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Interprofessional collaboration in interdisciplinary healthcare teams: A quantitative descriptive study

Medpoklicno sodelovanje v interdisciplinarnih zdravstvenih timih: kvantitativna opisna raziskava

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Keywords: team work; healthcare professionals; mutual relationships; mutual attitude; communication

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ABSTRACT

Introduction: With the introduction of new concepts of work culture and contemporary forms of collaboration in interdisciplinary teams, inter-complementarity and understanding of the skills of each professional group have become indicators of successful interprofessional collaboration. The aim of this study was to identify the characteristics of the process of interprofessional collaboration in healthcare teams, as well as to pinpoint the key components of effective collaboration.

Methods: In this non-experimental quantitative study, we used a modified Interprofessional Collaboration Scale in order to assess interprofessional collaboration in interdisciplinary teams. Our random sample included 203 healthcare professionals. Of these, 147 (72.4%) were nurses, 27 (13.3%) were doctors and 29 (14.3%) were other healthcare professionals. Data were analysed using basic descriptive statistics, correlation coefficient (Spearman correlation), Kolmogorov-Smirnov and Shapiro-Wilk tests and Mann-Whitney U test.

Results: The results show statistically significant differences in the level of satisfaction between individual health profiles. On average, doctors rated their collaboration with nurses most positively ($\overline{x}$ = 3.03, s = 0.26) and were also satisfied with their collaboration with other healthcare professionals ($\overline{x}$ = 2.86, s = 0.22). Nurses rated their collaboration with doctors least favourably ($\overline{x}$ = 2.36, s = 0.42).

Discussion and conclusion: The results provide information on the evaluation of the current level of collaboration in interdisciplinary teams, with doctors rating this collaboration more positively and nurses being more critical in their assessment. The differences in the views and attitudes of healthcare professionals regarding the importance of collaboration indicate that there is a need for changes in formal education in the field of interprofessional collaboration.

IZVLEČEK

Uvod: Sodobni čas prinaša nove koncepte delovne kulture in nove oblike sodelovanja v interdisciplinarnih timih in prav medsebojna komplementarnost ter razumevanje spretnosti posameznih poklicnih skupin so kazalnik uspešnega medpoklicnega sodelovanja. Namen raziskave je bil ugotoviti značilnosti procesa medpoklicnega sodelovanja v zdravstvenih timih in identificirati ključne komponente dobrega sodelovanja.

Metode: V neeksperimentalni opisni kvantitativni raziskavi je bil uporabljen prirejen vprašalnik za oceno medpoklicnega sodelovanja v interdisciplinarnih timih. V priložnostni vzorec sta bila zajeta 203 zdravstvena delavca. Od tega je bilo 147 (72,4 %) medicinskih sester, 27 (13,3 %) zdravnikov in 29 (14,3 %) drugih zdravstvenih sodelavcev. Podatki so bili analizirani z osnovno deskriptivno statistiko, korelacijskim koeficientom (Spermanova korelacija), Kolmogorov-Smirnovovim in Shapiro-Wilkovim testom ter Mann-Whitneyjev U-testom.

Rezultati: Ugotovitve kažejo statistično pomembne razlike o stopnji zadovoljstva med zdravstvenimi poklici. V povprečju so najbolj zadovoljni zdravniki s svojim sodelovanjem tako z medicinskimi sestrami ($\overline{x}$ = 3,03, s = 0,26) kot z drugimi zdravstvenimi sodelavci ($\overline{x}$ = 2,86, s = 0,22). Najmanj zadovoljne so medicinske sestre s sodelovanjem z zdravniki ($\overline{x}$ = 2,36, s = 0,42).

Diskusija in zaključek: Na osnovi rezultatov smo dobili vpogled v oceno trenutne stopnje sodelovanja v interdisciplinarnem timu, pri čemer so zdravniki optimistični v oceni sodelovanja, v nasprotju pa so medicinske sestre v svoji oceni bolj kritične. Različni pogledi in odnos zdravstvenih delavcev do sodelovanja kažejo potrebo po umestitvi teme poklicnega sodelovanja v formalno izobraževanje.

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Introduction

Perfection in collaboration is a concept which is almost impossible to achieve, as healthcare professionals often hold different views on how to provide the best patient care (Schot, Tummers, & Noordegraaf, 2019). While lack of knowledge and fear of losing one's autonomy can lead to the emergence of defence mechanisms which may hinder effective interprofessional collaboration, extensive expertise in one's own profession and consideration of innovative approaches from other professions undoubtedly increases the possibility of equal collaboration (Reeves, Pelone, Harrison, Goldman, & Zwarenstein, 2017). Most authors provide a similar definition of interprofessional collaboration, namely as an enhancement of the traditional team approach to patient care (Kendall-Gallagher, Reeves, Alexanian, & Kitto, 2017) involving two or more professionals from different fields of healthcare to achieve the best treatment outcomes (Serrano-Gemes & Rich-Ruiz, 2017). This goal can only be achieved if the interprofessional collaboration approach involves all healthcare professionals and healthcare providers engaged in patient care (Ciemins, Brant, Kersten, Mullette, & Dickerson, 2016; Schot et al., 2019) to jointly strive for the formation of a so-called communicating professional team which enables collaboration by establishing optimal interdisciplinary relations.

Effective interaction between healthcare professionals brings important benefits to collaboration and consequently compensates for potential deficiencies in interpersonal relationships (Pullon, Morgan, Macdonald, McKinlay, & Gray, 2016). Without doubt, promoting collaboration and respect for the values (both professional and personal) of all professionals are activities which lead to improved collaboration (Veingerl Čič, 2017). In practice, the level of interprofessional collaboration is still unsatisfactory, as healthcare professionals too often act as individuals (Vestergaard & Nørgaard, 2018). The dominance of doctors still has professional power over other colleagues (Wieser et al., 2019), as doctors are traditionally accustomed to dominant roles, and similar perceptions held by members of other professions create barriers to changing the attitudes related to existing relationships (Bowles et al., 2016). Future healthcare professionals should therefore be guided already during their formal training to change such stereotypical assumptions through practical experience, as they can later lead to negative outcomes of collaboration (Foster & Macleod Clark, 2015).

Previous research on interprofessional collaboration in Slovenia shows that most studies still focus on the two most common profiles in healthcare (Strauss, Goriup, Križmarić, & Koželj, 2018; Rojko, 2019) and rarely on collaboration in a broader team of healthcare professionals (Korenčan, 2020).

Aim and objectives

The aim of this study was to identify the key components and outcomes of effective interprofessional collaboration and to determine how interprofessional collaboration is evaluated by healthcare professionals who are members of interdisciplinary teams. At the same time, we also examined the relationship and interconnectedness of socio-demographic variables as well as some characteristics of the work process and their impact on the level of healthcare professionals' satisfaction with interprofessional collaboration.

We formulated the following hypotheses:

H1: There are statistically significant differences between nurses, doctors, and other healthcare professionals which determine their level of satisfaction with interprofessional collaboration.

H2: There are statistically significant differences in the perception of interprofessional collaboration according to healthcare professionals' age, length of service (work experience) and working hours.

H3: There are no statistically significant differences between individual healthcare organisations (primary, secondary, tertiary level of healthcare and social care settings) and the level of satisfaction of healthcare professionals with interprofessional collaboration.

Methods

A quantitative non-experimental descriptive research design was used. Data were collected through a questionnaire survey.

