

# Care in movement: Health psychology in the Sofia Feldman Maternity Hospital in Belo Horizonte, Brazil

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## Abstract

Psychologists in hospital settings are part of a complex network of professional relationships in constant negotiation. In addition, psychologists have skills that enable them to work with social phenomena and to act strategically within them. This is especially important in inter-disciplinary team work where professional boundaries can generate barriers to change. This article shows how psychologists of a maternity hospital in a working-class district of a large Brazilian city adapted to an integral approach to health care in a way that helped other professionals to rethink practices.

## Keywords

childbirth, community involvement, hospital psychology, integral care, pregnancy

## Introduction: psychological practice in hospital settings

In Brazil, health psychology as a formal area of work dates basically from the 1980s, when the first selection panels for psychologists in the health services took place. This is a change that is strangely associated with the reorientation of Brazilian health services to primary care, as presented in the introductory paper of this special number of the *Journal of Health Psychology*. However, psychological practice in health settings antedates this formal recognition, especially with regard to its presence in hospital settings. This can be seen, for example, in the pioneering work of Mathilde Neder and Aidyl Macedo de Queiroz who, since 1957, worked in the rehabilitation services of the São Paulo University hospital (Hospital das Clínicas).

Neder's description of the trajectory of psychology at this leading public university hospital points to the gradual institutionalization of psychological services in various sectors which, in 1987, are grouped together to form the Psychology Division, contributing to the formalization of a mode of working that became known as Hospital Psychology and in due course became an autonomous field (Neder, 1992).

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In 2000, The Federal Council of Psychology recognized and later produced rules for the exercise of Hospital Psychology as a speciality within the profession and laid down norms for professional recognition (resolutions 014/2000 and 02/2001). However, as empirical research has shown (e.g. Rosa, 2005; Yamamoto et al., 2002), there is in fact an extensive variety of activities developed under the rubric of hospital psychology, based on an equally wide range of theoretical and methodological frameworks. This is also recognized in the Federal Council's own resolution when describing (in article VII) what the hospital psychology specialist can do. The field ranges from attention in health institutions to teaching in universities and research; attending patients, family members, health team professionals and administrative staff as well as students and research workers; developing activities at different levels of complexity to support and recuperate physical and mental health; including individual and group psychotherapy; attention in open wards; intensive therapy; psychodiagnosis and interconsult; and work with multidisciplinary teams, participating in decisions involving patient care and supporting the teams in developing working patterns and relations (Conselho Federal de Psicologia, 2001).

Despite such a variety of possibilities, in general, as the authors of an important practical guide to Hospital Psychology affirm (Lazzaretti et al., 2007: 9, 26), 'Hospital Psychology is an extension of Clinical Psychology in the hospital setting'. Here, the psychologist,

... acting as a health professional, seeks to deal with the demands that are made and the necessities of care ... health institutions require the professional to work actively and dynamically, given that there is not the time for a full psychotherapeutic process.

As such, psychologists in hospital settings are part of a complex network of professional relationships that are in constant negotiation. They are also involved, along with other professionals, in processes of change that might require rethinking practices. This article looks at the way in which the psychologists in a maternity hospital

located in a working-class district of a large Brazilian city adapted their practices to meet the challenges of an integral approach to health care and in doing so helped other professionals to break down a number of hospital barriers.

Following a brief comment on methods, the article begins with a description of how the hospital came into being and the way in which practical issues led the search for what later became recognized as very innovative solutions. Against this background, we then look more closely at the way health psychologists have themselves redefined their role and the way in which they deal with the constant flux of everyday issues. We then go on to discuss how 'networks of care' are built up and sustained and conclude, as our title suggests, with the proposal that 'doing' psychology in a hospital setting needs to be understood as a highly dynamic process of opportunities and choices.

