Successful Studies Of Cooperation Between Doctors And Workers In Various Fields Of Health Care

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1. Introduction

The healthcare systems worldwide are facing challenges that demand increased collaboration between different healthcare professions. As the spectrum of host and patient factors determining successful health care is wide, patients often encounter various reverberations, frequently via multiple health care institutions and worse with incomplete medico-social information exchange than demographic data transfer [r 1]. However, professional boundaries between medicine on the one hand and social and economic professions on the other side pose insurmountable barriers to health care improvement as inpatient health professionals protect their specific attributes and positions against expected encroachment. Due to sector-specific views among professions included in the care of persons with complaints using the same medical (diseases) or physical syndrome (organ failure, dysfunctions) malaise, potential for common care management is often not exhaustively exploited. Product of sector specific professional policies that set the overall satisfaction with intersectoral cooperation in health care rank at 3.25 between 5 (excellent) and ± 9% of social workers and ± 7% of physicians have to propose negative value judgments [r 2] [r 3] [r 4]. Only 27.6%, 26.4%, and 37.8% (social workers, nurses, physicians) notice interdisciplinary work with problems [r 2]. Preferences for

professional autonomy would benefit patient care management if integrated and thus coordinated services were possible [r 2]. Nurses are in 28% more often socially involved than physicians, social workers also see their role in signposting health care institutions. On the other hand, physicians more often signpost help outside the health care sector than public health nurses do. In health care settings it is often observed today that there is not an interaction between medicine, care and other professions, so as to form an interdisciplinary, integrated and evolutional perspective. Each profession keeps their expertise in reserve for also far them delineated issues and considerations and passes on to others or even rejects patients in need when approached by other professions. The accepted consequences with regard to the fundamental understanding of medical care as a cross-sectional task often has less in common with the well-being of the patient than with exercises of power, professional dominance and maintenances of the privileges. Assessment of the importance of extraordinary areas of activity (communication and negotiation as well as networking) of health professionals and approximate analyzes for strengthening the high need for multisectoral collaboration in health care settings cannot be found.

1.1. Background and Significance

In one of the five studies (study I), experienced physicians present how they ask the nurses for help to co-construct care in their work practices. The findings show that the nurses' initiative was not only followed up on. Therefore, physicians should not explain, but continually negotiate the care. The study concludes that physicians should build up enduring patient knowledge and respect the nurses' contributions, and that the nurses should be interactive in their care reasoning. Docility among nurses is always entwined with relationship-strengthening care reasoning of the health care workers. Even in a structuring power relation, workers dare to challenge institutional practices from within and maintain agency. This may be one explanation for negative relations between power and nurse satisfaction with the collaboration, while some other characteristics of the nurse dispositions have stronger impact on physician satisfaction with the collaboration (Ushiro, 2009).

This thesis presents five individual studies (studies I–V) that concern the cooperation between doctors and workers in various fields of health care. Although knowledgeable workers have insight

into what medical treatment and nursing care are suitable and feasible in relation to a patient's living conditions, previous research shows that the workers are in a subordinate position in their cooperation with professional staff. This means that the workers often have small opportunities to influence their work and the organization of their work. Despite the fact that these skilled health care workers are important both in achieving successful medical care and in realizing the quality of care with good nursing ethics, previous research argues that these opportunities are too small.

2. Theoretical Framework

In the context of the theory of social exchange, the goal is to explore alternative sources of motivation for cooperation between primary care personnel and their relationship with the perception of work-life quality. Sociological theory usually deals with social structures and institutions that exert a great constraint on behavior through norms, values, roles, and socialization. However, economists have researched the motivational causes of cooperative behavior. Empirical studies show a positive but limited association between cooperation and interactions of social exchange. When the cost of cooperation is low, there are no conflicts of interest, the level of trust is high, and both parties expect future interactions.

The practice of reward systems in formal organizations has, for a long time, been based on two fundamental hypotheses: the rationality of economic behavior and the necessity of control. This is still true for typical cost-making activities, characterized by scarce and obstructive resources. Activities where the meaning of cooperation is relatively transparent and the monitoring procedure is low-cost. In contrast, the typical budget-executing activities are characterized by multiple stakeholders, shared and incomplete preferences, and flexible authority. These activities require the development of multiple and complex skills. Therefore, they better approximate relational (or interactive) contracting and new organizational forms. These forms are characterized by a high level of trust and a flexible and decentralized control system. This system reduces the asymmetry of information between the principal and the agent.