Description of the research instrument

We conducted a survey using the Interprofessional Collaboration Scale (ICS) (Kenaszchuk, Reeves, Nicholas, & Zwarenstein, 2010), the aim of which is to assess interprofessional collaboration between nurses, doctors and other healthcare professionals and which is a commonly used questionnaire in research worldwide (Bowles et al., 2016; Romijn, Teunissen, de Bruijne, Wagner, & de Groot, 2016; Halbert, 2017; Wieser et al., 2019). The questionnaire is freely available online. Following a pilot study which confirmed the comprehensibility and clarity of the questionnaire, we calculated its preliminary internal reliability (Cronbach's coefficient α), which was 0.73.

The questionnaire also included socio-demographic data (gender, age, level of education, length of service) and other data related to the characteristics of work at different levels of healthcare (average total number of hours spent at work). The ICS questionnaire, consisting of 26 statements, was used to assess nurses' working relationships with doctors and other healthcare professionals (physiotherapists, occupational therapists, pharmacists (masters of pharmacy) and vice versa. Respondents were asked to

rate their level of agreement with each statement on a four-point Likert scale from 1 (Disagree) to 4 (Strongly Agree). A reliability test conducted on the final sample of all useful respondents yielded a Cronbach's alpha coefficient of 0.841, confirming the high reliability of the questionnaire.

Description of the sample

We used a random sample of healthcare professionals, comprising a total of 203 participants. Most of them were female (n = 154, 75.9%), with a mean age of 35.9 years (s = 8.94). In terms of their professional profile, most participants were nurses with secondary or tertiary level of education (n = 147, 72.4%), followed by a group of other healthcare professionals: physiotherapists, occupational therapists and pharmacists (n = 29, 14.3%) and a group of doctors (n = 27, 13.3%). In terms of the level of healthcare provision, respondents were employed at the primary (n = 40, 19.7%), secondary (n = 64, 31.5%) and tertiary (n = 78, 38.4%) levels of healthcare and in social care institutions (n = 21, 10.3%). Their years of service (average values calculated from data divided into five groups according to the number of years of work experience) totalled an average of 13.0 years (s = 0.92), and their working hours an average of 45.1 hours per week (s = 6.91).

Description of the research procedure and data analysis

The questionnaire was emailed to healthcare professionals working at different levels of the health system. Participation in the survey was voluntary and anonymous. The online questionnaire, accompanied by a statement of purpose and method of completing the questionnaire, was made available on the 1KA online survey platform from 14 October 2020 to 4 November 2020. The data from the participants' responses were collected in a database on a web server. In the process of data collection, a database of participants' responses was created, excluding their first and last names and e-mail addresses to ensure anonymity.

The empirical data obtained were processed using the IBM SPSS statistical software, version 22 (SPSS Inc., Chicago, IL, USA). The following statistical analyses and tests were conducted using this software: descriptive statistics, correlation coefficient (Spearman correlation), Kolmogorov-Smirnov test, Shapiro-Wilk test, and Mann-Whitney U-test.

Results

A comparison of the average values of scores for individual statements (Table 1) shows that, on average, respondents neither agreed nor disagreed or agreed to

Table 1: *Descriptive statistics of satisfaction with interprofessional collaboration*

Statement	$\bar{x}$	***Me***	***s***	***KA***	***KS***	***Min***	***Max***
'We' have a good understanding with 'them' about our respective responsibilities.	2.89	3	0.63	−0.61	1.20	1	4
'They' are usually willing to take into account 'our' availability when organising their work.	2.68	3	0.71	−0.57	0.29	1	4
I feel that patient treatment and care are not adequately discussed between 'us' and 'them'.*	2.39	2	0.72	−0.11	−0.36	1	4
'We' and 'they' share similar ideas about how to treat patients.	2.72	3	0.55	−0.49	0.25	1	4
'They' are willing to discuss 'our' work issues.	2.57	3	0.73	−0.39	−0.13	1	4
'They' cooperate with the way 'we' organise care.	2.45	3	0.78	−0.15	−0.45	1	4
'They' would be willing to cooperate with new practices related to 'our' work.	2.66	3	0.69	−0.44	0.16	1	4
'They' do not usually ask for 'our' opinion.*	2.63	3	0.71	−0.35	−0.02	1	4
'They' anticipate when 'we' will need their help.	2.47	2	0.72	0.04	−0.25	1	4
Important information is always passed on from 'us' to 'them'.	2.94	3	0.67	−0.18	−0.10	1	4
Disagreements with 'them' often remain unresolved.*	2.44	2	0.67	−0.26	−0.31	1	4
'They' think their work is more important than 'ours'.	2.27	2	0.84	−0.20	−0.97	1	4
'They' would not be willing to discuss their new practices with 'us'.*	2.62	3	0.63	−0.62	0.24	1	4
Total	2.60	2.62	0.41	−0.21	−0.08	1.38	3.85

*Legend: * – reverse coding; $\bar{x}$ – average; Me – median; s – standard deviation; KA – skewness; KS – kurtosis; Min – minimum; Max – maximum*

some extent with the statements measuring satisfaction with interprofessional collaboration ($\bar{x}$ = 2.60, s = 0.41) and (*Me* = 2.62). Most respondents agreed most strongly with the statements "Important information is always passed on from 'us' to 'them'" and "'We' have a good understanding with 'them' about our respective responsibilities", and agreed least with the statements "'They' think that their work is more important than 'ours'" and "I feel that patient treatment and care are not adequately discussed between 'us' and 'them'".

On average, the level of satisfaction with interprofessional collaboration between doctors and nurses was rated higher by doctors than by nurses, with the exception of the statement "Important information is always passed on from 'us' to 'them'". When we compare the perceptions of doctors and other healthcare professionals, we find that comparable to the attitude of doctors and nurses, satisfaction scores were higher for collaboration of doctors with other healthcare professionals than vice versa. Again, the only difference was observed in the statement "Important information is always passed on from 'us' to 'them'". When we compare the perceptions of collaboration between nurses and other healthcare professionals, we find that the levels of satisfaction with interprofessional collaboration are quite similar in these two groups. On average, satisfaction with interprofessional collaboration was rated highest by doctors for their collaboration with nurses ($\bar{x}$ = 3.03, s = 0.26), followed by doctors' satisfaction with collaboration with other healthcare professionals ($\bar{x}$ = 2.86, s = 0.22). Nurses expressed the lowest levels of satisfaction with their collaboration with doctors ($\bar{x}$ = 2.36, s = 0.42).

In terms of the age groups of respondents, the youngest group (up to 30 years of age) ($\bar{x}$ = 2.67, s = 0.42) rated their satisfaction with interprofessional collaboration highest, followed by the age group of 41 years and older ($\bar{x}$ = 2.59, s = 0.38) and the age group between 31 and 40 years ($\bar{x}$ = 2.54, s = 0.42). In terms of the length of service, respondents with the least work experience (up to 10 years) ($\bar{x}$ = 2.63, s = 0.43) and respondents with the most work experience (21 years or more) expressed the highest satisfaction with interprofessional collaboration ($\bar{x}$ = 2.63, s = 0.37). On average, the group with between 11 and 20 years of service was the least satisfied ($\bar{x}$ = 2.52, s = 0.40).

