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Social and healthcare professionals' work to establish coherent rehabilitation pathways for people with inflammatory arthritis: a qualitative study

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Abstract

Background Professionals in health and social care are challenged by the complexity and fragmentation across primary and secondary levels of care. To study coherent rehabilitation pathways, we focused on people with inflammatory arthritis admitted to a specialised rehabilitation stay as these pathways will involve a myriad of different professionals from primary and secondary levels of care. This study aimed to explore how health and social care professionals establish coherent rehabilitation pathways for people with inflammatory arthritis across primary and secondary levels of care and how organisational factors influence on workflow.

Methods Twenty-four situations between professionals and clients were observed during an inpatient rehabilitation stay. In addition, semi-structured interviews with 26 health and social care professionals from primary and secondary levels of care were conducted. An abductive approach guided the analysis and applied person-centred and integrated care concepts.

Results Three themes were derived from the analysis: (1) Person-centred interactions with clients, highlighting that professionals wanted to respond to clients' preferences; (2) inter-dependent interactions between professionals, reflecting dependence on collaboration across primary and secondary level of care; and (3) economic and cultural frameworks influence professionals' work.

Conclusion Professionals strive to take a person-centred approach and must coordinate and communicate with other professionals to create coherent rehabilitation pathways. However, economic and cultural frameworks influenced by the logic of public management and medical professionalism may hinder these intentions.

Clinical Trial Number Not applicable.

Keywords Integrated care, Person-centred care, Inflammatory arthritis, Coherent pathway, Continuity of care, Interprofessional collaboration

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Introduction

Lack of coherence between services and organisations in health and social care is a common complaint among clients and healthcare professionals [1–7]. "Client" describes any person, patient, user, or citizen with an illness requiring contact with social and health services. Coherence in rehabilitation pathways describes the provision of health and social services in a manner whereby the client experiences continuity of care.

Lack of communication and coordination between professionals can result in clients being referred from one specialist to another, overlapping consultations, repeated tests and examinations, and a lack of follow-up services, increasing the risk of mistakes [1–6]. Clients with one or more chronic conditions have particularly complex care pathways and need rehabilitation that includes continuous support from professionals in social and healthcare [2, 6, 8, 9].

For clients, lack of coordination may result them in that they feel they need to take on responsibility for which they are often underqualified and thus increases insecurity about whether or not the services and treatments are adequate or appropriate [4, 10, 11].

Lack of coherence in the healthcare system leads to inefficiency, for example, the delay of information due to different types of communication systems across organisations [2, 6].

For society, fragmented rehabilitation pathways can increase economic costs because of repeated tests and readmissions [2, 12] and clients' continued reduced functional levels, reducing the ability to work [13], and increasing social costs [2, 12].

This study has chosen the trajectories of chronic inflammatory arthritis (IA) clients as their rehabilitation involves many professionals across primary and secondary health and social care to address the disease's physical, psychological, and social consequences [10, 13–16].

The Danish healthcare system is primarily publicly funded and organised on three administrative levels [17], as illustrated in Fig. 1.

Danish municipalities are responsible for the provision of social care services.

Thus, this study aimed to explore how health and social care professionals establish coherent rehabilitation pathways for people with inflammatory arthritis across primary and secondary levels of care and how organisational factors influence on workflow.

Methods

Study design and approach

The qualitative study was designed with observations [18, 19] and semi-structured interviews [20–22]. The study was inspired by the sociological approach Institutional Ethnography (IE) [23, 24] as the aim of the study encompasses an investigation of how the social organisation of the professionals' work is influenced by organisational factors. Organisational factors such as structures, systems, rules, laws, bureaucracies and government impact social organisations [24]. Culture is a structural factor that describes a group of individuals sharing basic assumptions, norms and values, repeating behaviour over time, and introducing this behaviour to new members [25].

We adopted a Nordic approach to IE [23, 26] that encourages researchers to be flexible in the

