INTERPROFESSIONAL COLLABORATION AMONG REHABILITATION PROFESSIONALS

Muhamamd Naveed Babur, Maria Liaqat

ISRA University Islamabad Pakistan

ABSTRACT

Objective: To determine interprofessional collaboration among rehabilitation professionals in stroke rehabilitation.

Study Design: Comparative cross sectional survey.

Place and Duration of Study: Data was collected from all major cities of Pakistan in 12 months from Nov 2015 to Nov 2016.

Material and Methods: A structured questionnaire of interprofessional collaboration was filled by physiatrists, physical therapists, prosthetists/orthotists, occupational therapists and speech-language pathologists having two years of professional experience into total sample size of 139.

Results: Post Hoc analysis for comparison between the occupations shows that there is significant difference for communication, accommodation and isolation between the rehab physicians and all other occupations included in the study with the *p*-value less than 0.05.

Conclusion: The benefits of interprofessional collaboration cannot be denied in developing countries and barriers to development of multidisciplinary team are huge. We need to step forward to overcome these barriers and play our role in development of multidisciplinary teams so that our patients and team members get benefit from this already research proven approach.

Keywords: Interprofessional collaboration, Multidisciplinary team, Rehabilitation professionals.

INTRODUCTION

Interprofessional collaboration is the way toward maintaining and creating effective interprofessional working associations with learners, experts, patients/customers families and groups to enable optimal health outcomes.

According to the World Health Organization (WHO), multiple disciplines, if work together as a team, can work more efficiently to help enhance the patient's condition by the implementation of interprofessional collaboration. They can figure out how to cooperate and respect each other's perspectives in healthcare in a more productive manner. Healthcare does not depend solely on one health professional but various disciplines are involved that work together to meet the needs of patients. There is a lot of research available to demonstrate that patient results, nature of care and cost of care conveyance are altogether improved when multiple disciplines work as a group toward a shared goal that focuses on the patient[1].

Interprofessionalism was not a part of the traditional health science education system. In our system there is a particular school for each speciality for each health care discipline i.e. school of nursing, school of medicine, pharmacy school and was immersed in a single point of view. The ultimate goal of each speciality is to provide best care to patients and it is possible only when healthcare providers identify themselves as a fundamental part of a larger healthcare team and not just learning roles specific to their discipline. The inefficiencies in patient care can be reduced when we refocus our work through a lens of interprofessionalism. This means that treatments and assessments should be done together. And instead of focusing on specific diagnosis or treatment the focus should be on the patient as a whole[1].

Correspondence: Dr Muhammad Naveed Babur, Professor ISRA University Islamabad Pakistan *(Email: naveedphysio@gmail.com)*
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The purpose of conducting this study is to explore interprofessional collaboration among rehabilitation professionals. Interdisciplinary group work has increased over the previous decade, but there is little evidence about the best method for conveying interdisciplinary organization team work[2].

Most of the existing research has explored the impact of one or a couple of these perspectives, as opposed to analyzing the connections among a few of these segments on patient outcomes and on the scope of the staff. Also, the interventions intended to enhance interdisciplinary cooperation tend to concentrate on specifics of team work activities which include case-conferencing approaches[3,4], sharing of patient files[5] and meeting style or frequency[6-9]. There is no systemic framework available till date through which the activities of interdisciplinary team work can be organized.

An extensive variety of terms is used to describe collaborative working plans between professionals[10]. In literature, different terms are frequently used interchangeably that include interdisciplinary, multi professional, inter-professional, multidisciplinary[11]. The term 'team work' is also used in conjunction. However, there are some consistent differences which though difficult can be useful to comprehend. The terms inter and multi-disciplinary[12] are broad terms as compared to inter or multi-professional that are generally narrower[13-15]. This refers to groups comprising solely of professionals from various disciplines, or if nothing else to the connections between the professionals in groups that may likewise incorporate the other non-professional staff. The terms inter and multi-disciplinary are more extensive and incorporate all the individuals from health care teams, professional and non-professional. Different authors proposed utilization of the prefixes multi, inter or trans to reflect the differing intensities of coordination[16].