For each of the two correlations, we used the Mann-Whitney U-test to test whether the differences in the mean values for each statement were also statistically significant (Table 2). Based on the results of the comparison between doctors' ratings of their

Table 2: *Comparative analysis of relations*

Statement	***ZM-MZ***		***DZ-ZD***		***MD-DM***	
	U-test	***p***	***U-test***	***p***	***U-test***	***p***
'We' have a good understanding with 'them' about our respective responsibilities.	1260.0	< 0.001	362.5	0.585	2034.0	0.626
'They' are usually willing to take into account 'our' availability when organising their work.	837.5	< 0.001	291.5	0.030	1978.0	0.439
I feel that patient treatment and care are not adequately discussed between 'us' and 'them'.*	1219.0	0.001	234.0	0.004	2073.0	0.798
'We' and 'they' share similar ideas about how to treat patients.	1473.0	0.014	378.0	0.749	2124.0	0.970
'They' are willing to discuss 'our' work issues.	848.5	< 0.001	275.0	0.018	1692.5	0.047
'They' cooperate with the way 'we' organise care.	422.0	< 0.001	247.5	0.005	1651.5	0.033
'They' would be willing to cooperate with new practices related to 'our' work.	797.0	< 0.001	331.0	0.201	1836.5	0.152
'They' do not usually ask for 'our' opinion.*	653.0	< 0.001	226.5	0.002	1855.0	0.197
'They' anticipate when 'we' will need their help.	669.0	< 0.001	208.5	0.001	2100.0	0.889
Important information is always passed on from 'us' to 'them'.	1295.5	0.003	378.0	0.794	1657.5	0.029
Disagreements with 'them' often remain unresolved.*	1607.0	0.087	297.0	0.079	1873.0	0.245
'They' think their work is more important than 'ours.'	336.0	< 0.001	220.0	0.001	1725.0	0.065
'They' would not be willing to discuss their new practices with 'us'.*	1265.0	0.001	278.0	0.011	1763.5	0.087
Total	298.0	< 0.001	183.0	0.001	1995.5	0.586

*Legend: * – reverse coding; U-test – Mann-Whitney U-test; p – statistical significance; ZM-MZ – comparison of assessment between doctors with nurses - nurses and doctors; DZ-ZD – comparison of assessment between other healthcare professionals with doctors - doctors with other healthcare professionals; MD-DM – comparison of assessment between nurses with other healthcare professionals - other healthcare professionals with nurses*

Table 3: *Average level of satisfaction with interprofessional collaboration by level of healthcare provision*

Statement	*Level of healthcare*			
	Primary	*Secondary*	*Tertiary*	*Social care institutions*
	$\bar{x}$ *(s)*	$\bar{x}$ *(s)*	$\bar{x}$ *(s)*	$\bar{x}$ *(s)*
'We' have a good understanding with 'them' about our respective responsibilities.	2.99 (0.52)	2.89 (0.67)	2.90 (0.67)	2.69 (0.56)
'They' are usually willing to take into account 'our' availability when organising their work.	2.76 (0.72)	2.68 (0.60)	2.63 (0.80)	2.76 (0.62)
I feel that patient treatment and care are not adequately discussed between 'us' and 'them'.*	2.56 (0.78)	2.45 (0.69)	2.24 (0.73)	2.43 (0.63)
'We' and 'they' share similar ideas about how to treat patients.	2.79 (0.47)	2.76 (0.51)	2.67 (0.62)	2.69 (0.52)
'They' are willing to discuss 'our' work issues.	2.74 (0.65)	2.55 (0.64)	2.55 (0.81)	2.40 (0.73)
'They' cooperate with the way 'we' organise care.	2.48 (0.67)	2.53 (0.72)	2.40 (0.88)	2.36 (0.79)
'They' would be willing to cooperate with new practices related to 'our' work.	2.70 (0.66)	2.64 (0.62)	2.67 (0.75)	2.57 (0.70)
'They' do not usually ask for 'our' opinion.*	2.74 (0.65)	2.48 (0.70)	2.72 (0.74)	2.60 (0.70)
'They' anticipate when 'we' will need their help.	2.59 (0.61)	2.40 (0.74)	2.47 (0.76)	2.43 (0.70)
Important information is always passed on from 'us' to 'them'.	3.01 (0.72)	2.98 (0.65)	2.92 (0.68)	2.81 (0.59)
Disagreements with 'them' often remain unresolved.*	2.66 (0.73)	2.36 (0.65)	2.35 (0.68)	2.57 (0.50)
'They' think their work is more important than 'ours.'	2.38 (0.80)	2.29 (0.81)	2.21 (0.91)	2.29 (0.74)
'They' would not be willing to discuss their new practices with 'us'.*	2.76 (0.62)	2.53 (0.60)	2.65 (0.67)	2.52 (0.55)
Total	2.70 (0.40)	2.58 (0.37)	2.57 (0.45)	2.55 (0.38)

*Legend: * – reverse coding;* $\bar{x}$ *– average; s – standard deviation*

collaboration with nurses and nurses' ratings of their collaboration with doctors, we found that the differences were statistically significant for all statements except for the statement "Disagreements with 'them' often remain unresolved". A comparison of healthcare professionals' satisfaction ratings regarding their collaboration with doctors and doctors' satisfaction ratings regarding their collaboration with other healthcare professionals also revealed many statistically significant differences between the groups. The lowest number of statistically significant differences was identified between nurses' satisfaction ratings regarding their collaboration with other healthcare professionals and vice versa. When we compare the mean scores for satisfaction with collaboration between individual groups, we find that the differences in mean scores for doctor-nurse and nurse-doctor collaboration and physician-other healthcare professionals (and vice versa) collaboration are statistically significant. This shows a statistically significant difference in the mean values of mutual satisfaction regarding collaboration between doctors and nurses. This also applies to the mean values of mutual satisfaction regarding collaboration between doctors and other healthcare professionals.

We found no statistically significant differences between the different age groups. However, we did find statistically significant differences between groups of different years of service. The comparison of groups with a length of service of up to 10 years and between 11 years and 20 years showed statistically significant differences in satisfaction with interprofessional collaboration. The group with up to 10 years of service was on average more satisfied than the group with between 11 and 20 years of service. There was also a statistically significant difference between the groups with 11 to 20 years of service and 21 or more years of service. Those with more work experience were on average more satisfied with interprofessional collaboration.

We also found statistically significant differences in satisfaction with interprofessional collaboration between the groups depending on the working hours. The group with the most working hours per week ($\bar{x}$ = 2.67, s = 0.45) was the group that was also most satisfied with interprofessional collaboration, while the group with 41 to 50 working hours per week was the least satisfied ($\bar{x}$ = 2.51, s = 0.42). On average, doctors reported working 49.2 hours per week, nurses 45.2 hours per week and other healthcare professionals 40.8 hours per week. The respondents with the highest number of working hours per week were on average more satisfied with interprofessional collaboration in all statements. The difference between the group averages also proved to be statistically significant.

Table 3 shows that there are statistically significant differences in the level of satisfaction with interprofessional collaboration between the primary

and secondary and between the primary and tertiary levels of healthcare.

On average, respondents working at the primary level of healthcare were most satisfied with interprofessional collaboration ($\overline{x}$ = 2.70, s = 0.40), followed by those at the secondary ($\overline{x}$ = 2.58, s = 0.37) and tertiary levels ($\overline{x}$ = 2.57, s = 0.45) and social care institutions ($\overline{x}$ = 2.55, s = 0.38).