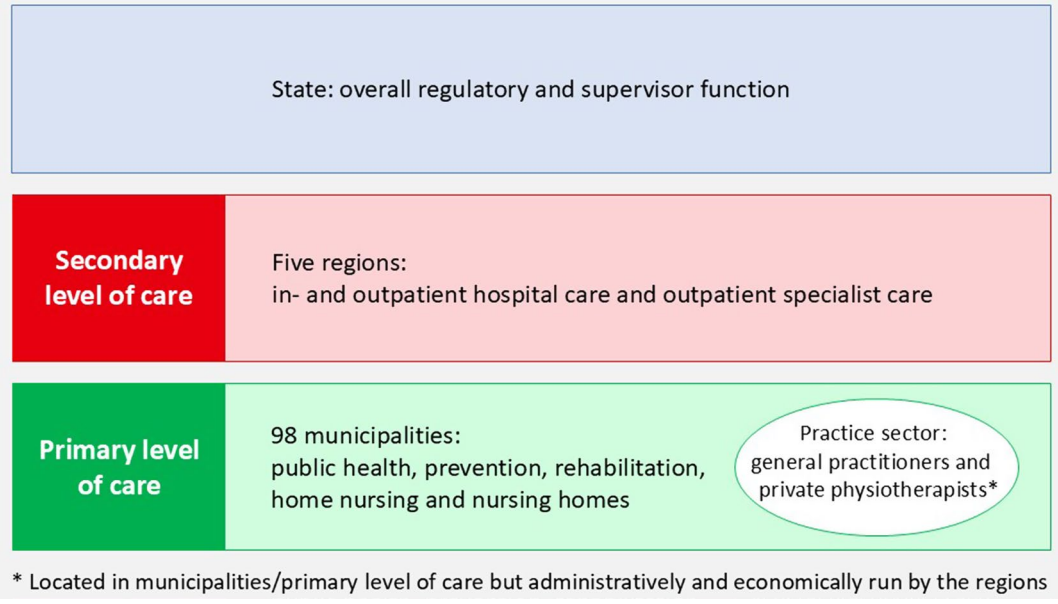

Fig. 1 The Danish Healthcare System

methodological approach, such as applying theories and methods and considering elements rather than one entire approach [23].

We used the concept "work " from IE [24, p. 151] to explore how health and social care professionals establish coherent rehabilitation pathways. Health and social care professionals' work refers to any activity, including emotional work, thinking, physical work or communicative action [23, 24].

By exploring work through the lens of IE, professionals will act with "consciousness, mind, thought and subjectivity" [24, p. 25]. In keeping with IE [23, 24], our study focused not only on the individual professionals' work to establish coherent rehabilitation pathways; we also aimed to explore how structural factors influence the professionals' work.

IE considers individuals' work and structural factors in an organisation important. In the current study, this means that the professionals' work cannot be explored in isolation but must be considered together with structural factors. To explore how structural factors influence the professionals' work, we also examined "ruling relations", which equates the structural factors in IE. "Ruling relations" are "forms of consciousness and organization that are objectified in the sense that they are constituted externally to particular people and places" [24, p. 13].

The Standards for Reporting Qualitative Research" criteria have guided the reporting of this study [27].

Table 1 Observed situations, content and professional represented

Content	Number of situations ($n=24$)	Professionals
Before admission to the rehabilitation stay		
Dialogue, assessment, goal setting and action planning	1	Rheumatologist, nurse, physiotherapist and occupational therapist
Dialogue, assessment, goal setting and action planning	3	Nurse, rheumatologist
Dialogue, assessment, goal setting and action planning	1	Physiotherapist and occupational therapist
Dialogue, assessment, goal setting and action planning	1	Physiotherapist
Dialogue, assessment, goal setting and action planning	1	Occupational therapist
Dialogue, assessment, goal setting and action planning	1	Rheumatologist
During admission at the specialised rehabilitation hospital		
Physical exercise (individual and group-based)	1	Physiotherapist and occupational therapist
Physical exercise (individual and group-based)	4	Physiotherapist
Patient education regarding illness and pain management (group-based)	2	A nurse and a nursing assistant in each session
Dialogue regarding opportunities for support from social care	2	Social worker
Multidisciplinary conference	2	Rheumatologist, nurse, physiotherapist and occupational therapist
Multidisciplinary conference	1	Nurse, physiotherapist and occupational therapist
Informal meeting	1	Nurse
Meeting regarding discharge	1	Rheumatologist, nurse
Meeting regarding discharge	2	Rheumatologist

Setting, participants and recruitment

Setting

During a previous study, we investigated 11 clients' experiences of barriers and facilitators in achieving coherent rehabilitation [10]. The present study continued following these 11 clients during a two-week inpatient rehabilitation stay at a rheumatology hospital providing specialised care across all of Denmark's five regions.

Participants

We aimed to include professionals representing different disciplines from the municipalities, public hospitals, and the rheumatology hospital and who had provided health and social care to the 11 clients from the previous study [10]. Thus, the professionals participating in the present study were professionals the 11 clients had met before and during the rehabilitation stay.

Recruitment

The starting point and recruitment in the present study was participant observations [18, 19] of situations in which the professionals interacted with clients during the rehabilitation stay. The criteria for referral to the specialised rehabilitation stay is an assessment that there is a rehabilitation potential. Among the clients, referred for a rehabilitation stay, we included those with complex care needs as they involved a diversity in contacts to various professionals. To reflect sample specificity and aim, a variety of interactions with various health professionals at the hospitals were selected for observation across the 11 clients (pre-assessment meetings, goal setting, clinical encounters with a rheumatologist, nursing staff, occupational therapists or physiotherapist, consultations with a social worker). In total, 24 situations involving interactions between professionals and clients were observed. Although the interactions were planned as formal conversations, some situations were more informal. Please, see Table 1.

At a former research employee Tine Mecklenborg's (TM) request, the 11 clients were asked to choose 2–3 professionals to approach in terms of participation in semi-structured interviews in the present study [20–22] if the clients considered, that the professional had helped

them establish coherence during their entire rehabilitation pathway. This approach can be described as similar to snowball sampling [28].

