

Research Article

The Professionalism in Collaboration between Health and Social Care Workers: A Survey to Members of the Finnish Trade Unions

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Received 20 December 2023; Revised 14 April 2024; Accepted 10 July 2024

Academic Editor: Tushar Singh

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Background. Professionalism in collaboration means working based on competencies and ethics, showing accountability and respect in communication and care by each professional group. It is required to ensure seamless, integrated, and quality of care for patients. Previous research has focused on professionalism among single professional groups; little is known about how ethics of professionalism appear in collaboration between different professional groups. Our aim was to fill the gap in this knowledge. The objectives of the study were how health and social care workers evaluated professionalism in collaboration, how professionalism was associated with the various professional groups, and how it was related to the personal characteristics of the workers. **Methods.** A cross-sectional study with an online survey was conducted in collaboration with 15 professional trade unions in Finland. The 26-item Interprofessional Professionalism Assessment questionnaire was used. The R program, version 4.0.2, was used for advanced descriptive and statistical methods. **Results.** Together, 1,769 trade union members participated in the study, representing eight professional groups and students from care, rehabilitation, and social services. The mean professionalism score was 4.20 ± 0.70 out of 5, suggesting excellent professionalism in collaboration. Care assistants, childcare and youth workers, and nurses scored professionalism statistically significantly higher than social workers ($p < 0.001$). Participants who experienced mutual ethical reflections at work ($p < 0.001$), received organizational support for ethical practice ($p < 0.01$), and experienced satisfaction at work ($p < 0.001$) scored professionalism statistically significantly higher. **Conclusions.** Professionalism in collaboration between health and social workers was very consistent and strong, despite the fact that different professional groups participated in the survey. Organizations should further work satisfaction and opportunities to participate in shared ethical reflection. Future studies should investigate organizational structures and leadership that support this kind of well-executed professionalism in collaboration between professional groups and if workers recognize these.

1. Introduction

Health and social care professionals are increasingly engaging in interprofessional collaboration. This enables them to work toward the common goal of quality integrated patient-centered care [1, 2] and ensure that clients, patients, and the general population benefit from the best health and well-being [3–5]. Interprofessional collaboration requires various competencies from each professional, and their work is guided by communication and openness in duties and responsibilities [2, 5].

The ability to resolve disagreements in the best interests of clients and patients is essential [6]. Diverse professional groups work in collaboration and all have their own background, regulations, and ethical values and principles that guide their work [7, 8]. Collaboration involves multiple factors. It is carried out in changing environments, such as multicultural teams [9], in the homes of clients and patients [10], and in close, remote [11, 12] and digital environments [12, 13].

Successful interprofessional collaboration requires shared values and positive attitudes towards others in the

profession [2]. Professionalism involves working according to a professional knowledge base and in collaboration with others in clinical practice [14–17]. Professionalism in collaboration means working based on competencies and ethics, showing accountability and respect in communication and care by each professional group [2–5]. It is required to ensure seamless, integrated, and quality of care for patients [1–5]. The way professionalism is conducted has been associated with the personal and work-related characteristics of workers, such as age, education, experience, and their position at work [15–17]. Stronger professionalism has been associated with longer work experience and continuous learning [17, 18]. Several factors have strengthened how professionalism is demonstrated in practice, including reflections on lifelong learning at work [18], the surrounding culture [14], and work satisfaction [14, 16, 18]. Higher levels of professionalism have also been described in relation to better ethical work environments [19]. However, other factors have been associated with poor and inadequate professionalism, such as poor organizational and communication cultures [15] and lack of support and guidance [16]. When professionalism has focused too closely on the conduct of a person's own professional group and its perspectives, it has hindered the flow of information between professional groups [16]. Professionalism in collaboration requires working according to competencies and ethics [2–5]. It is about achieving and expressing key values and shared principles [2–5]. Fundamental aspects are altruism in care and ethical practice and that each professional shows proper respect and responsibility during communication and their contribution to care [2–5]. Professionalism is particularly important in collaboration, in order to provide clients and patients with seamless and high quality of care [1–5]. When professionalism is demonstrated by each member of the professional groups in collaboration, it is also expected to improve client and patient satisfaction with their integrated and quality of care [2, 3, 5] and promote collaboration through improved clinical practices [3, 5, 14].

Previous studies on professionalism have focused on perceptions and recognition of professionalism between physicians and medical students [20, 21] and among social workers [22]. Studies have also defined the professionalism of individual health workers, such as nurses [14] and occupational therapists [17]. Previous studies have evaluated professionalism in collaboration, by observing behavior between healthcare workers and students [5, 23, 24] and have found that it varies between professionals. Professionalism in interprofessional collaboration in hospitals has been reported to be low, scoring 1.04–1.31 out of 5 [23, 24]. However, it has been excellent for healthcare students, with a range of 4.35–4.59 out of 5 [5]. Education and interventions that focused on interprofessional professionalism have been significant when it comes to developing collaborative behavior [25]. However, there is still a need to improve the skills involved in professional collaboration [24]. Existing studies have tended to focus on single professional groups and the use of self-assessments has been limited. However, health and social care services require professionalism in collaboration to be achieved to

ensure seamless, integrated, and quality of care [1, 2]. There are no studies based on self-assessment of ethics of professionalism in collaboration with multiple health and social care groups. Therefore, it is clearly necessary to increase our understanding of how health and social care workers understand professionalism and how it is demonstrated when providing care and social services. The aim of this study was to fill the gap in this knowledge and describe the perceptions of health and social care workers of the ethics of professionalism in collaboration in their daily work. The study objectives were how health and social care workers evaluated their professionalism in collaboration, how professionalism was associated with the various professional groups, and how it was related to the personal characteristics of workers.