Interprofessional collaboration scale was designed to collect the perceptions of inter-professional collaboration among three different groups including doctors, nurses and allied health professionals. The allied health professionals include physical therapists, pharmacists and social workers. In particular, view of communication, accommodation and isolation are measured in a 13-thing review. Parallel forms of the overview match diverse "rater-target" dyads. That is, the nurses rate their working associations with specialists and the other way around; nurses rate allied health professionals and vice versa; and allied health professional rate physicians and vice versa. The validity study was based only on nurses' perceptions of their working relationships with physicians (other dyads still need to be examined). The sample consisted of 479 respondents working in inpatient wards/services in 15 community and academic hospitals in Canada. The study reported good factor structure and expected patterns of correlations with related existing instruments, such as the Attitudes towards Health Care Teams Scale and the Nursing Work Index. The essential purpose of the tool is to lend itself to different studies and thereby contribute to the research base in support of interprofessional collaboration[17].

A prospective study was conducted to examine the efficacy of the Toronto Stroke Networks Virtual Community of Practice (VCoP) as a contributor to meaningful IPC in stroke rehabilitation. The participants included in the study are mainly clinicians and some administrators. The VCoP was developed to connect stroke healthcare providers, support implementation of best practices, and improve patient outcomes. The VCoP, a secure social media platform, fosters cross system inter-professional collaboration (IPC) across the continuum of stroke rehabilitation. Value creation to support IPC was evaluated through thematic analysis of interviews and focus groups and descriptive statistics for VCoP utilization. The VCoP has 380 members, 8 interprofessional groups, and 20 discussion forums. Preliminary data showed increased sharing of personal experiences, new connections through joint

projects and application to practice as a result of learning. Further thematic analysis will be available at the time of publication[18].

PATIENTS AND METHODS

Data was collected through major cities of Pakistan from Nov 2015 to Nov 2016. Total 139 health care professionals including physiatrists, physical therapists, prosthetists/ orthotists, occupational therapists, speech-language pathologists, were included in the study. The study design was campartive cross sectional. The study tool was a questionnaire/ scale. Data was analysed through SPSS 21.

RESULTS

The tool used in the study, Interprofessional Collaboration Scale, is a 13-item tool that has three subscales on a 4-point scale. It includes communication, accomodation and isolation (fig-1). A significant difference is seen for communication, accomodation and isolation between the rehab physicians and all other occupations included in the study using interprofessional collaboration scale (fig-2).

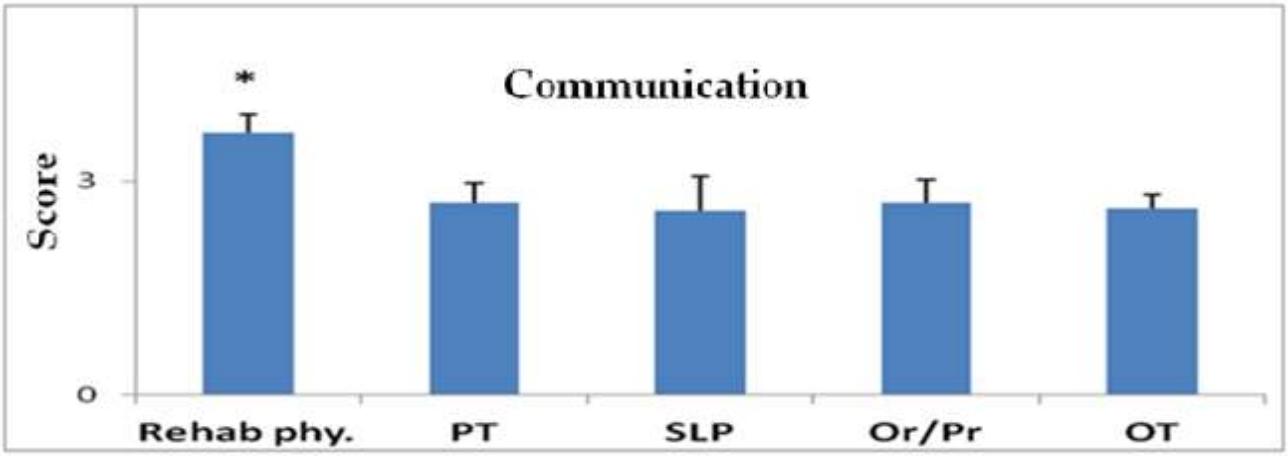

Figure-1: Occupation vs mean scores on communication aspects.