## A brief comment on methods

Working with processes of innovation requires both diachronic and synchronic perspectives. The synchronic – looking sideways at the same time across a number of experiences – permits us to argue that the Sofia Feldman Hospital is in many respects, and especially in the Brazilian context, an important case to study. Throughout some 30 years in which childbirth practices moved in an interventionist and medical direction, it firmly marched in the opposite direction and has done more than survive. This latter point is not insignificant. There are a number of examples of natural and normal childbirth clinics around the country, but their concern is mainly with the process of birth. Few have found themselves immersed in wider community processes, as has the Sofia, which began life in the community it served and has continued to this day to follow the request made by one of its founders to never separate the hospital from the community.

The second perspective, diachronic, enables us to answer questions about the innovation process itself: about how things happened and why certain challenges helped to create new practices. This is equally important, for without it there is a tendency to assume that the first

approach – which metaphorically provides a photo – can be translated into a set of ‘what to do’ instructions. Simplifying, this a-historic perspective often leads to the best practices approach, much loved by certain international agencies and which can be summed up by the expression – ‘do this, it works’. An alternative, the innovations approach, that was developed during the 10 years of the Public Management and Citizenship Program, is more concerned with identifying the clues that can help to strengthen many other different approaches to localized problem solving that are important for those involved (Farah and Spink, 2008; Spink, 2000). Put together, these different perspectives require a mix of working with population-based statistics; publicly available documents; conversing with people as they go about their everyday affairs (a technique that some refer to as shadowing); and, occasionally, some more focussed interviews. This places this report as part of the case study tradition (Flyvberg, 2006) or what we have referred to as an everyday conversations approach (Spink, 2008). We have drawn on the extensive case study carried out by Brigagão et al. (2010), which included observations in the day-to-day, conversations, documents and interviews with the hospital’s medical founders. This was complemented by publications by the hospital staff, including an unpublished study on the early history (Madeira et al., 2009), updated statistical information on birth patterns available for the period 2010–2015 and discussions with the hospital psychologists. The study was cleared with the ethics committee of the Centre for Public Administration and Government and also approved by the hospital staff of the Sofia Feldman.

## **Sofia Feldman Hospital and the challenges for work in a multi-professional team**

### *Organizational and institutional frameworks*

In 1974, José de Souza Sobrinho, a member of the Christian voluntary organization of St.

Vincent de Paula, active in the poor outskirts of Belo Horizonte, puts forward the idea of building a hospital in the northern working-class region of the municipality, comprised largely of self-built houses with no public services. This was a period in which access to public health was restricted to those who were formally employed; the remaining population had to depend on charity-based services. The Vincentians considered the proposal financially beyond their scope, but agreed to letting him go ahead, providing he accepted responsibility and there was no onus for the society. Souza Sobrinho (known to everybody as Mr Zé) found a vacant lot in the Tupi District that belonged to Max Golgher, himself a paediatrician, who was willing to donate it for philanthropic purposes providing it carried the name of his grandmother, Sofia Feldman.

Two young doctors from the Federal University of Minas Gerais, Ivo de Oliveira Lopes (obstetrician) and José Carlos da Silveira (paediatrician), were working in the same area within the scope of the Catholic Community Base organizations (*Comunidade Eclesiais de Base*). Souza Sobrinho had plans for a 150-bed general hospital, but was persuaded by the three doctors to focus on providing maternity services, partly because these were in high demand in the area but also because of the viability of attracting volunteers.

They were a very unlikely group as Ivo Lopes later recalled:

I went to talk with Mr Zé and had a surprise when I found out that he was a member of Arena and on the extreme right. [...] I discovered that Max Golgher was also from the right. So I went to talk to Mr Zé and told him that I wasn’t from the right, but from the left. He didn’t see this as a contradiction because we all wanted the same thing – the hospital. He only asked that we would never take control of the hospital away from the community and would always let the community be involved. (Madeira et al., 2009: 9)

Work started on the hospital in the middle of the military regime and despite political differences, the community involvement demanded by