2. Methods

2.1. Design. This was a cross-sectional study design with an online survey that was conducted in collaboration with 15 professional trade unions in Finland from 8 March to 31 May 2022. It used advanced descriptive and statistical methods. Data were collected using the Finnish version of the IPA [5, 26] questionnaire (F-IPA) and complemented with questions on personal characteristics. Permission to use the IPA [5, 26] was obtained by e-mail from its developers on June 26, 2020.

2.2. Sample and Recruitment of Study Participants. The target group was professionals and students in care and services, such as care, medicine, rehabilitation, and social work. They had to have work experience in health and social care and be a member of a professional trade union at the time of the survey. The students were included because they participate in interprofessional collaboration in health and social care. In Finland, health and social care students can work as a substitute already during their studies. They also join professional trade unions from the very beginning of their studies. Convenience sampling was used to reach enough participants to represent a wide range of professional groups working in health and social care.

Participants were recruited through 15 Finnish trade unions and professional associations, with 120,332 health and social care worker members. Two of the professional associations represented physicians and 11 trade unions and associations represented other health professions, namely, care assistants, nurses, nurses involved in diagnostic care and oral health, and rehabilitation workers. One represented social care professions and one comprised both health and social care professions, namely, care and assistive workers, childcare and youth workers, and nurses. Trade unions and associations were contacted and asked to invite their members to participate in the study by e-mail, newsletter, or closed professional social media groups. The invitation described the study and how it would be carried out and provided a link to the online questionnaire in the REDCap 14.0.16 software [27, 28].

2.3. Data Collection. The IPA questionnaire [5, 26], which was developed by the Interprofessional Professionalism Collaborative [26], was used to measure professionalism in

collaboration between different health and social care workers. The IPA description partly reproduces developers' [26] wording. Six domains focused on shared ethical values and principles of interprofessional collaboration that demonstrated professionalism and collaboration [5, 26]. There were five items on communication, reflecting comprehensive and understandable communication and considering the needs of other health and social care workers. Five other items on respect related to understanding the culture, values, contributions, and expertise of other health and social care workers and professions in care, as well as their roles and responsibilities [5, 26]. Altruism and caring comprised four items that focused on considering the needs of patients and other professionals with empathy and compassion. The four elements of excellence reflect the individual's responsibilities and contribution to the care process, in terms of coordination and documentation of care to ensure quality care [5, 26]. Ethics and accountability both comprised four elements that addressed how collaborative work ensured ethical practice, how individuals took responsibility for their own work, and how they prevented and addressed possible care-related disadvantages [5, 26]. The responses used Likert scales from one to five [5, 26], from strongly disagree to strongly agree, and included the option to neither agree nor disagree. Professionalism in collaboration was achieved well or a lot if the participants said they agreed or strongly agreed. If they disagreed or strongly disagreed, this meant that professionalism was poorly realized or not at all. Scores were interpreted as low (1–2), moderate (2.1–3.0), good (3.1–4.0), and excellent (4.1–5.0). If the participant ticked option six, to say they did not have the opportunity to observe the item in their environment [5, 26], this was recorded as a missing response. According to the developers of the questionnaire [5, 26], higher scores suggest a more developed professionalism behavior in collaboration between different professions. Each domain included an open question, so that participants could provide comments on positive professionalism in collaboration or any improvements that were needed [5, 26]. The IPA [5, 26] also contained two global items about the levels of professionalism when interacting with members of other health and social care professions and the general professionalism between the different professions. Responses that used five-point formats for both of these global items have ranged from low to excellent [5, 26]. In the developmental study by Frost et al. [5], Cronbach's alpha for the entire scale was 0.960 and other studies have reported ratings of 0.830 [23, 25] and 0.934 [24].

The IPA questionnaire [5, 26] was cross-culturally adapted to the Finnish care and services context in five stages [29]. This study used the method of Beaton et al. and the description of the methods partially reproduces their wording [29]. First, it was translated from English to Finnish by a qualified translator [29]. Second, the translator and research group established a synthesis, which was based on agreeing on the concepts that were used to relate to the phenomenon. Third, another qualified translator performed a backward translation to the original English language [29]. Fourth, the research group reviewed both the translated

versions [29] for Finnish culture and language. Furthermore, several members of the collaborative that developed the IPA [26] reviewed the back-translated version to see if its content matched the original. Their feedback resulted in minor corrections to the back-translation, mainly for individual words. Lastly, a pilot study [29] was carried out with 20 health and social care professionals and students, who evaluated the clarity of the instructions, the items, and the response options. The participants were asked to provide suggestions if any part of the items or response options were unclear [29]. Agreement was defined as a rate of at least 80% for each item [30]. No changes were needed as a result of the pilot study, and the Cronbach alpha [31] for this stage was 0.951.

2.4. Background Information. Questions were asked about 20 demographics related to personal and work, including age, professional degree, and level of education [5, 15, 16]. Participants were asked about their position at work [15, 16], their work experience in years [5, 15, 16], and if they worked remotely with clients or patients [11–13]. The questions also explored the amount of interprofessional collaboration [5], mutual multiprofessional ethical reflection [32], and multiculturalism on their workplace [9]. They were also asked about training in interprofessional ethics [23] if they received support from their leaders or organization for ethical practice [15, 32], and their satisfaction with work [14, 16, 17] (Table 1).

