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# ETHICS AND PROFESSIONALISM IN COLLABORATION AMONG HEALTH AND SOCIAL CARE WORKERS

Piiku Pakkanen

TURUN YLIOPISTON JULKAISUJA – ANNALES UNIVERSITATIS TURKUENSIS
SARJA – SER. D OSA – TOM. 1861 | MEDICA – ODONTOLOGICA | TURKU 2025

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## ABSTRACT

Ethics and professionalism are the fundamental basis of collaboration among different professional groups to secure integrated, joint and seamless person-centered care for patients and clients. The aim of this study was to explore and describe ethics and professionalism in collaboration among health and social care workers and the related factors. This new knowledge can be used to support health and social care workers in their work of providing integrated high-quality person-centered care.

The study utilized mixed methods. Meta-synthesis of previous knowledge of ethics in interprofessional collaboration was carried out using data collection from electronic databases and manual search. A cross-sectional survey was conducted with two instruments, the Nurses' Professional Values Scale-3 and the Interprofessional Professionalism Assessment. The data was collected among health and social care workers (n=1,823) in collaboration with 15 Finnish professional trade unions. The quantitative data was analysed by statistical methods and qualitative data with inductive content analysis.

Based on the findings of the meta-synthesis, ethics in interprofessional collaboration was related to health and social care workers' understanding of the role of the patients and other professionals in the care process. Ethical conflicts in collaboration were connected to respecting patients' own will, honesty to patients and the conduct of proper pain management. Based on the findings of the cross-sectional survey, professional values and professionalism in collaboration were highly consistent among professional groups. Workers who received support for their ethical practice from their organization and experienced work satisfaction had statistically significantly stronger professional values and scored higher than others in professionalism in collaboration.

To ensure person-centered health and social care services, structures and leadership methods are needed to develop to support shared values among different professionals. More research is needed on the realization of ethics and professionalism in collaboration related to person-centered care in integrated care.

KEYWORDS: Collaboration, cross-sectional survey, ethics, health and social care workers, integrated care, interprofessional, meta-synthesis, person-centered care, professionalism, professional values, shared values

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## TIIVISTELMÄ

Etiikka ja ammatillisuus ovat sosiaali- ja terveydenhuollossa työskentelevien ammattiryhmien välisen yhteistyön perusta. Näin voidaan turvata yhtenäinen integroitu ja saumaton henkilökeskeinen hoito ja palvelut. Tämän tutkimuksen tarkoituksena oli kuvata etiikkaa ja ammatillisuutta sosiaali- ja terveydenhuollon työntekijöiden välisessä yhteistyössä ja sekä siihen yhteydessä olevia tekijöitä. Tuotetun tiedon avulla voidaan tukea ammattilaisia toteuttamaan eettistä henkilökeskeistä hoitoa ja palvelua.

Tutkimus toteutettiin monimenetelmällisesti. Aikaisempi tutkimus kuvattiin metasynteesin menetelmällä. Sen aineisto haettiin elektronisista tietokannoista ja manuaalisena hakuna. Poikkileikkaustutkimuksessa käytettiin kahta mittaria, jotka olivat Ammatilliset arvot hoidossa ja palveluissa sekä Moniammatillinen yhteistyö sosiaali- ja terveydenhuollossa. Aineisto kerättiin sosiaali- ja terveydenhuollon ammattilaisilta (n=1,823) yhteistyössä 15 ammattijärjestön kanssa. Määrällinen aineisto analysoitiin tilastollisin menetelmin ja laadullinen aineisto induktiivisella sisällön analyysillä.

Metasynteesin perusteella etiikka moniammatillisessa yhteistyössä kytkeytyy siihen, miten sosiaali- ja terveysalan ammattilaiset hahmottavat asiakkaan, potilaan ja muiden ammattilaisten roolin hoidossa ja palveluissa. Eettiset konfliktit ammattien välisessä yhteistyössä kohdistuvat asianmukaiseen potilaan tahdon kunnioittamiseen, rehellisyyteen potilasta kohtaan sekä asianmukaiseen kivun hoitoon. Poikkileikkaustutkimuksen perusteella ammattilaisten kokemus eettisiin kysymyksiin saadusta organisaation tuesta ja työtyytyväisyydestä oli tilastollisesti merkitsevästi yhteydessä koettuihin ammatillisiin arvoihin ja ammatillisuuteen yhteistyössä.

Henkilökeskeisen sosiaali- ja terveydenhuollon varmistamiseksi tarvitaan rakenteita ja johtamisen menetelmiä yhteisten arvojen tukemisessa ammattien välisessä yhteistyössä. Lisää tutkimusta tulee kohdistaa etiikan ja ammatillisuuden toteutumiseen yhteistyössä suhteessa henkilökeskeiseen hoitoon ja palveluihin.