Discussion

The results of our study show that, on average, interprofessional collaboration was rated most positively by doctors and least positively by nurses. Hierarchical relationships, which still characterise the collaboration between nursing and medical staff, often result in poor communication as well as unresolved conflicts within the professional groups (Foth, Block, Stamer, & Schmacke, 2015). Despite the fact that doctors are still at the top of the hierarchy scale, successful collaboration within teams requires the development of profession-based identity of all team members (Romijn, Teunissen, de Bruijne, Wagner, & de Groot, 2016). Using the ICS, a similar study was conducted in Italy, which found a rather heterogeneous assessment of collaboration between different healthcare profiles. Similar to our study, nurses rated their working relationship with doctors relatively negatively, but still described the collaboration as positive (Wieser et al., 2019). This paradox, which is often observed when studying the relationship between doctors and nurses, is nothing new. Therefore, more emphasis should be placed on strategies directed towards reducing this gap in collaboration, i.e., strategies which would aim to promote equality between the two professional groups and strengthen the weaker group in the relationship (Huq, Reay, & Chreim, 2017).

In terms of the length of service, many studies seem to agree that, on average, those with the most work experience and those at the beginning of their careers are the most satisfied with interprofessional collaboration (Ilić et al., 2017; Serrano-Gemes et al., 2017). Similar results were also obtained in our study, which showed statistically significant differences between the groups with different years of service.

Our comparison between the length of working hours and perception of interprofessional collaboration also revealed statistically significant differences. One possible reason why the group with the longest working hours rated interprofessional collaboration most positively is that this group mainly included doctors, who were also most satisfied with collaboration with the other two groups of healthcare professionals. Comparable results were also obtained in the study by Bowles et al. (2016), who examined potential factors influencing perceptions of interprofessional collaboration at the individual and organisational levels, and found both the length of working hours and increased workload to be positively associated with higher interprofessional collaboration scores across all professional groups of respondents.

The level of healthcare provision was also found to be an important factor, as on average, healthcare professionals at the primary level of healthcare were the most satisfied with interprofessional collaboration, while, as expected, those working in social care settings reported the lowest satisfaction with interprofessional collaboration. Similar results are also reported in a study by Pullon et al. (2016), who report that outpatient staff at the primary level of healthcare are more likely to recognise the benefits of interprofessional collaboration, as smaller and long-standing interdisciplinary teams tend to be formed in this setting, resulting in higher levels of confidence. Conversely, a study by Brečko (2018) reports higher levels of dissatisfaction with interprofessional collaboration in social care settings. The author notes that healthcare professionals' satisfaction with interprofessional collaboration at this level of healthcare can only be improved by measures aimed at improving care through a clear management vision.

As for the limitations of our study, we must note the random sample and the subjectivity of the ICS, as it is based on respondents' self-assessment of the relationship and collaboration between healthcare professionals. When interpreting the results, we also had to take into account the fact that the survey included a relatively small sample of different professional groups, as well as the fact that the composition of individual interdisciplinary teams often varies from one institution to another.

The results and findings of our study can form the basis for further research on interprofessional collaboration in interdisciplinary teams, as the relationships between different healthcare professions are also crucial for the professional development and professionalisation of nursing care. Creation of a high quality, equal and respectful relationship between different professional groups is an important element of the concept of professionalisation, and can only be achieved through an in-depth exploration of all components needed by both individuals and professional groups.

Differences in the perceptions and attitudes of healthcare professionals towards interdisciplinary collaboration show that it is necessary to make certain changes in formal education with regard to the topic of interprofessional collaboration, as interprofessional education that promotes the development of profession-based roles leads to better collaboration between healthcare professionals in nursing practice. A joint interdisciplinary curriculum which would include all students from different fields of health education should therefore be considered for the future. Such early socialisation in terms of quality collaboration would

facilitate and, most importantly, improve the culture of professional collaboration in healthcare. Further research is also needed in the field of psychometric validation of the questionnaire and its further adaptation to the cultural context of the health system in Slovenia.

Conclusion

The structure of healthcare teams has changed in recent years, and the growing demands and needs for holistic patient care also call for better synergy and collaboration between different healthcare services. The results of our study show that satisfaction with collaboration between healthcare professionals in the Slovenian cultural sphere still leaves much room for improvement. Nevertheless, individual parts of the study show that healthcare professionals are increasingly aware of the importance of a collective team identity and consequently of effective interprofessional collaboration.

Slovenian translation/Prevod v slovenščino

Uvod

Popolnost v sodelovanju je pojem, ki ga je skoraj nemogoče doseči, saj med zdravstvenimi delavci pogosto obstaja razlika v drugačnem pogledu na to, kako zagotoviti najboljšo zdravstveno oskrbo pacientov (Schot, Tummers, & Noordegraaf, 2019). Pomanjkanje znanja in strah pred izgubo avtonomije posameznika lahko povzroči nastajanje obrambnih mehanizmov za dobro medpoklicno sodelovanje; obširno strokovno znanje o lastni stroki in upoštevanje inovativnosti drugih strok pa vsekakor izboljša možnost enakovrednega sodelovanja (Reeves, Pelone, Harrison, Goldman, & Zwarenstein, 2017). Večina avtorjev medpoklicno sodelovanje opredeljuje podobno: gre za nadgradnjo tradicionalnega timskega načina zdravstvene obravnave pacientov (Kendall-Gallagher, Reeves, Alexanian, & Kitto, 2017), ki vključuje sodelovanje dveh ali več strokovnjakov različnih področij zdravstva s ciljem doseganja najboljših izidov zdravljenja (Serrano-Gemes & Rich-Ruiz, 2017). Omenjeni cilj bomo torej osvojili le, če v sodelovanje hkrati vključimo vse zdravstvene izvajalce in sodelavce, ki sodelujejo pri obravnavi pacienta (Ciemins, Brant, Kersten, Mullette, & Dickerson, 2016; Schot et al. 2019), in skupaj stremeli k t. i. komunicirajočim profesionalnim timom, ki omogočajo optimalne interdisciplinarne relacije pri sodelovanju.

Dobra interakcija med zdravstvenimi delavci prispeva pomembne prednosti na področju sodelovanja in posledično izravna morebitne pomanjkljivosti v naših odnosih (Pullon, Morgan, Macdonald, McKinlay, & Gray, 2016). Spodbujanje sodelovanja in spoštovanje vrednot (tako poklicnih kot tudi osebnostnih) vseh zaposlenih sta vsekakor aktivnosti, ki vplivata na boljše sodelovanje (Veingerl Čič, 2017). V praksi je medpoklicnega sodelovanja še vedno premalo, saj zdravstveni delavci prepogosto delujejo kot posamezniki (Vestergaard & Nørgaard, 2018). Prav tako ima pristransko gledano v odnosu do preostalih sodelavcev zdravniška dominanca še vedno profesionalno moč v odnosu (Wieser et al., 2019), saj so zadnje omenjeni tradicionalno vajeni dominantnih vlog, prav takšno doživljanje pripadnikov drugih poklicev pa povzroča ovire pri sodelovanju in onemogoča spremembo pogleda na obstoječa razmerja (Bowles et al., 2016). Zaradi omenjenega pogleda moramo zdravstvene delavce že v času formalnega izobraževanja usmeriti k temu, da skozi svoje praktične izkušnje spremenijo stereotipna predvidevanja, ki lahko pozneje implicirajo negativne rezultate sodelovanja (Foster & Macleod Clark, 2015).