2.5. Data Analysis. The R program version 4.0.2 [33] was used to analyze the data. Frequencies and percentages were used for categorical data and means and standard deviations for continuous data.

Nine professional groups were formed based on the professional degrees of the participants. Care assistants covered practical nurses, dental assistants, pedicurists, and other care and assistive workers. Childcare and youth workers covered children's nurses, childminders, children's instructors, and youth workers. There were three nursing categories. Nurses were nurses, midwives, and public health nurses. Nurses in diagnostic care were bioanalysts, laboratory staff, optometrists, and radiographers. Nurses in oral health were dental hygienists and dental technician. The physicians covered specialists and residents in various fields of medicine. Rehabilitation workers comprised physical therapists, occupational therapists, podiatrists, and rehabilitation instructors. Social workers were geriatric nurses, social care workers, social workers with a bachelor's degree, and social advisors. The last category was students. The remote work variable provided five options: yes daily, yes weekly, yes monthly, yes yearly, and yes. It was split into yes for the first three categories and no for the other two. The Spearman correlation coefficient [34] was used to explore the correlations between the Finnish version of the IPA [F-IPA] and its five domains, and between F-IPA and two global items. The Kruskal–Wallis H test [35] was used to examine the total and factor sums between the professional groups. Linear regression analysis [36] was used to explain

TABLE 1: Personal and work-related characteristics of study participants.

<i>Age (years) (n = 1,765)</i>	
Mean age (years)	n (%)
Range	48.00 ± 11.59
	18–77
<i>Work experience in health and social care (years) (n = 1,656)</i>	
Mean work experience	19.22 ± 12.41
Range	<1–56
<5	275 (17%)
6–15	445 (27%)
16–25	388 (23%)
>25	548 (33%)
<i>Education level (n = 1,768)</i>	
Secondary level	554 (30%)
University of applied sciences	1,078 (59%)
Other university	139 (8%)
Student	45 (3%)
<i>Professional group (n = 1,769)</i>	
Care assistants	541 (31%)
Nurses	320 (18%)
Nurses in diagnostic care	214 (13%)
Rehabilitation workers	224 (13%)
Social workers	199 (11%)
Nurses in oral health	95 (5%)
Childcare and youth workers	68 (4%)
Physicians	46 (3%)
Students	50 (3%)
<i>Interprofessional ethics' training in last 5 years (n = 1,616)</i>	
Yes	343 (21%)
No	1271 (79%)
<i>Position at work (n = 1,767)</i>	
Employee	1510 (85%)
Leader	152 (9%)
Student	41 (2%)
Other	64 (4%)
<i>Share of interprofessional collaboration in own work (n = 1,767)</i>	
<25%	679 (38%)
26–50%	388 (22%)
51–75%	253 (14%)
76–100%	447 (25%)
<i>Multiculturalism in work community (n = 1,660)</i>	
Yes	831 (50%)
No	824 (50%)
<i>Remote client/patient work in own work (n = 1,717)</i>	
Yes	865 (51%)
No	852 (49%)
<i>Mutual ethical reflection at work (n = 1,491)</i>	
Yes	512 (34%)
No	971 (65%)
Don't know	8 (1%)
<i>Support for ethical practice</i>	
By superior (n = 1,616)	Mean out of 5
By organization (n = 1,656)	3.01 ± 0.87
	2.95 ± 0.81
<i>Satisfied with work (n = 1,734)</i>	
	3.06 ± 0.75

the differences between study variables and the personal characteristics of study participants. Due to the large number of variables, model selection was used by genetic algorithm with Akaike's information criterion [37]. Separate models were estimated for the total F-IPA questionnaire and

each of its factors. These models were used to calculate Tukey's contrasts [38] for pairwise comparisons between the professional groups. Due to the low number of participants, students were excluded from the regression analysis. The internal consistency of the Finnish version of the IPA was ensured by Cronbach's alpha [31]. Complete data of more than 70% were included. A significance level of $p < 0.05$, with a 95% confidence level, was established.

2.6. Validity and Reliability. The Keiser–Meyer–Olkin test (0.969) [39] and the Bartlett test of sphericity ($p < 0.001$) [40] suggested that the data were suitable for factor analysis [41]. Eigenvalues [41] of more than 1.0 were expected, but lower values of 0.822 to 13.605 were approved on the advice of the IPA developers [5]. Explorative factor analysis [41], with the principal axis extraction method and Varimax rotation, revealed five factors for the Finnish version of the IPA [F-IPA], which explained 69.59% of the total variance. The variances for the domains were ethics and accountability (52.325%), communication (6.395%), respect (4.321%), excellence (3.385%), and altruism and caring (3.161%). Factor loadings ranged from 0.345–0.923. Communalities <0.30 were excluded [41], with the exception of the communality value for item number 14, which was 0.263. The research group decided to keep this in the analysis due to its theoretical meaning for wholeness [41] and the distinct loading of the factor (0.044). Communalities in other items ranged from 0.509 to 0.796. The correlations between the total F-IPA and individual factors varied from 0.81 to 0.88. The correlations between factors between each other ranged from 0.63 to 0.77. Correlations between the total F-IPA and two global items, 27 and 28, were 0.48 and 0.53, respectively. Two global items had strong correlations with each other (0.71). Cronbach's alpha [31] for the F-IPA Assessment was 0.964 and alpha ranged from 0.837 to 0.912 for five factors.

