The ability to cross professional boundaries is an essential part of the occupational therapist's professional identity when working in acquired brain injury rehabilitation in municipal service provision

Original research article

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Background Due to changing rehabilitation pathways, patients currently spend less time in hospital and are sent back to municipal care earlier than before. Studies show that occupational therapists (OTs) experience working with patients with acquired brain injury (ABI) to be a complex process and that in some situations, they fail to believe in their own professional expertise. ***Aim*** This qualitative study aimed to explore how the professional expertise of OTs working in ABI rehabilitation in municipal service provision is understood. ***Material and Methods*** One monoprofessional focus group interview with OTs and five focus group interviews with municipal interprofessional rehabilitation coordinating units were the basis for the study. Data were analyzed using systematic text condensation. ***Findings*** A holistic view and strategically selected areas of expertise were found to characterize the work of OTs in the municipal setting. A composed base of knowledge enables OTs to be rehabilitators with multiple collaboration partners. ***Conclusion*** The OT's area of expertise within adaptation, assistive devices, and cognition is considered to be valuable in ABI rehabilitation in a municipal setting. A practical synthesis of knowledge and the practice of transprofessional collaboration and role release furthermore enable the OT to take the position of a multifarious rehabilitator.

Keywords: Municipality, Occupational Therapist, Acquired Brain Injury, Rehabilitation, Interprofessional Collaboration

Introduction

Acquired brain injury (ABI) is an injury to the brain that occurs after birth (Kamalakannan et al. 2015). It is one of the leading causes of death and disability and a major challenge for patients, their relatives, the care system, and society (Bertilsson et al. 2015; Eriksson et al. 2006; Fallahpour et al. 2015). Impairments after ABI can be both physical and cognitive. Most often, the impairments cause limitations in a person's daily life. Patients with ABI are one of the main patient groups that occupational therapists (OTs) serve. The largest subgroup are those affected by stroke (Holmqvist et al. 2009; Wolf 2011).

Over recent decades, many countries have shifted responsibility for rehabilitation from specialist healthcare in hospitals to the primary healthcare systems in municipalities (Barnes

& Radermacher 2001; Geddes & Chamberlain 2001; Holmqvist et al. 2009; Smith & Roberts 2005). This shift of responsibility has resulted in patients spending less time in hospital and being sent back to municipal care and rehabilitation earlier than before (Holmqvist et al. 2009; Jones et al. 2007). The complexity and the number of tasks carried out in municipal care have therefore increased. This increase in responsibility has caused a high demand for expertise in municipal healthcare services, and professional expertise is one of the main keys to successful rehabilitation at all levels, including ABI rehabilitation (Barnes & Radermacher 2001; Jones et al. 2007).

The goal of rehabilitation for most patients is to improve their abilities, enabling them to continue living in their home environment. Training in daily activities is considered to be the most important factor in achieving this goal (Kielhofner 2009). This training, which requires assistance from professional experts, is usually described as the main area of responsibility of occupational therapy (Hammell 2006; Kielhofner 2009; Polatajko et al. 2013), with two important components of its philosophy being activity and occupation (Crepeau et al. 2013; Dickie 2013). Hence, the OT plays an important role in the professional team that cares for ABI patients (Holmqvist et al. 2009).

Previous studies show that OTs experience working with patients with ABI to be a complex process (Blackwood & Wilson 2009; Wolf 2011). In some situations, OTs believe they lack important ABI knowledge, which leads to the feeling of not having a strong enough theoretical foundation (Holmqvist et al. 2009) when planning interventions. This, in turn, leads to a lack of confidence in their professional expertise. Additionally, Blackwood and Wilson (2009) described a lack of detail both in terms of theoretical basis for the interventions used and in scientific evidence supporting the OT's daily practice. The shift of responsibility

from the specialist healthcare services to the municipalities makes it all the more important to explore the professional expertise OTs apply when working in ABI rehabilitation in a municipal setting.

The aim of this study was to explore how the professional expertise of OTs working in ABI rehabilitation in municipal services is understood, within both interprofessional and monoprofessional settings.