2.1. Interprofessional Collaboration Theories

In recent years, some theories of interprofessional collaboration have been developed that discuss the essence, principles of formation, factors contributing to this phenomenon, and methods of predicting the effectiveness of interaction between various participants in healthcare. For example, R. Spaulding points to the formation of successful professional interaction in which participants can easily switch roles and demonstrate an understanding of professional competences in a dialogue situation. The author's conviction is that the exchange of opinions on the component parts of professional practice will lead to successful cooperation between professionals of the scientific sphere. It was concluded that the effective implementation of interprofessional interaction in academic communities concludes and will contribute to the formation of active interaction with the use of resources of all occupational groups, research, creativity, synthesis of knowledge, and ideas of interprofessional training. (Kitsios & Kamariotou, 2021)

Professional interaction was chosen as a key component for achieving meaningful collaboration, and cultivation of interaction using a model for promoting single as well as group recognition was designed. The effectiveness of the consistent participation of the commodity group for students and the search for product-specific resources were the starting points for the implementation of the micro-teaching model. The model presented by E. MyFor also recognizes the "water" character of the professional "ice" of teacher occupation, the very uniform concepts and contexts for the concept of educational interaction, traditional interaction or teamwork, common understanding with the scientific sphere of interaction as a stabilizer of theoretical research professional direction.

3. Key Concepts

The following fundamental notions underlie the study. They are central to the character image of a professional in the field:

- Diagnosis: Dynamic happenings during the course of an exchange create conflicting descriptions of problem-solving context by technicians and lay workers. Each group tends to fix its understanding of the problem provided by the previous experience. Short-term evolutions change the conditions of formal designation. The quality of relations among actors varies during

the exchange. This study points out the role of a technician as a process leader in the task of designing and/or maintaining such quality.

- Autonomy: The use of the term in human relations must be captured in its concrete context. Is autonomy the expression of dependence or of bonding relationships?

- Skills: The significance of the term in professional and social environment changes sharply (e.g. take the words "caring" and "training" as synonyms of "practice").

- Paradox: One of the key impulses to problem-solving process, it must be developed and made useful in the study. The R & D project becomes means of solution rather than as a conflict statement. In particular at the worker-doctor level, it may provide the motivation for actors, and the academic actors participate in the project out of a sense to educate young professionals to human concern.

- The twin-track method: The ability to consider knowledge as emerging from individual and group exchanging cycles permits the user, along with the bottom-to-top approach, to tidy up the key concepts.

3.1. Roles and Responsibilities

The different public and private sector providers of clinical care, public health, and social support services work in the same geographical area. They might either meet for the first time when the needs of a single patient/client connect them, or they may have more or less established relationships based on shared geography, shared patients/clients, and/or formal governance relationships. Each side undertakes different specific tasks, usually with some level of community need driving the initial health or health care demands. In the setting of defined longitudinal primary care, there is both potential and documented actual success at designing and implementing systems that promote genuine effective and efficient teamwork between physicians and workers in various fields of health care. The relatively few but highly successful examples are driven by both grassroots initiatives and by carefully guided community-based workforce development research. (Wei et al.2020)

From the patient and physician care perspective, workers in various fields of health care include anyone with responsibilities and skills that can potentially help the patient achieve personal health and functional goals. It excludes clerical and billing professionals who are essential but who do not contribute to personal health or health care. The team includes other allied health professionals, traditional lay helpers, paraprofessionals with formal or informal health care roles, and nurses or medical health care assistants who are contributing as empowered professionals rather than as extension units of the physician. The various roles can optimally help a patient become better at doing key normal life activities, becoming more knowledgeable about personal health and resource availability, improve the capacity to self-manage future health risks, continue a satisfactory quality of life during an illness episode and/or during the natural dying process, and they can more formally represent the comprehensive primary care team to specialists during consultations. We limit discussion to formal roles that have accumulated a spectrum of successful models, as there are unique interactive aspects of daily work that have to be carefully protected in each specific situation.

4. Factors Influencing Cooperation

On the basis of the study, we can identify the main factors influencing effective cooperation between medical workers and various professional groups in the field of health care. We believe that cooperation factors might be divided into two major groups: system and individual. The cooperation factors may take the form of the requirements and skills of the cooperating parties, their social situation, social structure, and potential to act. System factors include the development of consistent and well-organized institutions as well as the ways of deliveries of public health services. Cooperation factors refer to the knowledge, skills, and attitudes of medical workers and workers in other fields of health care responsible for the direct provision of public health services. We can further subdivide cooperation factors identified in the formal study into a number of corollaries or specific traits.