Mr Zé remains true right up to today. Mr Zé went around the small businesses in the region asking for support and members of the local community joined in at the weekends to do the building work; self-construction was and still is a community-based working-class skill in Brazil. The foundations were laid and up went the walls; the second floor was built and a small health centre began to work basically manned by volunteers. The walk-in clinic and outpatients centre started in 1977 and in 1982 the hospital opened with six maternity beds and six paediatric beds, all in the open ward approach that continues to this day. The hospital ran on a voluntary basis until 1986, with Mr Milton, a local community member who was also a Vincentian, keeping account of all the contributors:

There were lots of contributors, friends, the local commerce, the man who sold building materials, the butcher, the supermarket, the vegetable stand and the baker's shop. Each day I would go to find meat somewhere; they weren't the best cuts but it was what we had to eat. The greens and vegetable weren't that great either and the bread was a bit old but it was what was available. (Madeira et al., 2009: 8)

From the point of view of international health policies, this was the aftermath of the Alma-Ata 1978 meeting with its emphasis on primary health care carried out by multidisciplinary teams. Although in sharp contrast with the hospital-based medical model then prevalent in Brazil, the Alma-Ata programme had strong repercussions in the emerging sanitary movement and its emphasis on collective health. While this was not very popular with the doctors at the Medical School of the Federal University, it certainly was with the nurses from the School of Nursing who, from the beginning, supported the hospital and, more importantly, its values.

In 1984, as a result of community pressure on the government, the hospital was included in the recently created Integral Health Actions (AIS) programme aimed at populations without health cover, with a special focus on mother and child health initiatives. Further agreements took

place in 1985 with the public health service and, slowly but surely, the Sofia Feldman Hospital began to make its presence felt. Inevitably, with the hospital moving strongly towards new public health agendas, there were tensions with the Vincentians regarding some issues such as birth control and, in 1988, they felt that they could no longer legally continue to provide the institutional framework for the hospital. The Foundation for Integral Health Assistance (FAIS) was then created as a lay social foundation but, as Ivo Lopes comments, 'Who took care of the hospital at first was a Vincentian and this continues until today. The president of FAIS is always a Vincentian' (Madeira et al., 2009: 11).

A further piece of the institutional jigsaw puzzle was added in 1994, when the hospital was in a severe financial crisis. This was the time of high inflation in Brazil and the hospital refused to cut down on its work. Under threats of either forcibly closing the hospital or having it taken over by the municipality, the local community once again took to the streets and created the Community Association of Friends and Users of the Sofia Feldman Hospital (ACAU/HSF). What had been a practice since the beginning now became an institutional arrangement, with ACAU/HSF as part of the day-to-day joint management of the hospital and active in its different coordinating committees. The only exception was the medical ethics committee where the health professions are directly responsible.

In 2003, as a result of widespread discussions by staff and community members about integral health care and management, a new organizational structure was introduced to strengthen even further the integrative care approach. Six 'care lines' were set up for staff and patients: perinatal care; institutional policies; teaching and research; staff support; administrative support and technical support. Each care line has a coordinator that, together with the clinical and administrative directors and the president of the ACAU/HSF, constitutes the collegiate management board. The hospital also created its own Health Board (*Conselho de*

*Saúde*) in order to strengthen the existing mechanisms for social accountability. In his interview for the Hospital's history project, Dr Golgher summarized the progress that had been made:

The seed of a dream that was placed in the ground has now grown; it is giving excellent fruits, thanks to the efforts of the community, the doctors, nurses and administrative staff. [...] And to think that the Sofia Feldman came about through the fortuitous meeting of two people who didn't know each other. [...] Certainly my grandmother must be smiling, wherever she is ... (Madeira et al., 2009: 16)

### *Hospital, its practices and its spaces*

Brazil is currently facing a major crisis in relation to birthing practices in ways which are difficult to understand from an Anglo-European perspective. Put simply, the current rate of caesarean section (C-section) births in the large private sector of health plans (covering some 24 million women) is over 80 per cent; in the public sector, it is over 40 per cent; and, in both cases, the numbers are rising (Barros et al., 2011; O'Dougherty, 2013).