In total, 30 social and healthcare professionals across primary and secondary levels of care were selected by the 11 clients to be invited to participate in the semi-structured interviews [20–22]. Eight of these professionals could not be identified, declined to participate, or were no longer employed. Of these, 4 were General Practitioners (GPs). We decided to substitute the four appointed GPs, who had declined to participate with four others to ensure GP representation in the study. These four new GPs were selected based on their knowledge and experience of working with clients with IA. In total, 26 professionals participated in the interviews. Please, see Table 2 for the characteristics of these participants.

Data generation - focused participant observations

The focused participant observations [18, 19] aimed to investigate the work of the professionals whilst interacting with clients and colleagues. Focused observations are limited observations to specific subjects and settings. Conventional ethnography investigates entire societies or cultures [18]. In focused observations, only situations where the interactions between the professional(s) and the client concerning creating coherent rehabilitation pathways were observed. The observations encompassed meetings in which the professionals and their colleagues discussed and planned interventions with clients during the rehabilitation stay. Observations were also conducted when professionals had conversations during tests, examinations, physical exercise, under supervision, or with group-based patient education.

Table 2 Characteristics of the interview participants and their organisational affiliations

Workplace (*n*)			
Professions (*n* = 26) *	**The specialised rehabilitation hospital**	**Municipalities**	**A public hospital**
Rheumatologist (3)	2		1
GP (4) **		4 (from 3 municipalities)	
Social worker (2)		2 (2 different)	
Physiotherapist (10)	3	7 (5 different municipalities and 2 from the same municipality)	
Occupational therapist (1)	1		
Nurse (4)	3	1	
Nursing assistant (2)	1	1	

n = number; GP = General Practitioner

*In Denmark, rehabilitation is not a medical specialisation for physicians anymore. At hospital level, taking part in rheumatology rehabilitation is part of the rheumatologists' role

**General Practitioners have a coordinating role in primary level of care

The situations were observed by TM ($n = 21$) and first author, Helle Feddersen (HF) ($n = 3$).

During the observations, the focus was on the actual actions taken by professionals as they worked to establish coherence for clients.

The professionals were familiar with the observers, due to their affiliation with the research department at the specialised rehabilitation hospital but they had never worked together in any clinical capacity. The clients involved in the situations observed may have been familiar with TM from an earlier study [10].

During the participant observations [18, 19], the observer focused on what the professionals in the rehabilitation hospital actually did when they worked to establish coherence across primary and secondary health- and social levels of care.

The observer had prepared short notes regarding issues raised in the previous client interviews before or in the beginning of their rehabilitation stay. The observer paid close attention to the professionals' work and how ruling relations influenced this work. During the participant observations [18, 19], the observer took quick handwritten field notes [29] where it felt natural and aimed to focus on disturbing the communication as little as possible. Along with the observations, reflective field notes were conducted to help the observer to remember thoughts and concerns in the observations [29]. Additional notes were prepared later as descriptive field notes [29].

A total of 37.75 h was used on focused observations, excluding waiting time before, between and after formal meetings with various professionals (See Table 1).

Data generation– semi-structured interviews

The interviews were semi-structured [22] with planned questions that could lead to further open-ended questions. An interview guide was prepared and adapted slightly for each interview. Some questions were common to all interviews, whereas others were individualised. Questions were chosen based on previously published studies [1, 4, 5, 8–11] about rehabilitation and chronic illness. More individualised questions were prepared based on information from observations or previous interactions with the client about their experiences with the social and healthcare system [10]. See Table 3 for an example of an interview guide.

All professionals except for the 4 extra GPs had worked with the clients before the 2-week rehabilitation stay. All professionals except the GP's and therapists from the rehabilitation hospital had the opportunity to follow up with clients in planned outpatient consultations, after the rehabilitation stay.

Table 3 Example of an interview guide with common and individualised questions

Content	Questions
Introduction	Welcome, aim and introduction
Information before admission to the rehabilitation stay	Tell us about your contact with [client name] during her illness and rehabilitation (from your initial contact) •What were your activities - describe your role? •How were these activities performed? •How is your work documented? •What guides your actions– are there written guidelines? (referral, content, scope)? •Who did you work with, and how (verbal/written contact)? •What worked well/less well (and why)? •How did you overcome challenges?
Information after discharge from the rehabilitation stay	How did you follow up after the rehabilitation stay? •Did you include any information from the program or other written documents in further actions? Did the admission at the rehabilitation stay any impact? - Request for the provision of handmade shoes or customised insoles? (Individualised question) - Discharge summary [client name] (Individualised question) •Have you been in touch with the rheumatology hospital or [client name]? (Individualised question) •How has the subsequent contact with [client name] been? •What is your role in follow up after discharge from the rehabilitation stay?
Closing	•Do you want to add anything more about your professional role in providing coherence for clients? Is there anything we have missed or not discussed?

In total, 22 interviews were conducted face-to-face, 3 interviews were online with camera and 1 interview was online without camera.