The following factors determine the successful nature of the doctors' cooperation: aptness in cooperation with health professionals; recognized standards of their skills; diversification of activities and the range of services performed; academic titles; enrichment of information vitae and constant updating of

knowledge; participation in specialized studies; autonomous managers in their job; ownership of current tools and technologies; and cooperation strategies. The results of the empirical study showed that cooperation of doctors with six groups of workers (who are not the direct recipients of the health care outcomes) plays a significant role in the doctors' professional profile. In particular, these groups include neuro-psychiatrists, psychologists, nurses, biomedical laboratory technicians, food-service workers, and cleaning staff.

4.1. Communication

Communication is another method of cooperation between a doctor and a worker. It is the stage at which information from the worker or other workers employed at the place is gathered and methods for solving health problems are discussed with the worker or organization. Thus, a physician often becomes an advisor with respect to health questions to organizations that have their own systems for solving various problems. (Halley et al.2021)

Communication substantially depends on the worker's motivation to cooperate with the physician. A worker himself (especially in the absence of acute pain) may neglect meetings with a physician or provide only fragmentary information about his complaints, his mode of life in and out of work, or intermediate results of treatment. Such behavior not infrequently is formed by the style of communication with health personnel in polyclinics. Some work collectives (large and small industrial groups, schools) have assigned the same role of "organizer of medical affairs" and physician to one person, usually a nurse. Such a person, if he has authority, often establishes warm, trusting relations with the members of the collective, making communication with the physician simple.

5. Benefits of Collaboration

Both clients and service providers can benefit when the knowledge and skills of all members of interprofessional teams are effectively utilized. For clients, an interprofessional team can provide more comprehensive services in a coordinated manner. Collaboration between clinicians with different roles can help produce an integrated plan of patient care. Although the contributions of Diagnosite specialists to preventive care may not be as extensive as those of other primary caregivers such as family physicians, we can use our influence to help promote preventive care. For

example, we can use educational materials to convey health promotion information to clients, ask them about other preventive interventions they may have received recently, or recommend or order particular preventive care interventions.

Cultures of medicine and the technical biomedical orientation of professionals can influence limiting beliefs about health. The control of specialist groups over their technologies and professional activities is difficult to challenge. This trend was relatively recent when compared to the time specialists have been practicing 'evidence-based medicine.' It is beneficial that patient-specific information be integrated into Diagnosite reports so that these groups can work more effectively. All specialists need to understand which parts of their knowledge can be shared with different client groups and how this can affect the professional status of the specialty. Efforts to improve self-reflection skills will aid in acquiring this understanding and will enhance communication effectiveness. These skills will then become central to shared client care strategies. Educational programs can include these concepts, but specialists should also consider reading literature discussing interprofessional collaboration.

5.1. Improved Patient Outcomes

Improved patient outcomes may result from better access and management of healthcare resources by all provider groups. Elimination of unnecessary duplication, replacement of scarce primary care resources by less scarce medical technology, and optimization of care that different types of doctor-and-worker groups can provide may all contribute to more efficient and effective care of patients. Improved health professional job satisfaction is also an important end in itself for the positive effect it can have on other providers' work activities, enhanced group and individual self-esteem, and the avoidance of burnout. (Drossman & Ruddy, 2020)

Successful studies of cooperation between doctors and workers in various fields of healthcare can be found. Analysis of the conditions that promote cooperation reveals that health professionals themselves are largely responsible for creating the opportunities and building the channels (the human contacts or personal relationships) that make each particular cooperation strategy work. The type of personal relationship that underpins joint nudging, joint resolution-solving, joint decision-making, shared

leadership, smooth teamwork, and open communication is especially important. A report presents a useful appendices framework for analyzing cooperation in healthcare organizations.

What policy implications might follow from studies such as these for policymakers wishing to implement public policy in health and social care organizations? First, one should concentrate on the human technologies of public policy. In other words, policy formulation and implementation should be primarily aimed at promoting the personal relationship behaviors of both the members of the organization (and across the separate profession or healthcare specialties subgroups and the different organizational group levels) and the reciprocal interactive effectiveness of these behaviors. Is there any theoretical basis for this emphasis on the importance of interpersonal and interorganizational relationships in policy formulation and implementation?

6. Barriers to Cooperation

Physicians and workers adhering to the metric scene often want to obtain more specialists and global systems of cooperation. These global approaches are insufficient and false. Specific studies of cooperation and directions are required. A series of individual, individual and organizational obstacles can disrupt effective and satisfactory coordination. Hopefully the experiences and actions of other societies will provide useful information. The more doctors have switched from the traditional care of individual care to global medicine and are more and more domestic, the more likely it is for the cognitive that better cooperation conditions are reached.