* Reliability analysis showed low reliability (α=0.34) of this subscale.
* Indicates a significant difference with all other groups ($p \leq 0.05$).

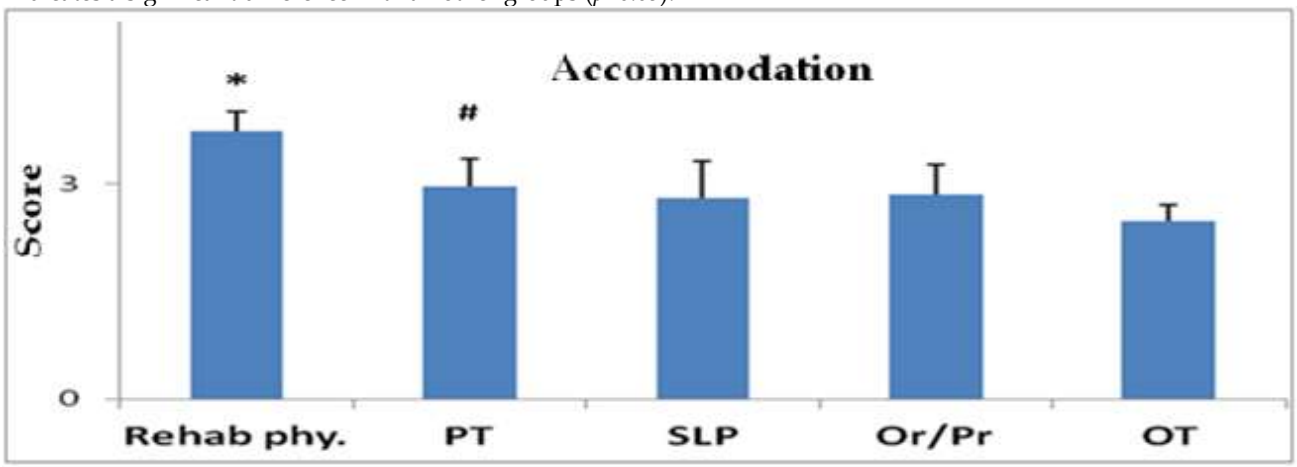

Figure-2: Occupation vs mean scores on accommodation tendencies.

* Good reliability of α=0.66 was found for this subscale.
* Indicates a significant difference with all other groups ($p \leq 0.05$).
* Indicates a significant difference with OT ($p \leq 0.05$).

DISCUSSION

There is significant difference for communication, accomodation and isolation

between the rehab physicians and all other occupations included in the study using interprofessional collaboration scale (fig-3).

There are many hindrances to inter professional collaboration and much has been written about it. Few barriers need to be highlighted that are relavant to physiotherapists. We can not live without competition as it is part of our professional and social culture. In any case, this means we should adopt practices to allow us to work in circumstances in which strength and status win. We should determine how to tune in, yet advocate as far as it matters for us. We should be focused to promote the quality of care of patients. Collaboration is achieved by coordinating the unique abilities of each individual with the other so that we can work together to discover better solutions.

In our discussion about collaborative practice with health care professionals, we found that since they carry out solo practice they think that collaboration is not relevant to them, which is very far from the truth. From our experiences, we have learned that we need to work at the side of the general practitioner. We might not see ourselves as a team now but gradually, as our practice becomes more community based and stronger collaborations are established, our coordination will also enhance. We all are aware of the fact that several physiotherapists who are working with in the organization with patients of chronic and complex disorders as of now have great associations and this process allows considerable progress. In any case, we ought to be aware of the need to teach others beyond the ones within the medicinal services about our ability component and volume of practice. There are numerous patients with terminal sickness and disability who might improve by using physiotherapy but are not getting proper attention, or don't know how to get to us, or essentially are oblivious to the idea of physiotherapy. On the off chance that we're to grasp the greater significant determinants of wellness[19]. We need strategies to improve collaboration with those whom we won't customarily have worked with. The failure of the evidence in support of collaborative exercise offers an opportunity for some to move ahead in changing their practices. There is a wide variety of systematic evaluation available on interprofessional collaboration. In 2007, an excellent proof in scientific schooling assessment studied 10,495 abstracts exploring, whether gaining this knowledge will contribute to inter professional practice and higher patient care[20]. Total 21 studies have met their standards[21,22]. In a study the consequences of interprofessional approach on expert practice demonstrated a