The face-to-face interviews were conducted at the workplace or online, according to personal preference. All interviews were digitally recorded and transcribed verbatim. The interviews had an average length of 43 min (31–69 min). The interviews were led by TM($n = 22$) and Co-author, Camilla Vestergaard Aarøe, CVA ($n = 4$).

The interviews with professionals from the specialised rehabilitation hospital were closely connected to the observations. Some of the interviewed professionals referred to observed situations or to their interactions with the involved clients from the previous observations, however information from the interviews were not present during the observations.

Reflections on information power regarding evaluation of the study aim, sample specificity, quality of dialogue, use of established theory, and analysis strategy [30], guided recruitment and when to halt the inclusion of interview participants and observations. The combination of semi-structured interviews and focused participant observations adhere to study aim and sample specificity in information power [30]. The combination of more than one data generation method add breadth and depth to the analysis and allows a more comprehensive understanding of a phenomena [28, 31–34].

Analysis

The analysis started with reading and re-reading the fieldnotes and the transcribed interviews focusing on the "work" [24] of the professionals.

The analysis continued by searching for disjuncture in the interviews or field notes. Disjuncture refers to disconnections between individual experiences, such as work, and how ruling relations impact professionals' work [24]. Disjuncture describes different versions of reality and is defined as "knowing something from a ruling versus an experimental perspective" [35, p. 48].

As proposed in the Nordic version of IE [23, 26], we applied an abductive interpretation [26, 32]. The abductive interpretation was a creative dialectic process examining data and existing theoretical perspectives to produce new insights [32].

Induction is used in a data-driven/empirical analysis, but Timmermans and Tavory argue that this kind of analysis will only deliver "facts" [36]. In a theory-driven analysis, existing and predetermined theoretical knowledge is used, but there is a risk of losing new insights with creative interpretations [36]. The advantage of using abductive interpretation is utilising creative dialogue between the empirical data and existing theoretical knowledge to gain new insights.

We applied abductive interpretation, initiating the analytic process with an empirical/data-driven approach without any specific and predetermined theoretical perspective, by immersion in the data. We wanted to identify the professionals' "work" that establishes coherent rehabilitation pathways, and then in the next phase, we searched for "disjunctures".

The abductive reasoning was applied as the interpretation was tried using theoretical knowledge about person-centred care (PCC) [37–42]. We realised that the PCC approach is a significant part of Integrated care (IC) [2, 37]. Therefore, we were inspired to include IC in our interpretation. In a creative dialogue between our data and the concepts of PCC and IC, we went back and forth between our data and the theoretical concepts in an iterative manner that enriched our interpretation of the data.

The software program NVivo, version 1.4.1 [43] facilitated this structured analysis process.

Person-centred care

The PCC concept focuses on an individual's needs, preferences, and values rather than favouring the preferences of the healthcare system or the professionals [12, 37–42]. PCC stresses that providers must take an individual, respectful and holistic approach when they engage with persons/clients [12, 38, 41]. This approach highlights the importance of establishing a good relationship between provider and client [42].

Integrated care

The concept IC focuses on ensuring professionals' coordination and communication are evident, avoiding fragmentation in the rehabilitation process, and enhancing the quality of care and client satisfaction with the system's efficiency [2, 44]. IC is "an approach for individuals or populations where gaps in care, or poor care coordination leads to adverse outcomes and care experiences" [2, p.12]. The PCC approach is a significant part of IC [45, 46].

Author team

The author team consisted of 4 healthcare professionals with extensive experience working with IA and 2 clients with IA. These clients were patient research partners from the specialised rehabilitation hospital. They participated in planning, analysing, reading, and commenting on the draft versions and approved the final manuscript. The first author conducted the initial coding, and the entire team was involved in the final analysis. All authors participated in the drafting and approval of the article.

Ethical considerations

In accordance with the Declaration of Helsinki [47], the participants received verbal and written information about the study from the interviewer. Informed verbal consent was obtained from participants before the observations, and written consent was obtained before the interviews. Participants were anonymised by only referring to their professional background. In accordance with Danish legislation (LBK nr 1338 af 01/09/2020, [Bekendtgørelse af lov om videnskabsetisk behandling af sundhedsvidenskabelige forskningsprojekter og sundhedsdatavidenskabelige forskningsprojekter] Promulgation of the law on scientific ethical treatment of health science research projects and health data science research), formal ethical approval was not required because no biomedical material was included [48], and The Regional Committees on Health Research Ethics in the Region of Southern Denmark waived the need for formal approval.

Data management was registered by the Danish Data Protection Agency (Ref. no.: 2015-57-0008 and later Ref. no.: 2018-529-0001). Data were stored and analysed in OPEN Analysis [49], which is a regional system that complies with current national and European General data protection regulations [49].

Results

The analysis derived three themes: (1) Person-centred interactions with clients, (2) inter-dependent interactions between professionals, and (3) economic and cultural frameworks influence professionals' work.