Key concepts

The work of OTs in ABI rehabilitation in a municipal setting requires different forms of knowledge applied in collaboration with different professionals. The Norwegian philosopher Grimen (2008) developed the concept of knowledge synthesis. He labeled a profession's base of knowledge as homogeneous if its elements were from the same scientific discipline or the same field of knowledge. In contrast, the base of knowledge is considered to be heterogeneous if its elements are from different scientific disciplines or different fields of knowledge (Grimen 2008). Further, a profession's base of knowledge constitutes a theoretical synthesis if the integration between the different elements is based on a comprehensive theory, and it constitutes a practical synthesis if the integration is based on the requirements of the professional practice (Grimen 2008).

Evidence-based practice performance requires three elements, all emerging from the specific clinical question to be answered (Herbert et al. 2011). In encounters with patients, a practitioner should apply clinical research knowledge and their own professional knowledge and ask the patient questions about their wishes and experiences (Dijkers et al. 2012; Herbert et al. 2011; Kristensen et al. 2011b). Evidence-based practice can be challenging to

implement effectively. The theoretical domains framework pinpoints 14 domains that should be considered in the implementation of evidence-based practice. They include organizational structures, for example environmental context and resources, as well as the individual therapist's characteristics, such as knowledge, skills, professional role, identity, and belief about capability (Cane et al. 2012; Michie et al. 2005).

Professional collaboration can take different forms, from multiprofessional to interprofessional to transprofessional collaboration and, ultimately, role release (Payne 2000). Role release can be seen as being the optimal form of cooperation for professionals in a collaborative team. In the performance of role release, the professional team members make adaptations to their role to take into account and interact with the roles of the other professionals (interprofessional collaboration) and to transfer information, knowledge, and skills across professional boundaries (transprofessional collaboration). Role release furthermore requires that team members take and use aspects of the primary functions of team members with other professional backgrounds (Payne 2000).

Material and methods

To explore multiple understandings, meanings, and perspectives of the topic (Ivanoff & Hultberg 2006), a qualitative approach using focus group interviews was considered to be an appropriate method (Morgan 2012). One monoprofessional focus group interview with OTs was conducted. The work of the OT in a municipal setting reflects the importance of interprofessional collaboration during the rehabilitation process. Hence, an empirical design that approached the research question from both an interprofessional and monoprofessional point of view was considered relevant. To meet this need, interprofessional focus group interviews with five municipal rehabilitation coordinating units were added.

The study was part of the project 'Transitions in rehabilitation: Biographical reconstruction, experiential knowledge and professional expertise'. Data collection commenced in April 2014 and was completed in September 2017.

Recruitment process and participants

The study included both rural and urban municipalities in southeastern Norway. Municipality populations ranged from 5,000 to 120,000 inhabitants. All participants had experience with ABI patients. However, they held different positions in the rehabilitation process (leaders and practitioners) and were organized differently in the participating municipalities. The criteria for including OTs in a monoprofessional focus group were that they were working in a municipal service and had a minimum of two years' experience working with ABI patients. Fifteen municipalities were asked to participate. Six took part. One municipality sent two representatives, which gave a total of seven participants representing rehabilitation in both institutional settings and the patient's home. The participating OTs' experience ranged from two to 30 years. The rehabilitation coordinating units in the municipalities were primarily functional units. The units were given different names in the municipalities, although they all played the same role of coordinating and ensuring patients received the health services they needed in the rehabilitation process within the municipality. Eighteen rehabilitation coordinating units were invited to participate. Eight accepted. Focus group interviews were conducted with these eight (Slomic 2018). Six of the transcribed interviews were used in the closer study of the OT's professional expertise. One of the interviews was excluded because no OT was employed in the municipality. Five interviews were therefore included in this study. The focus groups consisted of three to five participants, mainly nurses, physical therapists, and OTs.

Focus group interviews

The focus group interviews were conducted with two moderators and lasted from 78 to 109 minutes. The OT focus group interview took place in a university meeting room and was moderated by an OT and a sociologist. The coordinating unit focus groups interviews were conducted in their respective municipalities and were moderated by a medical doctor and a social scientist. With the intention to create a concretization of the reflections as well as a common point of reference, the focus group interviews utilized vignettes in addition to the interview guide (Eskelinen & Caswell 2006; Morgan 2012). The first vignette presented a 34-year-old father with reduced balance, reduced fine motor skills, and reduced memory as a consequence of traumatic brain injury. Dysfunctions after a traumatic brain injury and stroke can be very similar. Stroke patients are one of the largest groups served by OTs (Wolf 2011); therefore, an extra vignette of a stroke patient was presented in the OT focus group interview. This vignette comprised a 69-year-old male with severe hemiplegia, neglect, dysphagia, and aphasia. He and his wife had a house with a bedroom and toilet upstairs.