2.7. Ethical Considerations. Permission to use the IPA scale [26] was granted by the developers (e-mail 26 June 2020). Research approval was received from all organizations that participated in the research. Respondents gave their informed consent electronically before completing the survey. This was based on information about the study, its voluntary nature, and the option to discontinue participation at any point [42, 43]. According to the Finnish Medical Research Act [44], there was no need for specific ethical approval, as it was a noninvasive study and the participants were able and legally competent to decide whether they participated.

3. Results

3.1. Personal Characteristics of Study Participants. In total, 2,675 Finnish health and social care workers participated in this study and were included in the analysis if they responded to at least 70% of the survey. Those with missing demographic data, incomplete items, and participants who had no opportunity to observe factors in their work environment were removed. This meant that 1,769 completed surveys were included in the statistical analysis. The mean

age of the participants was 48 ± 11.59 years, and 58% had a degree from a University of Applied Sciences. The participants had 30 different degrees. They represented nine different professional groups: care assistants (31%), nurses (18%), rehabilitation workers (13%), nurses in diagnostic care (12%), social workers (11%), nurses in oral health (5%), childcare and youth guidance (4%), physicians (3%), and students (3%) (Table 1).

3.2. Health and Social Care Workers' Assessment of Their Professionalism in Collaboration. The overall mean scores were excellent for the total Finnish version of the IPA questionnaire (4.20 ± 0.70). The same was mainly true for the five domains of ethics and accountability (4.10 ± 0.84), communication (4.34 ± 0.73), respect (4.26 ± 0.84), excellence (4.00 ± 0.91), and altruism and caring (4.26 ± 0.69) (Table 2).

When it came to the ethics and accountability domain, participants scored the clarification of other health professions on unclear information as high or excellent. Discussions with others about the ethical implications of decision-making and reporting unprofessional or unethical behavior were scored as good (Table 3). Regarding the communication domain, the participants returned high or excellent scores for respectful interactions with members of other health professions, taking the needs of other professionals into account and responding to their questions in a way they could understand (Table 3). High scores were also recorded for the respect domain with regard to confidence without arrogance, while working with other professions, and respecting the contributions and expertise of other professionals (Table 3).

The lowest scores, or good, were recorded for the excellence of professionalism. This was especially true when it came to participants' expectations of reviewing all relevant documentation from other health and social care professions before making their own recommendations about care plans. The same score was recorded for contributions to patient care decisions regardless of hierarchy or profession-based boundaries (Table 3). Participants recorded high or excellent scores for honest and trustworthy interactions between different health and social care workers in the altruism and caring domain. They only scored good for placing the patient's or client's needs above their own needs and those of other professionals (Table 3).

3.3. Associations between Professionalism and the Various Professional Groups. When the professional groups were compared using Tukey's contrast, three groups generally assessed professionalism with statistically significantly higher scores than the social workers who assessed professionalism with lower scores: care assistants (β 0.43, 95% CI 0.11 to 0.75), childcare and youth workers (β 0.30, 95% CI 0.05 to 0.56), and nurses (β 0.42, 95% CI 0.01 to 0.82). Several groups provided statistically significantly higher scores for ethical and accountable professionalism than social workers. These were care assistants (β 0.54, 95% CI 0.13 to 0.95), childcare and youth workers (β 0.56, 95% CI 0.08 to 1.05),

nurses (β 0.41, 95% CI 0.06 to 0.76), nurses in diagnostic care (β 0.46, 95% CI 0.06 to 0.86), and nurses in oral health (β 0.51, 95% CI 0.06 to 0.96). Care assistants scored statistically significantly higher in the excellence domain than social workers (β -0.45, 95% CI -0.89 to -0.01, $p < 0.001$). In general, care assistants scored higher for altruism and caring than social workers (β -0.40, 95% CI -0.68 to -0.12, $p < 0.001$) and rehabilitation workers (β -0.28, 95% CI -0.53 to -0.04, $p < 0.01$). Childhood and youth workers also scored higher than social workers (β -0.40, 95% CI -0.73 to -0.07, $p < 0.001$). These differences were statistically significant. Pairwise comparisons did not show statistically significant differences between professional groups with regard to the communication or respect domains (Table 4).

3.4. Relations between Personal Characteristics of Workers and Professionalism. Older participants delivered higher professionalism scores ($\beta = 0.01$, 95% CI 0.00 to 0.02, $p < 0.05$). Participants with university degrees scored lower for professionalism in general ($\beta = -0.27$, 95% CI -0.45 to -0.09, $p < 0.01$) than those who had education from the University of Applied Sciences. There were statistically significant differences in how the professional groups scored professionalism. Participants who had received training in interprofessional ethics in the last five years tended to score professionalism ($\beta = 0.17$, 95% CI 0.04 to 0.29, $p < 0.01$), ethics and accountability ($\beta = 0.20$, 95% CI 0.04 to 0.36, $p < 0.05$), respect ($\beta = 0.21$, 95% CI 0.07 to 0.35, $p < 0.01$), and excellence ($\beta = 0.23$, 95% CI 0.06 to 0.40, $p < 0.01$) higher than those who had not received training. Students scored ethics and accountability ($\beta = -0.24$, 95% CI -0.48 to -0.00, $p < 0.05$) and respect ($\beta = -0.38$, 95% CI -0.58 to 0.17, $p < 0.001$) lower than those who had completed their education (Table 4).

Participants who spent 26–50% of their work time engaged in interprofessional collaboration returned higher scores in general (β 0.13, 95% CI 0.02 to 0.23, $p < 0.05$), and for ethics and accountability (β 0.18, 95% CI 0.04 to 0.32, $p < 0.05$) and excellence (β 0.28, 95% CI 0.13 to 0.44, $p < 0.001$), than those who engaged in less interprofessional collaboration in their work (Table 5).