The first two themes reflect the analysis using the concept of work in IE [24]. The third theme was derived from searching for disjuncture and ruling relations in the analysis. In the following, each theme is described in more detail and is illustrated by selected quotations and field notes. Healthcare professionals have used "patient" rather than "client" in the direct quotes describing the results below.

Person-centred interactions with clients

The initial analysis identified that the concept of PCC accurately reflected the approach professionals try to achieve when working towards coherence in rehabilitation pathways. The professionals' interactions with clients focus on each individual with respect for their norms, values, and wishes, which aligns well with the PCC approach [12, 37–42]. One of the professionals explained how he prioritised focusing on the client's perspective:

> *I care deeply about the patient's perspective because sometimes you have a tendency as a physiotherapist or healthcare professional to take your own……what do you call it…(thinking pause) agenda I suppose, as a starting point. So, I think you need a sort of different approach. You have to get into the patient's shoes and focus on the patient's agenda. (Private physiotherapist 1, municipality A)*

A recurring feature was the crucial importance of the professionals in encouraging good relationships and client confidence in light of the chronic nature of their illness. One professional expressed it as follows:

> *[Client name] is what's called a subsidised patient, so [free physiotherapy] is something you're given and can keep doing. That's why, as a therapist, it's really important to foster a relationship. A relationship that both she and I can maintain for a long time… Listening to her, …. I spend much energy on that. (Private physiotherapist 2, municipality B)*

The professionals reflected on the dilemmas when their professional competencies did not fit the client's wishes. One of the physiotherapists from the hospital talked about a recently diagnosed client who was very fatigued

and affected by pain. The physiotherapist assessed that the client may have lacked insight into her own health and needed education and medication to improve gait function. However, the client preferred physical exercise and upon the professional's reflection on the goals the comment was:

> *So…we really want to give her some information about what might benefit her to work on. In physiotherapy, it's especially her feet and her gait…I'm wondering if we managed to reach the goal that we set together? I mean, was [client name] in complete agreement? And I actually think not. I actually don't think she agreed. (Physiotherapist 1, rehabilitation hospital)*

When considering clients as independent and active individuals, concerns arose as to the clients' degree of responsibility and ability to manage, coordinate and follow up rehabilitation interventions. A GP said:

> *In reality, the patient should, as far as possible, be in charge and take responsibility for their own illness. But in reality, to be proactive, participate in discussions, and be a co-player with hospital doctors, not everyone can. Some people are more challenged than others in taking charge, understanding, and acting on the available options. (GP 1, municipality C)*

Inter-dependent interactions between professionals

The professionals depended on exchanges of information with others to deliver and coordinate the correct examinations, tests, and quality of care or treatment. In this regard, coordination with other professionals is crucial and aligns with the principles of IC [2]. The professionals in our study work with service delivery of clinical tasks, and these data were interpreted within the breadth of IC. The term "breadth" of IC [44], refers to horisontal and vertical integration of organisations. Horisontal integration occurs when organisations or units at similar levels work together. Vertical integration describes the process of professionals working across different organisations at different health and social care work levels. Vertical integration is a major characteristic of IC [44].

Professionals depend on collaboration, both internally within the same department and between departments, reflecting horisontal integration [44]. Horisontal integration was exemplified by a rheumatologist describing the importance of a nurse's role before a client consultation. He said:

> *Typically, they [clients] are referred here and in our case for some preliminary examinations by the nurses… He [client] has been to see one of my nurses to start with … so when [client] call on me for the first time, we have results of blood tests, X-rays, MRIs, and so on. (Rheumatologist 1, regional hospital)*

Professionals identified the importance of collaboration in providing coordination of services. One of the interviewed physiotherapists undertook the task of coordinating services during clients' admissions which can be interpretated as horisontal integration in IC [44]. The physiotherapist said:

> *The physiotherapist is chiefly responsible for planning the team program. So, I prepare weekly schedules for everyone, which includes training and education by the occupational therapist, the dietitian, social worker, doctors, nursing staff …It needs to be coordinated so that they [the professionals] have the time they need during these weeks. We need to find a time slot and room for the people who will be doing the teaching. (Physiotherapist 2, rehabilitation hospital)*

Another important aspect was the dependency on collaboration between professionals across organisations, corresponding to vertical integration in IC [44]. An example of this was expressed by a GP:

> *I am the link … I recently had a man with rheumatoid arthritis who had a severely swollen finger, and I called the rheumatologist on duty and said, 'What do I do about this? Should I just treat it with medication, or do you guys want to see him [the client]?' No, that was fine, I should just go ahead… then he [the client] came back a fortnight later and things had taken a turn for the worse. I called again and he got an appointment for the next day, so the collaboration was really great. (GP 2, municipality D)*

Furthermore, some professionals depended on referrals, documentation, or written assessments from others to legitimise interventions considered necessary for the client. This kind of dependency and vertical integration in IC [44] between the two represented organisations is represented in an example where a social worker from the municipal job centre, needed a medical assessment from the client's GP, to adapt the job to the client's functional level. She put it as follows:

> *He's [GP] the person who is responsible for referring to here, there, and everywhere… So he's the key person. … I write an extensive report for the GP, telling him what we are seeing [municipal, department for work], what have I seen in the records from the psy-*

chiatric ward and the rehabilitation hospital. It's also to guide him [GP] to the points I think he should pay attention to… The more research I do, the better answers I get back. (Social worker 1, municipality A)

Some professionals described poor communication between primary and secondary levels of care. A GP described feelings of inability to fulfil the role of having knowledge and overview of the clients' coherent pathway. He said:

Well, I'm not always aware of whether they [the clients] have been on a rehabilitation, and I think that's kind of a pity, eh, because it's sort of agreed on behind my back. A lot of time can go by before the patient says, 'Well, I also got much better when I spent a week at the rheumatology hospital.' I think– you stayed there? And they [the client] find it a bit odd that I didn't know about it, which makes sense. (GP 3, municipality C)

Lack of collaboration between the professionals meant that it was not always possible to establish coherence in the rehabilitation processes:

When considering interdisciplinary collaboration, it is very much that we each do our own thing. We set out an interdisciplinary goal together, but there won't be a joint evaluation on that [goal] in the end [involving all professionals]. I would like to have a shared ending that we all participate in. Because I think that would give the patient something extra, to round things off, to experience that connection. (Nursing assistant 1, rehabilitation hospital)

One of the clients repeatedly expressed a need for more help in the home after discharge. She requested additional assistance for personal care such as compression stockings and getting in and out of bed. The following field note demonstrates the nurse's intentions to follow up on this request.

The nurse nods and makes continuous notes. The nurse looks at the client and says she will now talk to other multidisciplinary colleagues and says, "we have to try what is possible" and "whether it can be more systematised." The client complains that in X-town "they think you're attacking them" … and explains that she was told [by the head of home care] that "it's not normal for a citizen to just call her like that" and that, "no one has said I'm normal".

The nurse says she will discuss it with the hospital social worker and would like to call and write to the municipality,… (Field note).

In relation to above, the observer made the following reflective field note:

Is more done for some clients? Is there too much consideration given? Does the practice change? Is more done for, for example for this patient I am following in this case? For example, will the nurse call the head of home care in municipality, which she does not always do, or is this happening because the client is well-informed about their rights and clear about expressing their wishes? (Field note).

In addition, a social worker took the initiative to arrange a meeting for the client above. This field note describes an informal hallway meeting between the social worker and the client.

The social worker briefly comes in and says that she would like to "make an appointment with the two of us" [the client and the observer], and we agree that the client will have a conversation with her at 9:30 AM on Wednesday. (Field note)

Reflective field note: The social worker addresses "the two of us." Do the professionals, see me [observer] as a part of the professional staff? (Field note)

Economic and cultural frameworks influence professionals' work

The professionals experienced that they could not always meet the clients' care needs because of structural issues such as organisational requirements for cost reductions, increased efficiency or documentation of services and outcomes. These demands led to a lack of time to prepare, implement, and follow up on communication with clients and to communicate and coordinate with other professional partners. The quotation below demonstrates how organisational regulations restrict the professional's ability to provide coherent services. He said:

The statistics will show if we provide too many individual treatments, as the cost per patient gets too high… You get a reprimand, where you are told that we can see that you are above average. In that case, I was told to correct things. …Then they [the Region] withdrew [the money]. That means you're being penalised financially. (Private physiotherapist 3, municipality F)

Demands regarding efficiency and lack of time meant that the professionals felt challenged. Lack of time decreased their possibilities to meet the clients as persons and create coherence in their rehabilitation pathways. The professionals needed time to prepare consultations and physical training, to get an overview of the clients' previous contacts with various professionals across primary and secondary level of care, and to ascertain why contact had been necessary.

This is illustrated by the following quotation:

> *We have about ten to fifteen minutes to prepare for these patients. But, often, I also have to get loads of practical things done within that amount of time. (Physiotherapist 3, rehabilitation hospital)*

During an interview, an occupational therapist explains that they offer a programme consisting of three educational sessions, where the first is about aiding assistance devices, the second about working positions, and the last about car adaptations. The occupational therapist states:

> *It is purely coincidental … that the second [training session] is about working positions and how to try out a lot of chairs, and that's what it's about, the issue she [the client] has, isn't it?….*
>
> *The interviewer asks: I: Okay, but those frameworks, are they described in writing?*
>
> *The occupational therapist responds: Yes, they are … We have, I mean, we have detailed descriptions of the resources we have, so we don't actually have the possibility for those individual ones, and if there are significant individual needs, then it requires a new admission. (Occupational therapist 1, rehabilitation hospital)*

In addition, requirements to document the provided care took time away from being able to establish a good relationship with the client. One of the professionals puts it this way:

> *A lot of the documentation that we provide may be accurate in terms of safety, but from a time perspective, it [documentation] drains so much energy from our contact with the patient. What I consider to be an ultimate core task, the relational work with the patient is diminished. (Rheumatologist 1, rehabilitation hospital)*

At the start of the rehabilitation stay, a team of professionals meet the client to assess and define goals. The fieldnote describes how professionals propose various services linked to their professional skills.