Dozdajšnje raziskave medpoklicnega sodelovanja v Sloveniji kažejo, da še vedno največ raziskovanja namenjamo proučevanju dveh najpogostejših profilov v zdravstvu (Strauss, Goriup, Križmarić, & Koželj, 2018; Rojko, 2019), raziskovanje pa je le redko usmerjeno k sodelovanju v širšem zdravstvenemu timu (Korenčan, 2020).

Namen in cilji

Namen raziskave je bil identificirati ključne komponente in izide dobrega medpoklicnega sodelovanja ter s ciljem ugotoviti, kako medpoklicno sodelovanje ocenjujejo zdravstveni sodelavci, ki so del interdisciplinarnih timov. Hkrati smo tudi proučevali povezanost in preplet socialno-demografskih spremenljivk, kot tudi nekaterih značilnosti delovnega procesa ter njihov vpliv na stopnjo zadovoljstva v medpoklicnem sodelovanju.

Postavili smo naslednje hipoteze:

H1: Med medicinskimi sestrami, zdravniki in drugimi zdravstvenimi delavci obstajajo statistično značilne razlike, ki opredeljujejo stopnjo zadovoljstva z medpoklicnim sodelovanjem.

H2: V percepciji medpoklicnega sodelovanja glede na starost, delovne izkušnje zdravstvenih delavcev ter med dolžino delovnega časa obstajajo statistično značilne razlike.

H3: Med posameznimi organizacijami zdravstvene dejavnosti (primarna, sekundarna, terciarna raven zdravstvene dejavnosti in socialnovarstveni zavodi) in stopnjo zadovoljstva z medpoklicnim sodelovanjem ne obstajajo statistično pomembne razlike.

Metode

Za raziskavo je bil uporabljen kvantitativni neeksperimentalni opisni raziskovalni dizajn. Podatki so bili zbrani z anektiranjem.

Opis instrumenta

Anketo smo izvedli z vprašalnikom o medpoklicnem sodelovanju (ang. *Interprofessional Collaboration Scale* – ICS) (Kenaszchuk, Reeves, Nicholas, & Zwarenstein, 2010), ki je namenjen oceni medpoklicnega sodelovanja med medicinskimi sestrami, zdravniki in drugimi zdravstvenimi delavci in je pogosto uporabljen vprašalnik v raziskavah po svetu (Bowles et al., 2016; Romijn, Teunissen, de Bruijne, Wagner, & de Groot, 2016; Halbert, 2017; Wieser et al., 2019). Vprašalnik je prosto dostopen na spletu. Po izvedeni pilotni študiji, ki je potrdila vsebinsko razumljivost in jasnost, smo izračunali preliminarno notranjo zanesljivost (Cronbachov koeficient α) vprašalnika, ki je znašala 0,73.

Vprašalnik je vključeval tudi socialno-demografske podatke (spol, starost, stopnja izobrazbe, delovna doba) in druge podatke v povezavi z značilnostmi dela na različnih ravneh zdravstvene dejavnosti (povprečno skupno število ur, ki jih zaposleni preživijo na delovnem mestu). Vprašalnik ICS je sestavljen iz 26-ih trditev, v katerih so medicinske sestre ocenile svoje delovne odnose z zdravniki in drugimi izvajalci zdravstvene oskrbe (fizioterapevti, delovni terapevti, magistri farmacije) in obratno. Anketiranci so se za oceno trditev opredelili s štiristopenjsko Likertovo lestvico, na kateri je pomenila 1, da se s podano trditvijo »sploh ne strinjajo«, 4 pa je pomenila, da se s podano trditvijo »popolnoma strinjajo«. Test zanesljivosti anketnega vprašalnika tudi na končnem vzorcu vseh uporabnih respondentov je pokazal, da je vprašalnik zelo zanesljiv, saj je koeficient Cronbach alfa pokazal 0,841.

Opis vzorca

Uporabljen je bil priložnostni vzorec zaposlenih v zdravstvu. v katerem je sodelovalo 203 zdravstvenih delavcev. Večina jih je ženskega spola (n = 154, 75,9 %), v povprečju starih 35,9 let (s = 8,94). Glede na poklic jih je bilo največ medicinskih sester – srednješolska in visokošolska izobrazba (n = 147, 72,4 %), sledila je skupina drugih zdravstvenih delavcev: fizioterapevti, delovni terapevti in magistri farmacije (n = 29, 14,3 %) in skupina zdravnikov (n = 27, 13,3 %). Glede na raven zdravstvene dejavnosti so anketiranci zaposleni na primarnem (n = 40, 19,7 %), sekundarnem (n = 64, 31,5 %) in terciarnem nivoju (n = 78, 38,4 %) ter v socialnovarstvenih zavodih (n = 21, 10,3 %). Vsa delovna doba (povprečje je izračunano iz razvrščenih podatkov v pet skupin po številu let delovnih izkušenj) se v povprečju giblje med 13,0 let (s = 0,92), v povprečju delajo 45,1 ure (s = 6,91) na teden.

Tabela 1: *Opisne statistike zadovoljstva z medpoklicnim sodelovanjem*

Trditev	$\bar{x}$	***Me***	***s***	***KA***	***KS***	***Min***	***Maks***
»Mi« imamo z »njimi« dogovorjene skupne odgovornosti.	2,89	3	0,63	−0,61	1,20	1	4
»Oni« so pri organizaciji svojega dela običajno pripravljeni upoštevati »našo« razpoložljivost.	2,68	3	0,71	−0,57	0,29	1	4
Menim, da »mi« in »oni« ne govorimo dovolj o zdravljenju in zdravstveni negi pacientov.*	2,39	2	0,72	−0,11	−0,36	1	4
»Mi« in »oni« delimo podoben pogled o zdravljenju pacientov.	2,72	3	0,55	−0,49	0,25	1	4
»Oni« so se pripravljeni pogovarjati o temah, povezanih z »našim« delom.	2,57	3	0,73	−0,39	−0,13	1	4
»Oni« sodelujejo pri organizaciji »naše« zdravstvene nege.	2,45	3	0,78	−0,15	−0,45	1	4
»Oni« bi bili pripravljeni sodelovati pri novih načinih »našega« dela.	2,66	3	0,69	−0,44	0,16	1	4
»Oni« »nas« običajno ne vprašajo za mnenje.*	2,63	3	0,71	−0,35	−0,02	1	4
»Oni« lahko predvidijo, kdaj »mi« potrebujemo njihovo pomoč.	2,47	2	0,72	0,04	−0,25	1	4
Pomembne informacije se vedno prenesejo od »nas« do »njih«.	2,94	3	0,67	−0,18	−0,10	1	4
Nesoglasja z »njimi« pogosto ostanejo nerazrešena.*	2,44	2	0,67	−0,26	−0,31	1	4
»Oni« menijo, da je njihovo delo pomembnejše od »našega«.*	2,27	2	0,84	−0,20	−0,97	1	4
»Oni« se z »nami« niso pripravljeni pogovarjati o novih načinih dela v zdravstveni negi.*	2,62	3	0,63	−0,62	0,24	1	4
Celoten vprašalnik	2,60	2,62	0,41	−0,21	−0,08	1,38	3,85

*Legenda: * – odgovori obratno kodirani; $\bar{x}$ – povprečje; Me – mediana; s – standardni odklon; KA – koeficient asimetrije; KS – koeficient sploščenosti; Min – minumum; Maks – maksimum*

Opis poteka raziskave in obdelave podatkov

Vprašalnik smo izvajalcem zdravstvene oskrbe zaposlenim na različnih ravneh zdravstvene dejavnosti posredovali po elektronski pošti. Sodelovanje v raziskavi je bilo prostovoljno in anonimno. Spletni vprašalnik, ki mu je bilo dodano pojasnilo o namenu in načinu izpolnjevanja, je bilo mogoče izpolniti v odprtokodni aplikaciji za spletno anketiranje 1KA od 14. oktobra 2020 do 4. novembra 2020. Podatki, ki so jih anketiranci posredovali z odgovarjanjem na vprašanja, so se zbrali v bazi podatkov na spletnem strežniku. V procesu zbiranja podatkov se je ustvarila podatkovna baza z odgovori anketirancev brez njihovih imen in priimkov ter elektronskih naslovov, s čimer je bila zagotovljena anonimnost.