In 2011, the Lancet Series published a six-paper report on Health in Brazil, prepared by a number of the country's leading health specialists. The introduction stated,

Brazil has made significant improvements in maternal and child health, emergency care, and in reducing the burden of infectious diseases. But the news is not all good. The country continues to have a burden of injury mortality that is different from other countries due to the large number of murders, especially using firearms. Obesity levels are increasing and caesarean section rates are the highest in the world. (Health in Brazil, 2011)

A good way to overview the impact of the Sofia Feldman's dedication to maternity and perinatal care is to note that while in the beginning its focus was on low-risk births, by 2000 it had become a key reference for high-risk pregnancies not only for the northern region of Belo

Horizonte but also for a considerable area of the state. The 'Sofia' as it is known continues to be an independent non-profit community-based organization within the Brazilian Unified Health System (which provides financial support). It has no private beds, charges no fees and is a leading exception to the national childbirth trend. With currently 150 beds and an average of about 1000 births a month, it has a C-section rate of 24 per cent (which includes a significant number of high-risk births) and very low levels of maternal and infant mortality. The hospital has also been innovating in the most practical of ways. It has not only adopted and adjusted existing techniques to its specific conditions, but has created new approaches often well ahead of formal recognition elsewhere. For example, from the beginning, the decision was taken to hand control of delivery over to obstetric trained nurses and holds the doctors in reserve for complications that would require surgery or highly specialized post-natal care. To quote one of the founding directors, 'It is the woman who gives birth, it is not a medical act' (RADIS, 2012: 16).

This decision would lead to a very close partnership with the School of Nursing at the Federal University of Minas Gerais. The result was an organizational culture that not only leaned heavily towards normal childbirth with female nursing teams, but also led to innovations in natural birth and integrated health care. A number of these have been reported both in Portuguese and in English from a medical and nursing perspective (Alves et al., 1999; Duarte et al., 2009, 2013; Lopes et al., 2010; Madeira and Duarte, 2006). Today, the Sofia is the Brazilian Ministry of Health's (2013) showcase example of patient-centred maternal care as can be seen from an official video available on YouTube. Since 2014, its obstetric nurses can be found carrying their inflatable birthing tubs up the steps and stairs of houses and apartment blocks as part of a new programme for natural birth at home. In a country in which the social division of classes has been described as social apartheid (Buarque, 1994), there are a growing number of women with access to private health plans who are

turning up at the door to join in its daily activities and be part of its open ward culture.

Yet, a further way of understanding 'Sofia' is to walk through the open gates on a sunny morning and find groups of women and their babies sitting on benches chatting; walk up to the reception desk to be greeted with a big smile or follow one of the staff into the intensive care unit or the intermediate care unit to find mothers being encouraged to stroke their babies, fathers holding new-borns in the Kangaroo method and everybody chatting away. All over the place there are people, talking, visiting, sitting at bedsides to keep expectant mothers company. A lot of the mothers-to-be are very young and there will always be someone sitting down to talk to them or include them in a discussion group. Fathers are just as much involved and are expected to learn about childcare and take part in the caring process. There are also babies everywhere. There may be various meetings taking place with a mix of professional administrative and community members. The Hospital Ombudsman's team from the ACAU/HSF will also be around, talking to patients and staff about the hospital and asking their opinion. The natural childbirth centre, with its baths and Pilates balls, is located just beside the main hospital gate. Across the road is one of the various houses that the hospital has acquired for women that have come from far away to stay near the hospital because of a high-risk birth diagnosis or that are getting ready to leave for home; known as the 'houses of the Sofias'.

For an organization that began with nothing and set out to do its work in a way that involved both integrative approaches to childbirth and perinatal care, with joint management between community, administrative and health staff, finding a way through difficulties seems to have become second nature. Many of the actions developed, which in today's terms could be called innovations, happened because there were issues to be solved or positions to be assumed.