Health and social care workers who experienced mutual ethical reflection at work scored general professionalism (β 0.15, 95% CI 0.07 to 0.24, $p < 0.001$) and ethics and accountability (β 0.21, 95% CI 0.10 to 0.33, $p < 0.001$), higher than those who did not experience mutual reflections at their work. Higher general scores for professionalism were also associated with greater support for ethical practice from an organization (β 0.14, 95% CI 0.05 to 0.22, $p < 0.01$), or being more satisfied with work (β 0.16, 95% CI 0.08 to 0.23, $p < 0.001$). These personal characteristics explained statistically significant differences in professionalism between health and social workers ($p < 0.05$ to $p < 0.001$). Remote client-patient work, or multiculturalism in the work community, had no statistically significant associations with professionalism (Table 5).

4. Discussion

This study produced new knowledge about the perceptions of health and social care workers of professionalism in

TABLE 2: Finnish Interprofessional Professionalism Assessment (F-IPA) total and factor means and statistically significant differences among professional groups.

	Total F-IPA mean (SD)	Ethics and accountability mean (SD)	Communication mean (SD)	Respect mean (SD)	Excellence mean (SD)	Altruism and caring mean (SD)
All health and social care workers	4.20 (0.70)	4.10 (0.84)	4.34 (0.73)	4.26 (0.84)	4.00 (0.91)	4.26 (0.69)
Care assistants	4.32 (0.71)	4.28 (0.82)	4.40 (0.74)	4.38 (0.82)	4.15 (0.90)	4.37 (0.70)
Childcare and youth workers	4.45 (0.60)	4.45 (0.69)	4.46 (0.70)	4.49 (0.69)	4.29 (0.87)	4.51 (0.59)
Nurses	4.23 (0.61)	4.08 (0.77)	4.44 (0.63)	4.29 (0.74)	4.09 (0.77)	4.29 (0.62)
Nurses in diagnostics care	4.09 (0.70)	4.02 (0.81)	4.19 (0.73)	4.13 (0.85)	3.75 (0.95)	4.21 (0.68)
Nurses in oral health	4.20 (0.57)	4.14 (0.69)	4.32 (0.65)	4.33 (0.71)	3.84 (0.94)	4.34 (0.50)
Physicians	4.09 (0.75)	3.96 (0.95)	4.29 (0.71)	4.23 (0.78)	3.90 (0.92)	4.08 (0.76)
Rehabilitation workers	4.18 (0.69)	4.02 (0.88)	4.37 (0.72)	4.28 (0.85)	4.01 (0.94)	4.23 (0.66)
Social workers	3.92 (0.74)	3.75 (0.89)	4.18 (0.81)	3.98 (0.93)	3.68 (0.97)	4.01 (0.78)
Students	4.12 (0.72)	4.06 (0.80)	4.12 (0.89)	4.21 (0.92)	3.93 (0.93)	4.15 (0.72)
<i>p</i> value	<i>p</i> < 0.001	<i>p</i> < 0.001	<i>p</i> < 0.001	<i>p</i> < 0.001	<i>p</i> < 0.001	<i>p</i> < 0.001

collaboration in their daily work and about their associated personal characteristics. Professionalism in daily work has previously been studied in hospitals, between individual professions, and their students [5, 23, 24]. In our study, the professionalism of health and social care workers was excellent in general and at least good in all domains. This suggested a more developed behavior when it came to professionalism [5] between different professional groups. Based on the results of our study, professionalism in collaboration between health and social care workers was very consistent and strong, despite the involvement of different professional groups. This was a significant result in relation to how research identifies ethical conflicts in interprofessional collaboration [45]. The results of our study are also encouraging, as we found a way to identify these issues and enable collaboration to be further developed. The results showed that health and social care workers had a common understanding, but realizing collaboration depended on work contexts and the common structures that organizations had built to support joint work. On this basis, professionals have good conditions for collaboration, even when dealing with demanding clients and patients. Nevertheless, more information is needed to assess the realization of professionalism in collaboration, for example, with regard to ethical conflicts.

4.1. Professionalism of Health and Social Care Workers in Collaboration between Professional Groups. Based on the findings of this study, individual participants agreed on what constitutes comprehensive and understandable communication with other health and social care workers. This included respectful interactions between health and social care workers, taking into account the needs of other professionals and responding to their questions intelligibly. No statistically significant differences were reported between the professional groups. This finding contradicted previous studies [23, 24], which found that communication was the least demonstrated behavior when it comes to professionalism. Organizations providing integrated care and services benefit financially when health and social care workers achieve successful communication. This is because

it contributes to removing and preventing gaps and overlaps in care and services. [46]. At the same time, clients and patients receive more open and up-to-date information about their care and services [47]. Although the professionalism was excellent between Finnish health and social care workers, the professions must expand their communication expertise in integrated services to embrace digital tools and networks [48, 49], as well as care and service environments with increasing multiculturalism [22, 50].