Pridobljene empirične podatke smo obdelali s statističnim programom IBM SPSS, verzija 22 (SPSS Inc., Chicago, IL, ZDA). Z uporabo navedenega programa so bile opravljene naslednje statistične analize in testi: izračun opisnih statistik, korelacijski koeficient (Spermanova korelacija), Kolmogorov-Smirnov test, Shapiro-Wilkov test in Mann-Whitneyjev U-test. V članku uporabljena izraza »medicinske sestre« in »zdravniki« veljata za nevtralni izraz tako za moški kot za ženski spol.

Rezultati

Primerjava povprečnih vrednosti ocen posameznih trditev (Tabela 1) je pokazala, da so anketiranci do trditev, s katerimi merimo zadovoljstvo z medpoklicnim sodelovanjem, v povprečju nevtralni oziroma se delno strinjajo ($\bar{x}$ = 2,60, s = 0,41) in (Me = 2,62). Najbolj se strinjajo s trditvama »Pomembne informacije se vedno prenesejo od "nas" do "njih"« in »Mi« imamo z "njimi" dogovorjene skupne odgovornosti«, najmanj pa s trditvama »"Oni" menijo, da je njihovo delo pomembnejše od "našega"« in »Menim, da »mi« in »oni« ne govorimo dovolj o zdravljenju in zdravstveni negi pacientov«.

Povprečne stopnje zadovoljstva z medpoklicnim sodelovanjem so večje v relaciji zdravnikov do medicinskih sester kot obratno, razen pri trditvi »Pomembne informacije se vedno prenesejo od "nas" do "njih"«. Pri primerjavi odnosa zdravnikov in drugih

Tabela 2: *Analiza primerjave povprečij med relacijami*

Trditev	***ZM-MZ***		***DZ-ZD***		***MD-DM***	
	U-test	***p***	***U-test***	***p***	***U-test***	***p***
»Mi« imamo z »njimi« dogovorjene skupne odgovornosti.	1260,0	< 0,001	362,5	0,585	2034,0	0,626
»Oni« so pri organizaciji svojega dela običajno pripravljeni upoštevati »našo« razpoložljivost.	837,5	< 0,001	291,5	0,030	1978,0	0,439
Menim, da »mi« in »oni« ne govorimo dovolj o zdravljenju in zdravstveni negi pacientov.*	1219,0	0,001	234,0	0,004	2073,0	0,798
»Mi« in »oni« delimo podoben pogled o zdravljenju pacientov.	1473,0	0,014	378,0	0,749	2124,0	0,970
»Oni« so se pripravljeni pogovarjati o temah, povezanih z »našim« delom.	848,5	< 0,001	275,0	0,018	1692,5	0,047
»Oni« sodelujejo pri organizaciji »naše« zdravstvene nege.	422,0	< 0,001	247,5	0,005	1651,5	0,033
»Oni« bi bili pripravljeni sodelovati pri novih načinih »našega« dela.	797,0	< 0,001	331,0	0,201	1836,5	0,152
»Oni« »nas« običajno ne vprašajo za mnenje.*	653,0	< 0,001	226,5	0,002	1855,0	0,197
»Oni« lahko predvidijo, kdaj »mi« potrebujemo njihovo pomoč.	669,0	< 0,001	208,5	0,001	2100,0	0,889
Pomembne informacije se vedno prenesejo od »nas« do »njih«.	1295,5	0,003	378,0	0,794	1657,5	0,029
Nesoglasja z »njimi« pogosto ostanejo nerazrešena.*	1607,0	0,087	297,0	0,079	1873,0	0,245
»Oni« menijo, da je njihovo delo pomembnejše od »našega«.*	336,0	< 0,001	220,0	0,001	1725,0	0,065
»Oni« se z »nami« niso pripravljeni pogovarjati o novih načinih dela v zdravstveni negi.*	1265,0	0,001	278,0	0,011	1763,5	0,087
Celoten vprašalnik	298,0	< 0,001	183,0	0,001	1995,5	0,586

*Legenda: * – odgovori obratno kodirani; U-test – Mann-Whitneyjev U-test; p – statistična značilnost; ZM-MZ – primerjava ocen skupin zdravnikov z medicinskimi sestrami – medicinske sestre z zdravniki; DZ-ZD – primerjava ocen skupin drugih zdravstvenih delavcev z zdravniki ter zdravnikov z drugimi zdravstvenimi delavci; MD-DM – primerjava ocen skupin medicinskih sester z drugimi zdravstvenimi delavci ter drugih zdravstvenih delavcev z medicinskimi sestrami*

zdravstvenih delavcev ugotavljamo, da so, podobno kot pri odnosu zdravnikov z medicinskimi sestrami, stopnje zadovoljstva večje v relaciji zdravnikov do drugih zdravstvenih delavcev kot obratno. Ponovno se pojavi razlika le pri trditvi »Pomembne informacije se vedno prenesejo od " nas" do "njih"«. Pri primerjavi odnosa med medicinskimi sestrami in drugimi zdravstvenimi delavci ugotavljamo, da je stopnja zadovoljstva z medpoklicnim sodelovanjem med tema dvema skupinama dokaj podobna. V povprečju so najbolj zadovoljni zdravniki z njihovim sodelovanjem z medicinskimi sestrami ($\bar{x}$ = 3,03, s = 0,26), čemur sledi zadovoljstvo zdravnikov z njihovim sodelovanjem z drugimi zdravstvenimi delavci ($\bar{x}$ = 2,86, s = 0,22). Najmanj zadovoljne so medicinske sestre z njihovim sodelovanjem z zdravniki ($\bar{x}$ = 2,36, s = 0,42).

Med starostnimi skupinami anketiranih so v povprečju najbolj zadovoljni z medpoklicnim sodelovanjem najmlajši (stari do 30 let) ($\bar{x}$ = 2,67, s = 0,42), sledi jim skupina, ki ima 41 let in več let ($\bar{x}$ = 2,59, s = 0,38), in skupina med 31 let in 40 let ($\bar{x}$ = 2,54, s = 0,42). Glede na celotne delovne izkušnje so v povprečju najbolj zadovoljni tisti, ki imajo najmanj delovnih izkušenj (do 10 let) ($\bar{x}$ = 2,63, s = 0,43), in tisti, ki jih imajo največ (21 let in več let) ($\bar{x}$ = 2,63, s = 0,37). Skupina, ki ima med 11 let in 20 let delovnih izkušenj, je v povprečju najmanj zadovoljna ($\bar{x}$ = 2,52, s = 0,40).