For example, by adopting the principle of low-risk births being the responsibility of obstetric nurses, the Sofia anticipated by a

number of years the recommendation of the Pan American Health Organization Conference of 1985 and created a practice some 30 years ahead of its time in Brazil. In a similar way, it adopted the principle that all mothers about to give birth can have a companion on a 24-hour basis: a woman or man, a family member or a friend. Meetings are held every morning with the companions, led by the social services team, and with the presence of one of the community ombudsman's team and someone from the Health Board. These discussion groups are focused on the birth experience and also on the resources that are available at the hospital including the discussion of civil (birth registry) and labour rights (maternity and paternity leave). There is a hospital car to take people to the registry office, important in a country where many people are still undocumented.

As the idea of the 24-hour companion began to take shape, it became clear that a number of women did not have anybody on whom to call. ACAU/HSF stepped in and began to mobilize volunteers from the community. This remained an informal local solution until the day that the Clinical Director, taking part in a seminar in Rio de Janeiro, heard a discussion about a 'new' international approach to birth care that needed to be introduced into the country. To his surprise, the description that followed fitted into what ACAU/HSF had already started; the difference was that now they had a word for the practice. In 1997, bringing together the experience of ACAU/HSF and the literature on the subject, the Community Doula Project began and the hospital staff created short courses on various childbirth-linked themes for the community volunteers. Four years later, the Ministry of Health asked the Sofia Feldman staff to assume the task of training other national health maternity units in instituting Doula Programmes.

But the Sofias are also the babies. Babies and mothers are kept together at all times. This decision, taken in 1982, was totally contrary to the then practice of keeping new-born babies in a special room, to be brought to the mother only for feeding. After 11 years, the Ministry of



Health would recommend keeping mother and child together in all Unified Health System hospitals.

Mothers and fathers can go to the intensive care unit at any time, day and night, and there is no special clothing to be used. The staff, nurses and doctors will regularly stop to chat about what is taking place and what procedures are being adopted. The Kangaroo mother technique is one of these procedures – but it applies to fathers as well. In 1989, the Sofia staff heard about an experience in Colombia where, in a maternity hospital that had no incubators, low birth-weight babies, usually premature, were being kept in skin-to-skin contact with their mothers chests, in a vertical position and swathed in a bandage and a T-shirt. It requires skill to teach the parent or family member of either sex how to support the baby in this position, but it has a tremendous impact on the sense of competence of the parents in dealing with a low birth-weight baby, strengthening maternal and paternal links, helping to promote breast milk and providing better thermal control for the baby. Some 12 years after the adoption of the Kangaroo method at the Sofia Feldman and a short while later at a philanthropic hospital in the north east of the country, the method was finally included among the recommended Unified Health System practices.

Being a reference centre for a wide geographical region has meant that not everybody is able to travel to the hospital close to the time of birth and mothers with low birth-weight babies or those in intensive care may not live in the surrounding communities. In order to solve this problem, a first residential centre for high-risk pregnancies with 12 beds opened in 2002 and a second house was later created for mothers whose babies were in the intensive care unit. With an increasing number of women with high-risk profiles coming to the residential centre and the wish of mothers of babies in intensive care to be nearer to their children, a new space was created for them on the fifth floor of the hospital and given the name of the Sofias' Space. Later, yet another house was created for those mothers who were waiting for

transference to their hometown, which became known as the Baby House. With so many mothers around, various other activities grew up: professional training, a beauty clinic, a crèche for staff and many other options for discussion and debate.

Pushing forward the boundaries of care in this manner has not been without difficulties for the hospital. Sofia is usually ahead of the Unified Health System policies on desirable care practices and – because of this – often works without the funding that these policies provide. However, it has never given up its 100 per cent public health commitment: all are welcome, nobody is refused, but there is no special treatment for anybody.

As this section has shown, Sofia is 'performed' in many ways and in a varied network of spaces and places. Its collective approach to childbirth, maternal and family care (for babies have mothers and fathers) is much more social than intellectual in origin. Knowledge has been key, but it is knowledge driven by social needs. The psychologists, among other professional groups, are very much part of this active performance and, like other staff, they can be anywhere, wherever they are needed: in the courtyard, in the intensive care unit, in the open wards, the corridors, the early morning meetings with the companions, at lunch in the different houses or just moving around. Anywhere, that is, apart from their consulting room which is usually only used for keeping coats and bags.