> *The occupational therapist asks the client the most important thing for her concerning knowledge. She replies that the most important thing for her is to sleep better and that her neck is the main problem …The physiotherapist says that the focus during the hospitalisation will be on the neck, and that the physiotherapists will focus on increasing the mobility of the neck a bit. … Earlier in the conversation, the client stated that she has weight issues and asks if the breathing problems could be related to weight. When she asks again why she has breathing problems, and the doctor says the cardiologists are examining her because they are specialists, and it can't be done here. The occupational therapist continued by saying they would look at her sleeping posture. The nurse says that the nursing staff will look into diet and weight. Without addressing the question to any particular person in the room, she asks if it would be appropriate for [client name] to participate in a group osteoarthritis seminar [held by the nursing staff during the rehabilitation stay]. The doctor says that pain relief might be more important. The nurse says that one thing to take care of is enough, but immediately concludes that they can try to achieve both, however the client is not involved in that discussion. (Field note)*

This field note demonstrates a client trying to understand whether there was a connection between her various symptoms and problems, and the professionals offering many different activities without coordinating them verbally to clarify the connection with the client. In addition, the client was minimally involved in the conversation. How the professionals collaborated can be seen as a traditional and culturally created way of collaboration between different professions [25]. The field note clearly demonstrates the traditional areas of focus for specific professionals, which can be seen as a culturally conditioned method of collaboration. This means that the values and norms each professional group bring to a collaboration can be interpreted as a traditional division of interests based on the professionals' work. The physiotherapist's area of interest is physical functioning, the occupational therapist focuses on sleep positions and special pillows to achieve good sleeping positions, the physician focuses on an examination of breathing problems and pain management, and the nurse's focus is on group-based arthritis seminars and weight loss. The field note shows that the conversations between the professionals reflect how each profession contributes with their particular expertise, with no involvement of the client.

Some of the professionals reflected on whether the use of guidelines limited their opportunities to engage with the clients with a PCC approach. A physiotherapist explained:

> *There are a number of things we do differently; that is, what we need to do according to regulations and guidelines…We have the same guidelines as everyone else. But we have a manager who… becomes frustrated if she hears someone say: "well, we usually do this" … She's not too keen on that, so I think that whole approach [of not doing as they usually do] is just hugely motivating and encouraging for us as colleagues. We are allowed to do the things we want to do. We just need to be able to argue professionally why it's a good idea in this context… (Private physiotherapist 4, municipality G)*

Discussion

The findings show that the professionals work to establish coherent rehabilitation pathways by using a PCC approach. In addition, they try to collaborate with colleagues across primary and secondary levels of care.

Briefly summarised, our analysis shows that professionals face challenges in providing person-centred care and collaborating with colleagues across primary and secondary health and social care levels. A physiotherapist experiences that statistics are used to monitor services and impose financial penalties if services do not fall within an average range. Lack of time reduces opportunity to prepare for consultations by reviewing clients' previous courses of treatment, thereby hindering coherent rehabilitation pathways. The shortage of time also results in lowering prioritisation of relational work with clients. A formal description of resources can prevent an occupational therapist from providing individually tailored guidance. Cultural aspects, such as traditions and habitual ways of working and collaborating, also make it difficult to establish coherence in patient care pathways.

These findings document dilemmas professionals must navigate in their work to establish coherence in the rehabilitation pathways. While they strive to meet the clients with a person-centred approach, sometimes it is difficult to combine PCC with professional competencies and identity. The professionals' work depends on information and collaboration with other professionals, horisontally and vertically across departments and primary and secondary care (horisontally and vertically integration within IC). Furthermore, structural issues such as economic and cultural framework influence collaboration between professionals and clients.

International and Danish authorities, interest groups and clinicians want to embrace the principles of a PCC approach [50–53]. Despite this, our analysis indicates that this is difficult to achieve due to organisational requirements for efficiency, economic cost reductions, and cultural barriers. These difficulties are considered a disjuncture [24], which explains the paradox between striving to meet the client with a PCC approach whilst meeting requirements for time and economic efficiency. This disjuncture can be understood in light of institutional logics [54]. A logic contributes to an overall understanding of how a certain part of the world works and how individuals understand their role. Driven by individuals who produce and reproduce their view of the world through actions, logic is affected by knowledge and culture (forms of practice, basic values, discourses, technologies and things taken for granted) [54]. Institutional logic consists of four concurrent logic components [54]. Market logic states that people act rationally and that market forces will provide maximum welfare and competition to ensure cost-effective practice. Public management logic that explains the distribution of value in society and assumes that democratic processes constitute the background for a neutral and rational administration process. Medical profession logic based on a biomedical model focusing on the best possible treatment for patients and professional development within the medical profession. Finally, care logic based on a bio-psychosocial model and on the quality of life of the patient [54].