Za vsaki dve medsebojni relaciji smo z Mann-Whitneyjevim U-testom preverili, ali sta povprečji pri posamezni trditvi tudi statistično značilno različni (Tabela 2). Na podlagi rezultatov primerjave ocen trditev med oceno stopnje zadovoljstva zdravnikov s sodelovanjem z medicinskimi sestrami in oceno stopnje zadovoljstva medicinskih sester s sodelovanjem z zdravniki smo ugotovili, da so razlike v vseh primerih statistično značilne, razen pri trditvi: »Nesoglasja z "njimi" pogosto ostanejo nerazrešena.« Primerjava ocen stopnje zadovoljstva drugih zdravstvenih delavcev z njihovim sodelovanjem z zdravniki in ocene stopnje zadovoljstva zdravnikov s sodelovanjem z drugimi zdravstvenimi delavci pokaže prav tako veliko statistično značilnih razlik med skupinama. Najmanj statistično značilnih razlik je pri oceni stopnje zadovoljstva medicinskih sester s sodelovanjem z drugimi zdravstvenimi delavci in obratno. Če primerjamo povprečne stopnje zadovoljstva s sodelovanjem med skupinami, ugotovimo, da sta povprečji relacij zdravnik–medicinska sestra in obratno; ter zdravnik–drugi zdravstveni delavci (in obratno) statistično značilno različni pri stopnji značilnosti manjši od 0,05. Povprečni medsebojni stopnji zadovoljstva s

Tabela 3: *Povprečje zadovoljstva z medpoklicnim sodelovanjem po ravni organizacije zdravstvene dejavnosti*

Trditev	***Raven organizacije zdravstvene dejavnosti***			
	Primarna	***Sekundarna***	***Terciarna***	***Socialnovarstveni zavodi***
	$\bar{x}$ ***(s)***	$\bar{x}$ ***(s)***	$\bar{x}$ ***(s)***	$\bar{x}$ ***(s)***
»Mi« imamo z »njimi« dogovorjene skupne odgovornosti.	2,99 (0,52)	2,89 (0,67)	2,90 (0,67)	2,69 (0,56)
»Oni« so pri organizaciji svojega dela običajno pripravljeni upoštevati »našo« razpoložljivost.	2,76 (0,72)	2,68 (0,60)	2,63 (0,80)	2,76 (0,62)
Menim, da »mi« in »oni« ne govorimo dovolj o zdravljenju in zdravstveni negi pacientov.*	2,56 (0,78)	2,45 (0,69)	2,24 (0,73)	2,43 (0,63)
»Mi« in »oni« delimo podoben pogled o zdravljenju pacientov.	2,79 (0,47)	2,76 (0,51)	2,67 (0,62)	2,69 (0,52)
»Oni« so se pripravljeni pogovarjati o temah, povezanih z »našim« delom.	2,74 (0,65)	2,55 (0,64)	2,55 (0,81)	2,40 (0,73)
»Oni« sodelujejo pri organizaciji »naše« zdravstvene nege.	2,48 (0,67)	2,53 (0,72)	2,40 (0,88)	2,36 (0,79)
»Oni« bi bili pripravljeni sodelovati pri novih načinih »našega« dela.	2,70 (0,66)	2,64 (0,62)	2,67 (0,75)	2,57 (0,70)
»Oni« »nas« običajno ne vprašajo za mnenje.*	2,74 (0,65)	2,48 (0,70)	2,72 (0,74)	2,60 (0,70)
»Oni« lahko predvidijo, kdaj »mi« potrebujemo njihovo pomoč.	2,59 (0,61)	2,40 (0,74)	2,47 (0,76)	2,43 (0,70)
Pomembne informacije se vedno prenesejo od »nas« do »njih«.	3,01 (0,72)	2,98 (0,65)	2,92 (0,68)	2,81 (0,59)
Nesoglasja z »njimi« pogosto ostanejo nerazrešena.*	2,66 (0,73)	2,36 (0,65)	2,35 (0,68)	2,57 (0,50)
»Oni« menijo, da je njihovo delo pomembnejše od »našega«.*	2,38 (0,80)	2,29 (0,81)	2,21 (0,91)	2,29 (0,74)
»Oni« se z »nami« niso pripravljeni pogovarjati o novih načinih dela v zdravstveni negi.*	2,76 (0,62)	2,53 (0,60)	2,65 (0,67)	2,52 (0,55)
Skupaj	2,70 (0,40)	2,58 (0,37)	2,57 (0,45)	2,55 (0,38)

*Legenda: * – odgovori obratno kodirani; $\bar{x}$ – povprečje; s – standardni odklon*

sodelovanjem zdravnikov in medicinskih sester sta tako statistično značilno različni. To velja tudi za povprečni medsebojni stopnji zadovoljstva zdravnikov in drugih zdravstvenih delavcev.

Med različnimi starostnimi skupinami nismo ugotovili statistično značilnih razlik med različno starimi skupinami. Ugotovili pa smo statistično značilne razlike med skupinami različnih dolžin in delovnih izkušenj. Primerjava skupin z do 10 let in med 11 let in 20 let delovnih izkušenj se statistično značilno razlikujeta v zadovoljstvu z medpoklicnim sodelovanjem. Skupina, ki ima do 10 let delovnih izkušenj, je v povprečju bolj zadovoljna od tiste, ki ima med 11 let in 20 let delovnih izkušenj. Prav tako obstaja statistično značilna razlika med skupinama z od 11 let do 20 let in 21 in več let delovnih izkušenj. Tisti z več delovnimi izkušnjami so v povprečju bolj zadovoljni z medpoklicnim sodelovanjem.

Nadalje smo ugotovili, da obstajajo statistično značilne razlike v zadovoljstvu z medpoklicnim sodelovanjem med skupinami po dolžini delovnega časa. Z medpoklicnim sodelovanjem je najbolj zadovoljna skupina, ki dela največ ur na teden ($\overline{x}$ = 2,67, s = 0,45), najmanj pa skupina, ki dela med 41 ur in 50 ur na teden ($\overline{x}$ = 2,51, s = 0,42). Zdravniki v povprečju delajo 49,2 ur na teden, medicinske sestre 45,2 ur na teden in drugi zdravstveni delavci 40,8 ur na teden. V vseh teh trditvah zadovoljstva z medpoklicnim sodelovanjem so v povprečju bolj zadovoljni tisti, ki delajo največ ur tedensko. Tudi razlika med povprečjema skupin je statistično značilna.

Tabela 3 prikazuje, da obstajajo statistično značilne razlike med primarno in sekundarno ter med primarno in terciarno ravnjo zdravstvene dejavnosti o stopnji zadovoljstva z medpoklicnim sodelovanjem.

V povprečju so najbolj zadovoljni z medpoklicnim sodelovanjem na primarni ravni zdravstvene dejavnosti ($\overline{x}$ = 2,70, s = 0,40), sledijo sekundarna ($\overline{x}$ = 2,58, s = 0,37) in terciarna raven ($\overline{x}$ = 2,57, s = 0,45) ter socialnovarstveni zavodi ($\overline{x}$ = 2,55, s = 0,38).