### **Health psychology in the day to day**

In this section, we focus on the part played by the hospital's psychologists as they move around the many different settings and services that make up the different bits and pieces of the Sofia Feldman complex. Psychologists were present among the early volunteers and their number grew during the 1990s to a full scale around the clock presence by the year 2000, with an approach to psychology in practice that can be sensed from the following excerpt from one of our field diaries:

We met Joana in the intermediate care unit where she was looking for a friend of hers whose baby had been recently moved there from the ICU. Julia (the psychology coordinator) and Joana talked together and calculated how long Joana had been in the hospital – it was 95 days. Joana told us that her baby had been born at 500 grams (1.1 lbs.) but was already nearly twice that weight. She added that the attention she had received from the doctors and all the staff was great and that one time her baby was very very ill and without saying anything, one of the psychologists was soon by her side to keep her company. She told us that the physiotherapist was also working with her in the ICU to help prepare the baby for feeding by getting her to put her finger in his mouth [...] he is already sucking very strongly.

With an average of 1000 births a month of which 40 per cent are high risk and many of the mothers to be from the further reaches of the state, there is a lot to be done. The team of eight psychologists (all women), plus two psychology residents from the neonatal specialization programme, provides 24 × 7 coverage in the hospital, alternating shifts and days. Their theoretical starting point is a view of health care as a multiple process that is translated into actions by the many different social and professional actors involved, using different spaces, places and techniques. This intuitive approach to the hospital as a social organization has many links to the notion of the intersections between the multiplicities of material and social worlds that, academically, is a feature of actor network theory (Law and Hassard, 1999).

The psychology team's approach is to work in a transversal manner with the other health professions to discuss and develop different collective health practices. There are also other practices that are more specific to the psychologist's trade that have been developed for work with high-risk settings. One constant Portuguese expression used by the health staff 'acolhimento' is difficult to translate in English as a single word, but is key to what follows. The expression has become the rallying point for much of the alternative and inclusive work on health care in

recent years (Franco et al., 1999) along with some important discussions on integrated health care (Campos, 2003). Like many other of the Sofia's practices including the community companions, it was yet another expression that fitted their approach to health care. The root of the expression is the Portuguese verb 'acolher', which Franco et al. translate as 'user embracement'. From the Latin *accolligere*, it includes the actions of welcoming, protection, reception, listening to and giving shelter. In English, it would be the fusion of 'giving a warm welcome' and 'lending an ear'. The proposal is that,

...health care clients are the centre of the health services' organization, including the following: 1) care for everyone seeking it, thus guaranteeing universal accessibility; 2) reorganization of the work process, such that its central thrust is shifted from the physician to the multi-professional staff, or user embracement team, in charge of listening to users and becoming involved in solving their health problems; and 3) solidarity, humanity and citizenship as parameters for the relationship between health care users and providers. (Franco et al., 1999: 345)

As part of the 'user embracement network', the psychologists can be found wandering around the hospital corridors – which are seen as places and spaces for interaction rather than simple passage ways – through the natural birth centre, visiting the intensive and intermediary care units as well as the different wards and houses. There is always someone to talk to, to pick up on a previous topic, to suggest an action: hospital patients, friends or family members or staff. This notion of moving around in the day to day, following the drifting tides of activities, began to be formulated as a serious focus of action in the late 1990s. In the year 2000, the psychology team took the decision that psychological knowledge could and should be used fluidly in making a serious contribution to creating new ways of 'being in hospital'. The result could be called as *care in movement*.

Their relation with the other members of the multi-professional network is intense and they are constantly on call to different parts of the



Sofia. They never refuse a call and despite the variety of ways in which they work they never stop being psychologists, contributing to the transformation of hospital practices, at times in very difficult and potentially traumatic settings.

## **Psychologist tales**

The following two descriptions of the way in which psychologists respond to daily issues were chosen from a number of different situations registered in conversations with the psychologists and in following them around the hospital. They are representative of the way in which the psychology team works on emerging concerns within the inter-professional 'user embracement' network approach (the names were changed).