Data analysis

The analysis was framed by Malterud's systematic text condensation (Malterud 2012) and was conducted by the first author and continuously discussed with the second author, who read all the transcriptions. 1) All the transcriptions were read to obtain an overall impression of the understanding of the professional expertise of the OTs working in ABI rehabilitation in a municipal setting. 2) Meaning units that addressed the expertise areas of the OT were identified and coded. 3) The contents of the code groups were condensed. 4) The contents of the condensates were synthesized into descriptions of the understanding of the OT's professional expertise within ABI rehabilitation in a municipal service provision. The results

were member checked with scholars and practitioners representing the participating professions. Examples are shown in Table 1.

[Table 1. approximately here]

Ethical considerations

This study was approved by the ethics committee of the Norwegian Centre for Research Data. All participants signed an informed consent form. The form stated that they could at any time refuse to participate, without giving an explanation and that the participants' identities would be kept confidential. The procedures followed were in accordance with the Helsinki Declaration of 1975, revised in 2000.

Findings

Four categories that address the OT's work with ABI rehabilitation in a municipal setting emerged:

Valuable expertise in a municipal setting

The overall understanding that emerged during discussions in the coordinating unit focus groups was that the OT has a specific expertise in the adaption of the physical environment. The highly visible nature of the provision of assistive devices in the municipal rehabilitation service was discussed:

> …we include the different professions in the assessing interviews, where there is mapping, and I guess the occupational therapist is often represented in these interviews to consider whether assistive devices or adaptation of the environment is necessary. (coordinating unit)

All five coordinating unit focus groups talked about assistive devices for both physical and cognitive impairments. Two of the coordinating unit focus groups also discussed the OT's expertise within cognitive training and the importance of this in the municipal rehabilitation service. The coordinating unit focus groups and the OT focus group all talked about the patient's home environment being the preferred arena for assessment and training. It was stated that the goals for rehabilitation in the municipal setting were often linked to the patient's home environment. The environment can often be adapted to compensate for physical impairments. The OT focus group further emphasized the frequency of cognitive impairments after ABI and how they are quickly revealed during observation of activities and should be taken into account when adapting the environment. OTs consider awareness training during both training sessions and environmental adaptation to be an important feature when dealing with patients who are suffering from cognitive impairments:

> Awareness training is fundamental to almost everything… to knowing, understanding, grasping … (OT)

OTs' expertise within adaptation and the provision of assistive devices is perceived to be the most visible area of expertise of their work in the municipal service provision, even though their expertise within cognitive training was discussed in two of the coordinating unit focus groups and was emphasized by the OT focus group.

Adaptation from a holistic point of view

The OT focus group stated that the OT's main focus in the rehabilitation process in a municipal setting is to uncover what is important to the patient. They described their use of activity analysis to pinpoint the demands a specific activity requires of the patient's functions and to identify the need for adaptation. Furthermore, they described clarification and the patient's prioritizing of roles as an important part of the rehabilitation process in a municipal

setting. This was not stated directly in the coordinating unit focus group interviews; however, the OT's expertise in adapting and facilitating a complex life situation with a holistic perspective was acknowledged:

> …if he [a fictitious patient] is sitting in a chair while playing, it is important for us to think: what is important to you to do with your children? Read to them? Swing on a swing in the kindergarten or kick a ball? There can be many things we should go into, so it is a bit of a job figuring out what to do, I think. Here the occupational therapist is going to do a fantastic job, I think. (coordinating unit)

Several of the participants in the OT focus group emphasized that activity analysis is used to pinpoint the patient's occupational challenges and that contributing to the solving of the occupational problem is based on a holistic perspective.