Diskusija

V izvedeni raziskavi smo ugotovili, da so v povprečju z medpoklicnim sodelovanjem najbolj zadovoljni zdravniki, najmanj pa medicinske sestre. Hierarhični odnosi, ki še naprej zaznamujejo sodelovanje med zdravstveno nego in medicino, imajo pogosto za posledice slabo komunikacijo, kot tudi nerešene konflikte znotraj poklicnih skupin (Foth, Block, Stamer, & Schmacke, 2015). Četudi se zdravnike na hierarhični lestvici še vedno uvršča najvišje, je za uspešno sodelovaje znotraj tima treba graditi poklicno identiteto prav vseh članov tima (Romijn, Teunissen, de Bruijne, Wagner, & de Groot, 2016). Z uporabo ICS je bila v Italiji opravljena podobna raziskava, ki je pokazala precej heterogeno oceno sodelovanja med različnimi zdravstvenimi profili. Podobno kot v naši raziskavi so medicinske sestre bolj ali manj negativno ocenile svoj delovni odnos z zdravniki, nasprotno pa so kljub temu sodelovanje opisale kot pozitivno (Wieser et al., 2019). Paradoks, ki ga pogosto opazimo pri opisovanju odnosa med zdravniki in medicinskimi sestrami, ni nekaj novega. Večji poudarek je zato treba nameniti strategijam, ki bi to razliko v sodelovanju zmanjšale, in sicer strategijam spodbujanja enakosti obeh poklicnih skupin in krepitvi šibkejše skupine v odnosu (Huq, Reay, & Chreim, 2017).

Glede na delovne izkušnje številni avtorji ugotavljajo, da so v povprečju z medpoklicnim sodelovanjem najbolj zadovoljni tisti, ki imajo največ delovnih izkušenj, in tisti, ki so na začetku svoje poklicne poti (Ilić et al., 2017; Serrano-Gemes et al., 2017). Tudi v naši raziskavi smo dobili primerljive podatke, ki kažejo na statistično pomembne razlike med skupinami različnih let delovnih izkušenj.

Primerjava med dolžino delovnega časa in stopnjo zadovoljstva z medpoklicnim sodelovanjem prav tako pokaže, da obstajajo statistično pomembne razlike. Morebitni razlog, zakaj so v skupini z najdaljšim delovnikom najbolj zadovoljni z medpoklicnim sodelovanjem, je ta, da so v tej skupini zajeti večinoma zdravniki, ki so tudi sicer najbolj zadovoljni s sodelovanjem z drugima dvema skupinama zaposlenih. Primerljive rezultate so pridobili tudi v raziskavi Bowles et al. (2016), ki so raziskovali mogoče dejavnike, ki na individualni ali organizacijski ravni vplivajo k njihovemu dojemanju medpoklicnega sodelovanja, in ugotovili, da sta tako dolžina delovnega časa kot povečan obseg dela pozitivno povezana z višjo oceno sodelovanja pri vseh poklicih respondentov.

Kot pomemben dejavnik se kaže tudi raven zdravstvene dejavnosti, pri kateri so v povprečju najbolj zadovoljni z medpoklicnim sodelovanjem zaposleni na primarnem nivoju zdravstvene dejavnosti, medtem ko je v socialnovarstvenih zavodih stopnja zadovoljstva pričakovano nižja. Podobne rezultate opisujejo tudi Pullon et al. (2016), ki so ugotovili, da zaposleni v ambulantni dejavnosti na primarni ravni zdravstva boljše prepoznajo prednosti medpoklicnega sodelovanja, saj se v tem okolju pogosto oblikujejo manjši interdisciplinarni timi, v katerih je zaposlena dolgoletna ekipa, v kateri se lažje razvije visoka stopnja zaupanja. Brečko (2018) nasprotno v svojih ugotovitvah poudari nezadovoljstvo z medpoklicnim sodelovanjem v socialnovarstvenih zavodih in poudari, da bo le izboljševanje zdravstvene oskrbe in jasna predstava vodstva *v* institucionalnem varstvu starejših vplivala k večjemu zadovoljstvu zaposlenih z medpoklicnim sodelovanjem tudi na tej ravni zdravstvene dejavnosti.

Med omejitvami raziskave omenimo priložnostni vzorec in subjektivnost ICS, saj ta temelji na samooceni odnosa in sodelovanja med zdravstvenimi delavci. Pri interpretaciji rezultatov je bilo treba upoštevati podatek, da je bil v raziskavo zajet relativno majhen vzorec različnih poklicnih skupin, kot tudi

dejstvo, da je sestava posameznih interdisciplinarnih timov pogosto različna v vsaki instituciji, zato bi posploševanje rezultatov raziskave lahko vodilo k prevelikemu posploševanju.

Rezultati in ugotovitve naše raziskave so lahko podlaga nadaljnjemu raziskovanju medpoklicnega sodelovanja znotraj interdisciplinarnih timov, saj so tudi odnosi med različnimi zdravstvenimi poklici ključnega pomena za strokovni razvoj in profesionalizacijo zdravstvene nege. Pomemben odnosni element koncepta profesionalizacije je namreč vzpostavitev kakovostnega, enakovrednega in spoštljivega odnosa znotraj različnih poklicnih skupin, za doseganje takega cilja pa je nujno poglobljeno raziskovanje vseh komponent, ki jih tako posameznik kot tudi posamezne poklicne skupine potrebujejo za osvojitev tega cilja.

Različni pogledi in odnos zdravstvenih delavcev na interdisciplinarno sodelovanje kažejo potrebo po preoblikovanju formalnega izobraževanja na temo medpoklicnega sodelovanja, saj se vpliv medpoklicnega izobraževanja pozitivno kaže pri sodelovanju zdravstvenih sodelavcev v praksi, saj se lažje prepoznajo različne vloge sodelujočih (Kamenšek, Kavčič, & Domanjko, 2020). V prihodnje bi bilo zato treba razmisliti o skupnem interdisciplinarno oblikovanem učnem programu, v katerega bi bilo treba vključiti vse študente različnih zdravstvenih področij smeri izobraževanja. Ti bi prav zaradi zgodnje socializacije v pomenu dobrega medsebojnega sodelovanja tudi v poklicnem okolju s sodelavci skupaj lažje, predvsem pa boljše nadgrajevali kulturo sodelovanja. Nadaljnje raziskave so tudi potrebne na področju psihometrične validacije vprašalnika in nadaljnjega prilagajanja kulturnemu kontekstu načina dela v zdravstvenem sistemu v Sloveniji.

Zaključek

Struktura zdravstvenih timov se je v zadnjih letih spremenila, vedno večje zahteve in potrebe po celostni obravnavi pacienta pa zahtevajo tudi boljše sodelovanje in integracijo storitev. V članku smo ugotovili, da se v našem kulturnem prostoru še vedno opaža veliko nezadovoljstva v sodelovanju z zdravstvenim osebjem. Kljub temu pa posamezni deli raziskave kažejo, da se pomena kolektivne identitete tima in posledično dobrega medpoklicnega sodelovanja zaveda vse več zdravstvenih delavcev.

Conflict of interest/Nasprotje interesov

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Ethical approval/Etika raziskovanja

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Author contributions/Prispevek avtorjev

The authors jointly conceptualised the study design, and the study was conducted by the first author. The co-author participated in the development of the questionnaire and interpretation of the findings. Both authors were equally involved in writing the article./Avtorja sta konceptualno skupaj zastavila raziskavo, ki jo je izvedla prva avtorica. Soavtor je sodeloval pri snovanju instrumentaraija in interpretaciji ugotovitev. Pri pisanju članka sta avtorja sodelovala enakovredno.

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