Sonia,

One morning, the psychologist was called to the Intensive Care Unit to talk to Sonia, who had just been told that her baby, a few days old, was very poorly and in risk of dying. Talking to the psychologist, Sonia said that her greatest sorrow was that her son would die without her ever holding him in her arms. The psychologist asked her to wait a moment and went off to talk to the head of the unit, asking that Sonia be allowed to hold the baby, without removing any of the life support and medication equipment. The lady doctor asked if she didn't think that was rather morbid to allow the mother to watch the baby's death, to which the reply was no because that was the mother's wish and it would probably help in the mourning process. Sonia stayed sitting in Intensive Care with her baby, warming him, singing to him and calming him. The baby died in her arms. Ever since that event, the Intensive Care team including in their protocol of practices not only keeping parents informed about the real situation of their babies, but asking them what they would like to do in relation to the baby and wherever possible create strategies to make this happen.

Maria and André,

Maria was young, less than 36 years of age, thin, smiling and quick talking who we met in one of

the corridors on one of our walks with the psychologists. She stopped and gave the psychologist a big hug and asked her if she was going to go and see André, her son, who was in one of the Intensive Care Units. Together they told us a bit of his story. Maria had a detached placenta and he suffered a lot, was born with problems and had to go into intensive care on life support. He was Maria's third child and it was very difficult for her to deal with this, especially with two other children (16 and 11) and with family and friends asking her what was the matter, why as he such a long time in hospital. Maria told us that after many conversations with the psychologist, she gradually understood what was happening and learned to recognize the small improvements, accept the tracheostomy and the later gastrostomy. Her dream was to have André at home so that he could see his room. In the seventh month he was allowed home under the constant attention of the nearby reference centre for health care but soon he was back again with pneumonia and had to have the breathing apparatus yet again. Maria knew it was important for him to be back in hospital, but he had been able to see his room. At eight months André had a serious convulsion and the team had to prepare Maria for his probable death. Maria told us that she prayed to God and asked him to let André live until his first birthday, so that the family, friends from church, neighbours and all who wanted to could take part. The psychologist agreed and said yes it was possible to have the party in the hospital. The hospital directors agreed for them to take over the main dining room for a short while and Maria was so happy that her initial list of invitations had over one hundred names. They negotiated a reduction to thirty. Despite further convulsions the party went ahead with the help of the multi professional teams. André recovered a little, Maria did the decoration and the invitations, the psychologist arranged the cake and the soft drinks and the Intensive Care staff managed to support André sitting up in a chair (with his breathing apparatus). The photos were still stuck to the wall beside the Intensive Care bed when we went with Maria and the psychologist to visit him. André died 2 months and 17 days after his birthday.

These two descriptions illustrate the way in which daily demands can lead to very specific

actions, initially of a one-off nature which may in turn feed back into future practices. Important here is an approach to possibilities that we have seen in other work on innovation: 'why not'. However, the psychologists are also present in many ordinary and regular events that take place on a daily or weekly basis around the hospital complex. In these, they will be working with obstetric nurses and general nurses, neonatologists, paediatricians and obstetricians as well as forming part of the wider support network which includes occupational therapists, social workers, physical education, nutritionists and members of the community through the Doulas and ACAU/HSF. In the following sections, some of these are briefly described.

### *Maternity ward*

Every day from 2.00 pm to 3.00 pm, a psychologist and a nurse will hold an open group discussion with mothers on matters linked to birth and childcare. They will also be constantly on call to deal with specific events that can happen at any time (spontaneous abortions, foetal loss, still births and very rarely maternal mortality). The intensive care (41 beds) and intermediate care (45 beds including 15 for Kangaroo Mothers) are always open to mothers and fathers who are seen as part of the care process and not visitors. In intermediate care, mothers have a bed beside their child and already begin to take over certain responsibilities. The psychologists are always there to listen and help, letting the parents know that they are not alone and talking to them about the different professionals in the broader support network. They also take part in the shift change sessions where information about patients is discussed.