Our study found that the weakest domain in collaboration was excellence in participants' responsibilities and their own contribution to the care process, as well as their contribution to care coordination and documentation to ensure quality care. However, perceptions of excellence in collaboration diverged between professional groups as social workers assessed it with lower scores than care assistants. The weak excellence result was in line with the findings of the studies conducted in hospitals [23, 24]. Sufficient attention should be paid to strengthening excellence because clients and patients who receive integrated care and services have increasingly demanding and diverse diseases and needs [51, 52]. At the same time, they are also willing to participate in decisions about their own health and well-being [53, 54]. Therefore, shared decision-making between the patient and all professions involved in their care and services is important when the best care and treatments are determined [47]. However, previous studies [45, 54] found that health and social care workers did not always follow the wishes and involvement of patients and caregivers and that this caused ethical conflicts.

4.2. Relationships between Workers' Personal Characteristics and Professionalism. The professions to which all the respondents in this study belonged were based on strong ethical foundations [2, 4, 55]. However, our results showed a lack of mutual ethical discussions on their work; only a third of the participants in this study had taken part in regular, mutual ethical reflection on their work. This raises questions about how ethical professionalism is supported during daily health and social care. It is also meaningful to question whether all health and social care workers received sufficient support for mutual ethical reflection. These results

TABLE 3: Total results for the Finnish Interprofessional Professionalism Assessment questionnaire completed by health and social care workers.

Item wording	Mean score	Number replied
<i>Ethics and accountability</i>		
Works collaboratively with members of other health and social care professions to resolve conflicts that arise in the context of caring for patients/clients	4.09	1,721
Discusses with members of other health and social care professions any ethical implications of health and social care decisions	3.71	1,651
Reports or addresses unprofessional and unethical behaviors when working with members of other health and social care professions	3.85	1,702
Engages with members of other health and social care professions in quality assurance/improvement activities	4.09	1,739
Seeks clarification from members of other health and social care professions about unclear information	4.52	1,745
Accepts consequences for his or her actions without redirecting blame to members of other health and social care professions	4.28	1,745
Works with members of other health and social care professions to identify and address errors and potential errors in the delivery of care and services	4.14	1,738
<i>Communication</i>		
Works with members of other health and social care professions to coordinate communication with patients/clients and family members	4.11	1,639
Demonstrates active listening with members of other health and social care professions	4.27	1,724
Communicates respectfully with members of other health and social care professions	4.54	1,727
Communicates with members of other health and social care professions in a way they can understand, without using profession-specific jargon	4.26	1,733
Responds to questions posed by members of other health and social care professions in a manner that meets the needs of the requester	4.51	1,714
<i>Respect</i>		
Demonstrates confidence without arrogance, while working with members of other health and social care professions	4.37	1,757
Recognizes that other health and social care professions may have their distinct cultures and values and shows respect for these	4.24	1,736
Respects the contributions and expertise of members of other health and social care professions	4.26	1,754
Seeks to understand the roles and responsibilities of members of other health and social care professions as related to care	4.23	1,752
Determines patient care roles and responsibilities in a respectful manner with members of other health and social care professions	4.21	1,739
<i>Excellence</i>		
Coordinates with other health and social care professionals and the patient/client, family, and caregivers to produce an optimal plan of care and services	4.09	1,670
Review all relevant documentation from other health and social care professions prior to making recommendations to plan of care and services	3.77	1,610
Contributes to decisions about patient/client care and services regardless of hierarchy/profession-based boundaries	3.89	1,635
Works with members of other health and social care professions to ensure continuity of care and services for patients/clients	4.25	1,712
<i>Altruism and caring</i>		
Offers to help members of other health and social care professions when caring for patients	4.27	1,747
Demonstrates empathy for members of other health and social care professions	4.20	1,756
Models for other health and social care workers compassion towards patients/clients, families, and caregivers	4.41	1,743
Places patient/client needs above own needs and those of other health and social care workers	3.94	1,741
Interacts with members of other health and social care professions in an honest and trustworthy manner	4.50	1,753

TABLE 4: Linear regression model of variation in professionalism behavior and related personal characteristics among health and social care workers.