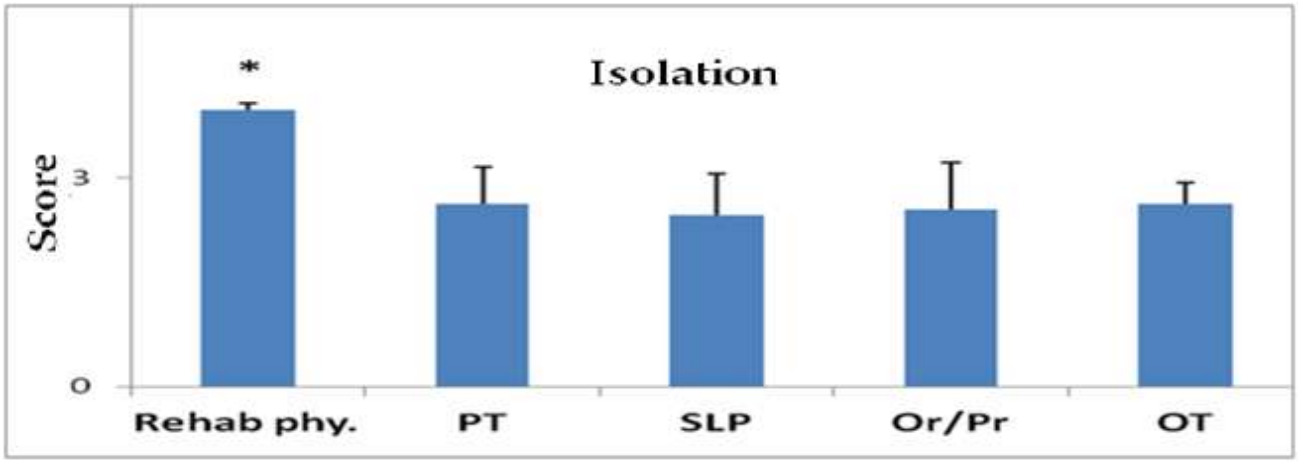

Figure-3: Occupation vs mean scores on subscale isolation.

* Indicates a significant difference with all other groups ($p \leq 0.05$).

* Good reliability of α=0.69 was reported for this subscale.

positive impact on those who suffered from abusive behavior at home, working with the community mental health carriers and those running inside the emergency room.

When care is provided by team work or through collaborative process, there is convincing evidence to prove better response of the patients. There is a lot of research available that proves that when practice is patient centered, the level of satisfaction improves. The change in medicinal results are also shown; for example, pediatric patients getting treatment from inter professional teams had significantly less asthma, weight loss was easier in obese indviduals and patients suffering from Alzheimer's received fewer anti-depressants and had apparently less behavioral and mental signs[16].

There is much evidence available now to support the efficacy of collaborative practice in enhancing the outcome. As the other IPC-related literature, the findings reveal that there are several culturally fixed boundaries that hinder information follow-up and communication among the health professionals. Inter-professional attitudes/stereotypes, inter-professional mistrust, and ways of thinking and behavior have been identified among the variables that could strengthen the boundaries and hinder the IPC. The way of life is changing, and physical therapists are the pioneers in this social move. We as physiotherapists have the learning, aptitudes, affectability, mindfulness and constancy to advance coordinated effort, however it is not generally simple. It is important that others understand our unique contributions, skills, and potential and that is the only way forward.

CONCLUSION

The benefits of interprofessional collaboration cannot be denied in developing countries and barriers to development of multidisciplinary team are huge. We need to step forward to overcome these barriers and play our role in development of multidisciplinary teams so that our patients and team members get benefit from this already research proven approach.

CONFLICT OF INTEREST

This study has no conflict of interest to declare by any author.

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