### *Houses*

In the different houses that form part of the complex and in the Sofia's Space on the fifth floor of the hospital for mothers whose babies are in intensive care, the psychologists can be found holding regular open discussions with those in residence about pregnancy, childbirth

and child rearing practices as well as other issues of family planning, gender and profession. They also participate in the many different activities being constantly proposed by members of the multi-professional team, which may be coordinated by the psychologists themselves or by the occupational therapists, physiotherapists, nurses, doctors and volunteers from the ACAU/HSF. The psychologists can also be found in the alternative therapies centre, located behind the 'Baby House' and close to the 'Beauty Saloon' where mothers learn skin care and a community hairdresser teaches basic skills. Alternative therapies include reflexology, acupuncture, moxibustion, homeopathy, Bach Flower therapy, music therapy, aromatherapy and nutritional advice – all focused on relaxation, recuperation and anxiety reduction.

### **Concluding remarks: building and sustaining 'user embracement' and networks of care**

Although they are only a part of the Sofia Feldman, the actions developed by the psychologists have made a significant contribution to creating and sustaining the networks of care that characterize the day to day of the hospital. Many may seem 'taken for granted' but in the hierarchical and professionally segmented world of health institutions, some are far from common. Perhaps, the first of these is their constant presence in all the multi-professional meetings, independently of the time of the day, and their constant emphasis on the collective importance of listening to what patients and their family members want to talk about and to recognize them as competent beings. A second key area of action has been their leadership in the Doulas project. Involved from the earlier years, they took over the formal coordination of the project from 2001, working with the Doulas to build up an array of non-medical skills and techniques for following childbirth. In 2014, the 10 women making up the Sofia Doulas team were incorporated within the hospital staff.

Finally, with the Sofia Feldman assuming an increasingly important role in professional development, especially in different forms of residency (gynaecology, obstetrics, paediatrics, neonatal care and obstetric nursing), the psychologists are involved in a new residency programme on multi-professional neonatal work which receives graduates from psychology, social services, physiotherapy, occupational therapy, speech therapy, nursing, nutrition and pharmacy.

It will probably not come as a surprise after the different descriptions of the Sofia Feldman, that those who work there are highly involved in the different activities that are taking place. The hospital has a day care centre for the young children of staff, most of whom have had their babies in the hospital. Some of the staff are themselves Sofias. Important here is to note that one of the 'care lines' in the hospital matrix is focused on staff personnel, which involves not only human resources professionals, but also coordinators, the ACAU/HSF ombudsman and the Hospital Health Council. 'Embracing the user' and 'networks of care' are two interlinked concepts that seem to pop out of the ground when the Sofia Feldman Hospital is considered and, in the case of the Sofia, form a broad cultural pattern that permeates the day to day.

The two terms draw in different bibliographies, some are academic and others are more personal. 'Networks of care' suggests links – as mentioned – not only to the heterogeneous world of actor network theory (Spink, 2010) and the intersection of materiality and sociality, but also to some very pointed arguments proposed by Rorty about everyday knowledge (Rorty, 2006). In Brazil, it has stimulated discussions about the ethics of psychological practice in institutions (Andrade and Morato, 2004). 'Embracing the user' is more difficult to translate into the often detached Anglo-American culture where uniforms distinguish status and difference and the most you can hope for is a handshake. 'Embracing' in Portuguese is also the word for the normal friendly greeting at the end of a letter or e-mail (the equivalent to best wishes): an 'abraço' – an embrace or a hug. In

the Sofia, it is a useful metaphor for an approach to practice, but it can also mean a real life hug.

This is the image with which we close the article. Perhaps, the most important conclusion from the Sofia Feldman for the health psychology community is to listen to what people intuitively want to do, trust them, speak frankly about prospects and be ready to embrace their concerns anywhere: in the corridor, in the ward or in the intensive care unit. It may not be a very academic or even elegant description of psychological theory, but it certainly seems to work in practice.

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