Conscious choices made on the basis of a composed knowledge base

The OT focus group talked about evidence-based practice. The OTs stressed that they strive to work in an evidence-based way, although they often feel that the complexity of the cases, which involve numerous diagnoses, make it difficult to apply the available scientific evidence. As professionals, they identified their experience-based knowledge and the patient's knowledge and involvement as the main elements of the daily practice in the municipal service provision. Several acknowledged that theories and methods were applied:

> The occupational therapist's work sometimes appears unstructured. Interventions are, however, based on structured assessments. The complexity of the cases, however, often forces the occupational therapist to pick out elements of different theories and tools and customize them to the individual case. (OT)

The OTs in the monoprofessional focus group stated that they work within an evidence-based practice but that their interventions are indeed based on several conscious choices concerning the individual case and involve both the OT's and patient's practical experience.

A rehabilitator with multiple collaboration partners

The OTs in the OT focus group labeled themselves as rehabilitators. This labeling was based on the assumption that the ideologies of both rehabilitation and occupational therapy are founded on activity and participation. The OTs added that they have several collaborative partners in the municipal setting. Who the partners are is determined by the case. The physical therapist was highlighted as being a frequent collaboration partner for the OT, both in the coordinating unit discussions and in the OT focus group. The OTs explained that they share important knowledge with physical therapists and that their respective fields of expertise complement each other well, particularly in activity-based training. With respect to the transfer of knowledge, the OTs find that they are in a good position to guide the care givers in the municipal rehabilitation service. One example was how to mobilize a patient and collaborate with care givers in the customization of a daily program for the patient:

> I am an occupational therapist… At the same time, I am more and more becoming a rehabilitator. We work in a truly interdisciplinary way in the team. We work with the same things, but seen through different lenses. We do learn a lot from each other. It is as if rehabilitation has become a profession. Occupational therapy is no longer the main role. (OT)

The OTs stress that they have a number of collaboration partners, including patients relatives. The OT focus group sums up their experience of the OT's contribution to the rehabilitation process through labeling themselves as rehabilitators.

Discussion of findings

The study aimed to draw attention to and explore how the professional expertise of an OT working in ABI rehabilitation in municipal service provision is understood interprofessionally and monoprofessionally. The findings indicate that even though the OTs' expertise in assistive devices is one of the most visible factors, their holistic perspective contributes to creating a multifarious position for them in the rehabilitation process. A diverse base of knowledge and multiple collaboration partners are described as characteristic of the OT. As discussed in the OT focus group, the role of OT requires the skill of high-level clinical reasoning to determine the best treatment for the individual patient (Fleming 1991).

Collaboration skills on the basis of a practical synthesis

The OTs were described in the coordinating units' discussions as holding various positions and belonging to a profession that works in many different fields. This perception can contribute to the role of occupational therapy being obscured (Finlay 2001). OTs furthermore indirectly confirm this assumption by partly identifying themselves as rehabilitators. The term "rehabilitator" can be interpreted as the ability to adapt or transfer knowledge in transprofessional teamwork and perform role release (Payne 2000). This assumed ability to perform role release can be due to occupational therapy's heterogeneous base of knowledge (Brown & Greenwood 1999; Grimen 2008; Spang & Holmqvist 2015). The practical synthesis (Grimen 2008) can be considered a weakness for the inexperienced OT in performing clinical reasoning and evidence-based practice (Kristensen et al. 2011a; Unsworth 2001). Nevertheless, this heterogeneity and practical synthesis can contribute to shape the OT's holistic view (Brown & Greenwood 1999; Finlay 2001). The holistic perspective may be interpreted as a necessity for OTs working within a municipal setting and in allowing them to assist in the rehabilitation process of a patient living with the consequences of ABI.

However, this heterogeneity of the knowledge base can also reinforce uncertainty around the role of the OT. The OTs' belief in their own capability and awareness of intuitive clinical reasoning (Cane et al. 2012; Unsworth 2001) can, in addition to the gained practical synthesis (Grimen 2008), be seen as important for them to establish a clear professional role and identity in the rehabilitation team in the municipal setting (Cane et al. 2012).