The traditional model of three services is hard to break stubbornly. The requirement of neighbor navigation and 'expert debates' can reduce consultations and improve communication. The particular problems of cooperating with single doctors can have equal effects on cooperation with other groups of doctors. Doctors in similar subjects or hospitals who believe that their unique interests require the cooperation of doctors outside are much needed in primary and secondary care, where each is treated. Preventive treatment should recognize the importance and promote the maintenance of 'good health'. The involvement of doctors in primary prevention and discussions of with the general responsibility of promoting the health of society at large are particularly important details. However, recognized and divisional

can prevent local contentment because departments go further than departments. Unrecognized division is accompanied by the inability to solve the main elements and problems of health care together.

6.1. Hierarchical Structures

Among the successful studies of cooperation between doctors and workers in various fields of health care, several successful joint efforts by optometrists and pharmacists (including junior university students) are described. The data are organized in a networked or hierarchical structure represented by prescribing optometrists, dispensing optometrists, and community pharmacists. Six hierarchical structures are identified. Hierarchical relationship descriptions are presented as a set of "responsibility statements". In any hierarchical structure, which involves a prescribing optometrist, the initial choice of medication is the responsibility of the prescribing optometrist; both prescribing optometrist and dispensing optometrist have a responsibility of deciding whether unauthorized changes are appropriate according to guidelines. (El-Awaisi et al.2021)

Hierarchies are characterized as systems of individuals with varying amounts of control in relation to mutual concerns. The model used for identifying responsibility utilizes skill, ethics, legal controls, code of practice, funding issues, and discussion. The same six hierarchical structures can be used to describe cooperative relations between community optometrists and general practitioners, where appropriate linking already exists because general practitioners preferentially refer to community optometrists. Any action, which is not allowed by the law and codes of practice, is unauthorized. In addition to unauthorized changes, there is the risk of 'drug interactions'; such risks are dealt with in the study by description rather than evidence of discussion because they cannot be associated with a particular prescription. The description of the two optometry structures is completed by describing the responsibility of the community pharmacist in the role of the 'Medication Expert'.

7. Case Studies of Successful Collaborations

Case study 1: Primary care and welfare services for frail elderly people. Although health workers and social workers operate within the same office environment and share a number of common tasks, they are usually trained in different disciplines and

have differences in work style and awareness about work. This difficult situation is becoming increasingly important now, when the supply of workers is low. This study was conducted in a rural area in Japan, using a variety of cooperative measures to bring this collaboration to a successful level and to improve the subjective assessment of cooperation. This led to the belief that coordinated support for elderly people is possible between health and welfare workers.

The following cases have been selected from studies carried out by the team to which the authors belong. The studies, with a few exceptions, are based on actual cooperative support for health and welfare in local communities. In each case, I have tried to maintain the fundamental spirit of these cases, which is neither to deepen discussion of the subjects used nor to introduce more interpretative racketing of the authors, by limiting my writing to straight, analytical description.

7.1. Hospital Settings

In summary, the working methods of various types of professional expertise and cooperation will now be discussed. Discussions of the process of medical care or problems in cooperation in these fields appear occasionally, but there are virtually no formal tools at present to understand the maximum potential for co-locally working within a department. From the optimistic results we obtained here with few tools, we believe that the scientific analysis of the methods and procedures for such corporate cooperation will benefit all concerned. To achieve this, we believe that our approach, involving standardized and systematic analyses of how resources are combined to achieve common goals, both with and without competition within the same area, is a step in the right direction. (Schot et al.2020)

One of the most successful forms of corporate cooperation is seen in hospital settings. Almost all patients are treated with many different professionals working together in a common framework, and one of the keys to successful hospital admittances is the careful co-location of this expertise within the same organizational structure. In this article, we are seeking a better understanding of the forms and benefits of such combinations in both their hospital and departmental aspects by considering various health care working forms. We hypothesize that the costs become subadditive when different workers work together in the same department. If

this hypothesis is correct, then the potential for increasing the total number of operations through a joint effort or a merger between indistinguishable health care service departments.

8. Best Practices and Recommendations

The gathered materials, the experience of colleagues, having worked in the field, and a small number of publications allow us to name some best practices and recommendations. It is necessary to complete and improve this list. The majority of medical functionaries are practically oriented, have a short period for adaptation and learning, and every time work in changed team conditions when they are appointed to positions. When there are short deadlines for these offices and there is high personnel turnover among young employees – that is peculiar to some branches of the occupation structure – we believe it necessary to use "distillates" of the collected experience in the role of supplements recommended in this or that exactly situation.

