commitment of all those involved. A sketch of a managerial approach derived from the practices that were developed was identified, indicating that hospitals as complex, professional organizations can not only learn from their own experience but are also capable of sharing it with other similar organizations. Due to the virtues of the programme, the hospital has enhanced the value added to the health services provided to the community and strengthened its legitimacy with society, at the same time strengthening the organizational dimension of the change process.

Further Research

We suggest that more studies on the existing professional sub-cultures as a source of problems towards the integration and improvement of health services. Moreover, learning from errors and failures constitutes a problem for the improvement of health services where lives are at stake, and this becomes another source for investigation in terms of the reliability of services.

A comparative study involving multiple case studies may make an important contribution to the discussions of this critical problem and benefit the organizations and the community. Since the services provided by hospitals depend on a myriad of resources and knowledge, studies seeking to analyze the processes and behaviours in clinical and managerial sectors and their impact on the quality and reliability of services may uncover new submerged realities and contribute to the improvement of human health services.

Note

1. The Brazilian National Health Service, known as the SUS was created by the 1988 Federal Constitution. It aimed to alter the situation of inequality in health services for the Brazilian people (Forte & Sato, 2006). The SUS health services are provided by public hospitals and hospitals that work as partners of the SUS. The latter are required to designate between 60 per cent and 70 per cent of their services to SUS patients. However, since public funding is limited to 40 per cent of the real cost of health services, the hospitals in question provide these services at a loss.

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