Three important expertise areas when working within a municipal setting

The OTs' expertise within environmental adaptation and assistive devices was frequently highlighted in the coordinating units' discussions. These are considered to be two important areas of expertise. The expertise within environmental adaptation is not unique to the OT working in the municipality but may be more visible in the municipality and private homes than in institutions, where the environment is already adapted to the disabled (Holmqvist et al. 2009; Holmqvist et al. 2014). Some members of the coordinating units furthermore acknowledged the OT's expertise within cognitive training. Cognition is a third important expertise area and was also pinpointed in the OT focus group, and it is described in previous research on OTs' contribution to the rehabilitation process of ABI patients (Blackwood & Wilson 2009; Holmqvist et al. 2009; Holmqvist et al. 2014). The participants in the OT focus group expressed that they consider the training of awareness to be fundamental to almost all occupational behaviour. Cognitive skills can be difficult to both reveal and train in an unfamiliar environment, such as a hospital, and the transferability of the trained skills from one setting to another can be challenging (Holmqvist et al. 2009). Training conducted in the patient's home environment can therefore be an important factor in enabling patients suffering from ABI to live as independently as possible. To reach this goal, the OT's capability in making use of their knowledge and skills in identifying meaningful activities and roles to the patient, as discussed in the OT focus group, can be considered an important contribution.

Methodological considerations

The focus group design was selected to obtain an understanding of the way the participants perceive the OT's contribution to the rehabilitation process (Krueger & Casey 2009). It is a limitation of the study that the stroke vignette was applied in the OT focus group only. However, the aim was not to give an in-depth presentation of the topic but more to explore (Ivanoff & Hultberg 2006; Kitzinger 1995) and describe a cross-sectional analysis to develop more insight and understanding (Krueger & Casey 2009; Malterud 2012). A triangulation of methods, for example the inclusion of observations, could have expanded the validity of the study. Nevertheless, focus groups share experiences and so express a collective view (Ivanoff & Hultberg 2006; Kitzinger 1995). Validation in the analysis is grounded in discussing ideas for the analysis with scholars and practitioners in a rehabilitation research group.

Conclusion

The OT's areas of expertise within assistive devices, environmental adaptation, and cognition are considered to be valuable in ABI rehabilitation within the municipality. Clinical reasoning, practical synthesis, the practice of transprofessional collaboration, and role release furthermore enable the OT to cross professional boundaries and take position as a multifarious rehabilitator in the rehabilitation process. Further research is needed to investigate and give a more in-depth description of the different forms of interventions provided by OTs in the rehabilitation process when working with ABI patients in municipal service provision.

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Declaration of interest

The authors report no conflicts of interest. The authors alone are responsible for the contents and writing of the paper.

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Table 1. The analytical process with examples

1. Initial themes	2. Identifying and sorting meaning units	3. Condensation	4. Synthesising	Final category
Adaptation	…then you might want to consult an occupational therapist to see: What can be done in a workplace to facilitate and adapt the environment to the function he has now, and the function he will possibly have in the future (coordinating unit)	The occupational therapist facilitates and adapts the environment according to the patient's function	The occupational therapist adapts the physical environment	*Valuable Expertise in a Municipal Setting*
The patient's interest and roles as the main focus	… and there is this thing about roles which is very important. Here in Norway, and certainly also in several other countries, we are in such a hurry to go back to work. This is in a way our identity. And he [the client case presented] is in a way, he cannot manage to be with his kids. He cannot manage to be at work. No wonder he is a bit depressed. So, in a way, he has not lost any value, that is a bit important I think I think (occupational therapist)	The clarification and prioritization of the patient's roles and resources is an important part of the occupational therapist's contribution to the rehabilitation process.	Clarification and the patient's prioritizing of roles is an important part of rehabilitation	*Adaptation from a Holistic Point of view*
Theoretical knowledge versus practical knowledge	…experiences and the patient's knowledge, I think, are the factors that fill the most, and there is less research. Now I'm lucky to work in a team with a young physiotherapist who brings us some research articles and so on. That helps a little, but there is not much about occupational therapy in them (occupational therapist)	The occupational therapist's professional experiences and patient knowledge play the main role in evidence-based practice	The professional's experience-based knowledge and the patient knowledge and involvement play the main roles in day-to-day practice	*Conscious Choices made on the Basis of a composed Knowledge Base*
Collaboration	… I think that occupational therapy and rehabilitation actually are two sides of the same thing, the basic ideology that they are based on is activity and participation, so there is not that big a difference (occupational therapist)	Occupational therapy and rehabilitation shares the basic ideology - which is activity and participation	The ideology for both occupational therapy and rehabilitation is activity and participation	*A Rehabilitator with multiple Collaboration Partners*