	Total F-IPA	Ethics and accountability	Communication	Respect	Excellence	Altruism and caring
Background variable	β (CI)	β (CI)	β (CI)	β (CI)	β (CI)	β (CI)
Intercept	3.29	2.87	3.90	3.27	2.97	3.74
Age	0.01 (0.00, 0.02)*	-0.01 (0.00, 0.02)	0.00 (-0.00, 0.01)	0.01 (0.01, 0.02)**	0.01 (-0.00, 0.02)	0.01 (-0.00, 0.01)
Education level						
Applied sciences	Ref	Ref	Ref	Ref	Ref	Ref
Secondary level	0.001 (-0.16, 0.16)	0.05 (-0.15, 0.24)	0.04 (-0.10, 0.19)	0.01 (-0.17, 0.19)	0.10 (-0.13, 0.33)	-0.05 (-0.18, 0.09)
University	-0.27 (-0.45, -0.09)**	-0.27 (-0.50, -0.05)*	-0.29 (-0.49, -0.09)**	-0.34 (-0.56, -0.12)**	-0.31 (-0.55, -0.08)**	-0.17 (-0.34, -0.01)*
Interprofessional ethics training in last 5 years						
Yes	Ref	Ref	Ref	Ref	Ref	Ref
No	-0.17 (-0.29, -0.04)**	-0.20 (-0.36, -0.04)*	-0.05 (-0.16, 0.06)	-0.21 (-0.35, -0.07)**	-0.23 (-0.40, -0.06)**	-0.10 (-0.21, 0.01)
Professional group						
Care assistants	Ref	Ref	Ref	Ref	Ref	Ref
Childcare and youth workers	-0.02 (-0.25, 0.22)	0.02 (-0.24, 0.29)	0.01 (-0.20, 0.22)	-0.02 (-0.27, 0.23)	0.05 (-0.25, 0.35)	0.00 (-0.20, 0.20)
Nurses	-0.13 (-0.30, 0.04)	-0.13 (-0.34, 0.079)	0.01 (-0.15, 0.16)	-0.11 (-0.30, 0.09)	-0.12 (-0.35, 0.12)	-0.18 (-0.32, -0.03)*
Nurses in diagnostic care	-0.18 (-0.38, 0.02)	-0.08 (-0.32, 0.16)	-0.13 (-0.32, 0.06)	-0.24 (-0.48, 0.00)	-0.46 (-0.78, -0.14)**	-0.20 (-0.37, -0.02)*
Nurses in oral health	-0.15 (-0.37, 0.07)	-0.03 (-0.30, 0.24)	-0.05 (-0.24, 0.14)	-0.04 (-0.28, 0.19)	-0.36 (-0.69, -0.02)*	-0.15 (-0.33, 0.04)
Physicians	-0.14 (-0.57, 0.29)	-0.20 (-0.76, 0.37)	-0.06 (-0.39, 0.28)	-0.01 (-0.45, 0.42)	-0.06 (-0.60, 0.48)	-0.46 (-0.92, 0.01)
Rehabilitation workers	-0.20 (-0.38, -0.02)*	-0.23 (-0.47, 0.00)	-0.08 (-0.25, 0.10)	-0.10 (-0.32, 0.11)	-0.15 (-0.40, 0.11)	-0.28 (-0.44, -0.12)**
Social workers	-0.43 (-0.64, -0.22)**	-0.54 (-0.81, -0.27)**	-0.19 (-0.38, -0.00)*	-0.34 (-0.59, -0.10)**	-0.45 (-0.74, -0.16)**	-0.40 (-0.58, -0.22)**

β : estimate of regression coefficient. Positive β reflects demonstration of more developed interprofessional professionalism behavior, and negative β lowers interprofessional professionalism behavior demonstration. CI: 95% confidence interval for β (lower bound-upper bound). *** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$.

TABLE 5: Linear regression model of variation in professionalism behavior and work-related characteristics among health and social care workers.

	Total F-IPA	Ethics and accountability	Communication	Respect	Excellence	Altruism and caring
Background variable	β (CI)	β (CI)	β (CI)	β (CI)	β (CI)	β (CI)
Intercept	3.29	2.87	3.90	3.27	2.97	3.74
<i>Work experience</i>						
In health and social care	0.01 (-0.00, 0.01)	0.00 (-0.00, 0.01)	0.01 (0.00, 0.01)**	0.00 (-0.00, 0.01)	0.01 (-0.00, 0.01)	0.00 (-0.00, 0.01)
<i>Position at work</i>						
Employee	Ref	Ref	Ref	Ref	Ref	Ref
Supervisor	-0.09 (-0.23, 0.04)	-0.07 (-0.26, 0.11)		-0.10 (-0.25, 0.06)		
Student	0.01 (-0.17, 0.19)	-0.24 (-0.48, -0.00)*		-0.38 (-0.58, -0.17)***		
Other	-0.33 (-0.63, -0.03)*	-0.41 (-0.70, -0.12)**		-0.40 (-0.88, 0.08)		
<i>Multiculturalism at work community</i>						
Yes	Ref	Ref	Ref	Ref	Ref	Ref
No	-0.05 (-0.13, 0.03)	-0.06 (-0.16, 0.04)	-0.02 (-0.08, 0.08)	-0.06 (-0.16, 0.04)	-0.03 (-0.14, 0.08)	-0.05 (-0.13, 0.03)
<i>Share of interprofessional collaboration at work</i>						
<25%	Ref	Ref	Ref	Ref	Ref	Ref
26-50%	0.13 (0.02, 0.23)*	0.18 (0.04, 0.32)*	0.05 (-0.05, 0.15)	0.02 (-0.11, 0.15)	0.28 (0.13, 0.44)***	
51-75%	-0.01 (-0.13, 0.11)	0.04 (-0.12, 0.21)	-0.06 (-0.17, 0.06)	-0.09 (-0.24, 0.05)	0.10 (-0.08, 0.27)	
76-100%	-0.01 (-0.12, 0.10)	0.06 (-0.07, 0.19)	-0.07 (-0.17, 0.03)	-0.10 (-0.23, 0.03)	0.17 (0.03, 0.32)*	
<i>Remote client/patient work in one's own work</i>						
No, at most yearly	Ref	Ref	Ref	Ref	Ref	Ref
Yes, at least monthly	0.01 (-0.08, 0.09)	-0.01 (-0.12, 0.09)	-0.02 (-0.10, 0.06)	-0.04 (-0.13, 0.06)	0.04 (-0.07, 0.16)	0.05 (-0.03, 0.12)
<i>Mutual ethical reflection at work</i>						
Yes	Ref	Ref	Ref	Ref	Ref	Ref
No	-0.15 (-0.24, -0.07)***	-0.21 (-0.33, -0.10)***	-0.12 (-0.20, -0.04)**	-0.11 (-0.22, -0.01)*	-0.12 (-0.24, -0.00)*	-0.09 (-0.18, -0.01)*
<i>Support for ethical practice by</i>						
Superior	-0.04 (-0.11, 0.03)	-0.03 (-0.11, 0.06)	-0.04 (-0.10, 0.03)	-0.06 (-0.14, 0.03)	-0.05 (-0.14, 0.04)	-0.01 (-0.07, 0.05)
Organization	0.14 (0.05, 0.22)**	0.18 (0.07, 0.28)**	0.10 (0.03, 0.18)**	0.13 (0.04, 0.22)**	0.13 (0.02, 0.24)*	0.06 (-0.01, 0.12)
<i>Satisfaction with work</i>						
No	Ref	Ref	Ref	Ref	Ref	Ref
Yes	0.16 (0.08, 0.23)***	0.17 (0.08, 0.26)***	0.10 (0.03, 0.17)**	0.18 (0.10, 0.27)***	0.18 (0.07, 0.29)**	0.13 (0.07, 0.19)***