An example of multiple and conflicting logics in the current study is seen when a physiotherapist cannot offer a client individual training because of the prevailing market logic and public management logic, despite medical profession logic that considers individual treatment to be the best. Another example of dilemmas arising from the differing logics is the physiotherapist describing how a professional group decided on methods to achieve goals without fully involving the patient. This practice does not align with PCC principles; rather, it is ruled by the logic of the medical profession. Interestingly, health professionals question the sense of market logic as not all clients can take responsibility and make rational decisions [55, 56].

Our findings also highlight that culture is important in collaboration. How the professionals communicate with clients and fellow professionals can be addressed as culture ruling the professionals' actions. The challenge of culture affecting the professionals' care provision with a person-centred approach is also supported by another study [57].

In alignment with our findings, other studies reported challenges faced by professionals working with a PCC approach due to organisational structures [54]. Culture among the professionals with patient contact [57] and culture within organisations [58] may affect service development and priorities and ultimately the PCC approach. Furthermore, Dixon-woods found, that externally set

priorities such as other organisations' agendas, outside the professionals involved in care, hindered the professionals' PCC approach with clients [57].

Our study shows that each professional group contributes with their unique knowledge and skills. In a multidisciplinary approach, the focus is on every specialist contributing with their own professional culture, practices, and ethos [59]. This can result in each team member being determined to target and formulate their own assessment and treatment plans [59]. This approach increases the risk of a fragmented and uncoordinated rehabilitation care pathway.

Interprofessional teamwork differs from multidisciplinary teamwork in the demand for professionals to think outside their own professional box yet operate within traditional roles and agree upon common goals and approaches. Interprofessional collaboration creates its "own momentum and ethos" [59, p.50], and the benefit of interprofessional collaboration is synergy in the work [59, 60].

Strengths and limitations

The concept of information power [30] strengthens the internal validity of this study. Previous studies have claimed that research can be improved by combining IE with other methods and theories [23], and our study corroborates this claim. The involvement of established theories about PCC and IC in the abductive interpretation is a strength and we adhere to the requirements for information power [30]. Furthermore, by applying an abductive interpretation of data [26, 36], we have achieved analytical generalisability [61].

The combination of interviews and participant observations (sample specificity [30]), is also considered a strength of this study as the unspoken, unrecognised and unconscious may appear in the observations. The combination of interviews and participant observations are also considered as a strength in other studies [62–64]. Furthermore, observations provide insight into what is happening here and now, whereas interviews provide insight into the participants' reflections before, during and after the interview. The inclusion of professionals from different parts of the health and social system allowed us to identify innovative issues with PCC compared to previous studies, focusing on single disciplines [65].

One limitation was that the clients appointing the professionals were included from one hospital. However, clients and the professionals participating lived in various municipalities in Denmark. This may result in possible bias for this study. Two reflective field notes gave examples of these concerns. The reflective field note regarding the nurse's work to help a client to achieve more help at home after discharge from the rehabilitation stay indicates actions affected by the observers' presence. The other reflective field note regarded the social worker's meeting "with the two of us", indicated that observers may be considered as a part of the clinical staff by the professionals. Another limitation is that some of the appointed GPs were unavailable, and substitutes were accepted, thus, the direct link between the clients and the appointed professionals was lacking. However, these GPs had extensive experience on their role on coherence in rheumatology rehabilitation in primary care with patients diagnosed with IA and the GPs from various locations, generating variation in relation to the cultural context.

Conclusion

To establish coherence in the rehabilitation pathways, the professionals across primary and secondary health- and social levels of care strive to take a PCC approach when meeting clients. Furthermore, the professionals depend on communication between colleagues within and between departments and across primary and secondary health and social levels. This coherence corresponds to horisontal and vertical integration according to the IC approach. However, structural issues such as economic and cultural frameworks and differing logics may hinder a coherent, coordinated client pathway.

Based on our findings, we suggest cooperation between professionals should be "interprofessional teamwork" to establish coherent rehabilitation pathways for people with IA. This approach is characterised by professionals who work within traditions whilst thinking outside professional role, to improve coherent rehabilitation pathways for people with IA.

Abbreviations

GP	General Practitioner
IA	Inflammatory Arthritis
IC	Integrated care
IE	Institutional Ethnography
PCC	Person-centred Care

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Author contributions

CVA and HF performed data collection. LA, BM, JS, JP and HF participated in planning the study and participated in the analysis. LA, BM, JS, JP, CVA and HF participated in drafting of the article and approved the final manuscript.

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Data availability
The datasets generated and/or analysed during the current study are not publicly available, in line with Danish law, but can be made available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate
Informed oral consent was obtained from the participants before the observations, and written consent was obtained before the interviews. In accordance with Danish legislation, formal ethical approval was not required since no biomedical material was included, and an inquiry sent to the regional ethics committee confirmed this by e-mail. The study was registered by the Danish Data Protection Agency (Journal no.: 2015-57-0008 and later Journal no.: 2018-529-0001).

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

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