Here are the most general examples. The doctor's quality as a team member is also called: "a good doctor is an elder brother, a good doctor is a leader." It is adequate to form interactions, both personal and professional. The feeling of control of conditions of execution of duties is important. The team and the head do not illustrate problems, shared with a doctor anyone. The medical worker's needs must be fully satisfied. There are many offers of increasing obligations for workers themselves, but they are not involved adequately in decision making. The employees believe that their viewpoint is not enough worth something and is not appreciated. Only players present in the industry can and must say how a product can be improved and be competitive more so than any scientist from the research tower, and so it is with systems of relations in a sector of health – only we ourselves are capable of and must determine the strategies of forward progress.

8.1. Team Building Activities

To improve the cooperation between doctors and workers in preventive health care, especially those situated in public health care facilities, we applied team building activities of sports and games as a way of addressing issues with participation while ensuring the successful interlinking of professionals. The given cooperation between leadership in a medical discipline and the nursing team members is a cornerstone for quality and successful health care for CCS patients, as well as mutual collaboration in

tackling inhibitory factors that can contribute to troubles due to weakly structured unit culture. While work motivation and job satisfaction are found to be significant factors in CCSs, decisive for improvement, building team relationships and team performance, the role of a team leader is recognized as crucial. (Islamov, 2021)

The investment in successful conflict resolution inside a healthcare team is much more efficient in public health facilities in contrast with no infrastructure conditions. Given the mutual satisfaction of nursing staff and the medical discipline on work as a leader, expending energy through a physical activity like basketball or soccer coaches which proceed the game activities where separated groups play in mutual cooperation, tackles a share of these issues. Leaders of each sector should emphasize time for programs where nurses and doctors interact and have time for team-building and important meetings about clinical issues. The joint activities and cooperation in solving leadership issues between staff levels and members seem to have clear beneficial effects; it should reduce frustration of any inhibitory phenomena and at the same time increase feelings of engagement and enthusiasm.

9. Future Directions

In conclusion, these successful studies of cooperation between doctors and workers in various fields of health care illustrate the beneficial impact that knowledge of actual work activities can have as we seek to better integrate technology into the health care setting. These examples have shown us that we should lose our "us versus them" mentality, that multidisciplinary teams need to be constructed based on necessary skills, that the inferred knowledge, skill, and training of others is to be minimized; needs for layered decision-making, lateral communication, trust, respect, ongoing dialog and cooperation among health care givers, and better perception among Information Technologists as to the relationship of patient activities and technologies to core professional skills and information needs.

In order to take the next logical step of using work analyses to build and evaluate tools that are of real benefit to nonproductive workers in health care, time and motivation must be available to all involved in the iterative process of tool creation, deployment, use, and evaluation. Perhaps we need to encourage health care workers to treat the designers of technology as they treat their

own carpenter or plumber: invite them in, feel free to ask silly questions in the search for understanding, test and tinker with mutually agreed-upon solutions, and above all dare to hope that a really useful and more informal communication can occur. In short, we need to show worker confidence that together we can build the arc of the healthcare delivery system - a method for achieving a mutual goal that serves not just technology or labor but patient needs as well.

9.1. Technological Innovations

10. Conclusion

Studies of effective cooperation between doctors and various workers involved in healthcare indicate that the key to successful professional interaction is the following criteria: the establishment of a clear form of interaction; the lack of role confusion (the clarity of mutual contacts); specific activities to motivate professional groups engaged in cooperation; skill in building social and professional contacts associated with the process and results of cooperative interaction. Given the rejoinder about the importance of identifying impediments to successful cooperation, priority must be given to developing effective policies that have helped build strengthened levels of cooperation and the ability to address and eliminate those forms of conflict and tension that inherently characterize interaction with other workers in healthcare.

Difficulties and failures in integrating modern health services are often caused by the poorly coordinated and embedded roles of their participants. But if the professional capability of each participating group and the existing possibilities of changes in the mode of interaction are valued at their proper worth, it becomes clear that the progress of complex interaction is determined, first and foremost, by group interactions and depends much less on the professional peculiarities of the participating groups. Successful work with various groups from different fields which may be involved in the care of an individual patient is also anticipatory, proactive. Smart, rational organization of necessary care with consideration of the role of the main groups of health system participants is the very antidote, the common answer to the problems of civilization medicine today.

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