estimate of regression coefficient. Positive β reflects demonstration of more developed interprofessional professionalism behavior, and negative β lowers interprofessional professionalism behavior demonstration. CI: 95% confidence interval for β (lower bound-upper bound). *** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$. Absences due to model selection by genetic algorithm with Akaike's information criterion.

were consistent with previous studies [56] since mutual ethical reflection in the workplace promoted the realization of professionalism in collaboration. The conduct of professions is based on values [3, 57], and it has been well recognized that conflicts between professions arise from ethical issues [45], which could be resolved with ethical reflection [56]. The values of health and social care workers are tied to the values of their own professions [58–60]. It is important to encourage leaders and organizations to have mutual ethical discussions on even the most difficult topics that arise during their daily work. These should cover collaboration between professional groups [2, 5], the increasing demands and needs of clients [47, 51], patients, and their close relatives, and the views of other stakeholders [2]. Leaders are role models for their employees and determine what kinds of values guide their work, in addition to professional values [56]. Their support plays an important role in ensuring ethical care practices [32]. But it is not just about practical ethical reflections in the work community. We also need to assess whether shared reflection [32, 61] is also needed between various stakeholders in integrated service systems, such as employees and patients from public, private, and nonprofit organizations. Organizational structures and processes, such as ethical committees and continued training [61] in interprofessional ethics, can support leadership. They could also help prepare health and social care workers for ethical reflections between organizations. It is also important to consider whether the results would have been different if the study had been carried out in another multicultural global context or culture. Other countries may have much more culturally heterogeneous working environments [9] and it would be useful to explore whether such contexts would have more meaning.

Our results showed that organizational support for ethical practice and worker satisfaction at work were related to a more developed professionalism behavior in collaboration between professional groups. Previous studies examined structures of organizational support, for example, ethical competence [45, 46] to be composed of encouragement on ethical activity, giving multifold information about resolving ethical issues, and having multidisciplinary conversations. In the future, it is necessary to investigate those organizational structures and processes that support professionalism in collaboration between health and social care workers and if all workers recognize these. It is also important to explore what kind of leadership supports the ethics of professionalism in collaboration. Previous research [14, 16, 17] has also shown a relationship between professionalism and work satisfaction, but among single professions. Therefore, it will be necessary to study the relationship between worker satisfaction at work and professionalism behavior in collaboration. This information could be used to develop structures to support professionalism and/or satisfaction at work if it is known which one can be supported by the other.

4.3. Limitations. This study had some limitations. The response rate of 2.2% may be considered low. We know how many invitations were sent by organizations to potential participants, but not how many reached them. The reminders

did not have a great impact on the number of respondents. It should be noted that the study was carried out during the COVID-19 pandemic and a national nursing strike occurred during the data collection period. These may have caused the potential harm to participation in the study. Response rates may have been affected by using e-mails and newsletters to reach participants, as the previous literature reported limited success with these methods [62]. Self-assessment has also been considered a weaker form of data collection [62]. However, it was necessary to reach as many respondents as possible from different professional groups, and the health and social care workers that we chose satisfactory represented the various Finnish health and social care professions [63]. In addition, there were consistent results from study participants from various work environments, which reinforced this study and its credibility. Carrying out the study in different contexts [5] or cultures [9] may have produced different findings than our Finnish results. It may not be possible to generalize our results to other settings, such as countries with more culturally heterogeneous working environments. However, professionals tend to share the same global values in health and social care [2, 55].

5. Conclusions

This study showed consistent professionalism in the collaboration between health and social care workers, despite the fact that it involved self-assessment by different professional groups in various working contexts. This was noteworthy with regard to the realization of integrated person-centered care. Regular mutual ethical reflections at work promoted professionalism in collaboration, but these discussions were only implemented in a minor way. Organizations should develop mutual ethical reflection activities to ensure that all individuals representing different professional groups are qualified to have these discussions in care, rehabilitation, and social services. In future studies, it is necessary to investigate possible organizational structures and processes that best support professionalism. It is also necessary to explore how leadership supports professionalism in collaboration. Furthermore, it is necessary to explore where ethical conflicts, identified in previous studies, arise when collaboration appears to be as harmonious as described in our study. This research produced fairly narrow knowledge about the studied phenomenon, as it studied the self-assessed perspectives of members of professional groups. Future studies need to gather the perceptions of professionalism in collaborative practice from other parties to broaden this understanding, such as patients, close relatives, and other stakeholders and organizations.

Data Availability

The authors are not able to provide direct access to this data, and any queries should be discussed with them.

Disclosure

The funders were not involved in any aspect of the study or the paper.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

Authors' Contributions

Annette Whibley, a professional medical editor from the UK, was involved in improving the English in this paper.

Acknowledgments

The authors thank all the health and social care workers, students, and organizations that participated in this study. This study was supported by the Foundation for Finnish Nursing Education and the Turku University Foundation. Open access funding was enabled and organized by FinELib 2023.

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