AVAINSANAT: Ammatillisuus, ammatilliset arvot, etiikka, henkilökeskeinen hoito, integroidut sosiaali- ja terveydenhuollon palvelut, jaetut arvot, metasynteesi, moniammatillisuus, poikkileikkaustutkimus, sosiaali- ja terveydenhuollon ammattilaiset, yhteistyö

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# Abbreviations

| | |
|---|---|
| ALLEA | All European Academies |
| ANA | American Nurses Association |
| APTA | American Physical Therapy Association |
| $\beta$ | Beta Coefficient |
| CFA | Confirmatory Factor Analysis |
| CINAHL | Cumulative Index of Nursing and Allied Health Literature |
| EFA | Exploratory Factor Analysis |
| ETENE | The National Advisory Board on Social Welfare and Health Care Ethics |
| F-IPA | Finnish version of Interprofessional Professionalism Assessment |
| F-NPVS-3 | Finnish version of Nurses Professional Values Scale-3 |
| ICM | International Confederation of Midwives |
| ICN | International Council of Nurses |
| IFSW | International Federation of Social Workers |
| IPA | Interprofessional Professionalism Assessment |
| IPC | Interprofessional Collaboration |
| IPEC | Interprofessional Education Collaborative |
| IPP | Interprofessional Professionalism |
| NPVS-3 | Nurses Professional Values Scale-3 |
| REDCap | Research electronic data capture |
| STROBE | Strengthening the Reporting of Observational Studies in Epidemiology |
| TENK | Finnish National Board on Research Integrity |
| WHO | World Health Organization |
| WMA | World Medical Association |

# List of Original Publications

This dissertation is based on the following original publications, which are referred to in the text by their Roman numerals:

I Pakkanen P, Häggman-Laitila A & Kangasniemi M. Ethical issues identified in nurses' interprofessional collaboration in clinical practice: a meta-synthesis. *Journal of Interprofessional Care*, 2022; 36(5): 725–734.

II Pakkanen P, Häggman-Laitila A, Pasanen M & Kangasniemi M. 2024. Health and social care workers' professional values: a cross-sectional study. *Nursing Ethics*, 2024; 31(5): 681–698.

III Pakkanen P, Häggman-Laitila A, Pasanen M & Kangasniemi M. 2024. The professionalism in collaboration between health and social care workers: a survey to members of the Finnish trade unions. *Health & Social Care in the Community*, 2024; Jul 10:2418812. Epub ahead of print.

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# 1 Introduction

Ethics and professionalism in collaboration among health and social care workers are the key factors that guarantee high-quality person-centred care (Frost et al., 2018; Hammer et al., 2012; Thompson et al., 2006). Succesful health and social care services of patients and clients are expected to be carried out in collaboration between different professional groups (Karam et al., 2018; WHO, 2016). Various care and service reforms with integrated care have been carried out to find a solution and respond to multiple needs of clients and patients globally (WHO, 2016) and also in Finnish society (Act on Organizing Healthcare and Social Welfare Services 612/2010; 612/2021; Kallio et al., 2022; Ministry of Social Affairs and Health, 2024a; Tiirinki et al., 2022). Aim to produce equal access of health and social care services for all citizens is based on both nationally and internationally (Baxter et al., 2018; The Constitution of Finland, 731/1999; National Advisory Board on Ethics in Social and Health Care [ETENE], 2011; Sandhu et al., 2021; WHO, 2018).

Through health and social care reforms, integrated care aims to improve the care and social service path of individuals (Kallio et al., 2022; Karam et al., 2018; Nicholson et al., 2018). The goal is to produce person-centered care and social services, provided in close collaboration between professionals patients or clients and their significant others (Baxter et al., 2018; Nummela et al., 2019; WHO, 2016, 2018). Simultaneously, the purpose is to take into account demographic change (Frost et al., 2018; WHO, 2017) as well as the global shortage of health and social care workers (Drennan & Ross, 2019; Vaseghi et al., 2022). A further intent is to develop the sustainability and cost-effectiveness of care and social services (de Matos et al., 2024; WHO, 2016). Integrated care has been shown to enable better access to services, while at the same time improving patient and client satisfaction (de Matos et al., 2024; Nurchis et al., 2022). In this thesis, the term 'integrated care' is used to describe reformed health and social care services.

Ethics in collaboration among different health and social care workers form the basis of integrated care. As the basis of work, professional values show the health and social care workers how the job should be done. At the same time, they provide a framework for the rights, duties and responsibilities of professionals, guiding their daily work and ethical decision-making in patient and client care. (American Nurses

Association [ANA], 2015; Kangasniemi et al., 2015; Weis & Schank, 2017.) Health and social care workers express their value orientation by how important they feel these values are (Weis & Schank, 2017). Professional values are most often described in the ethical guidelines of the profession, codes of ethics (International Council of Nurses [ICN], 2021; International Federation of Social Workers [IFSW], 2018; International Confederation of Midwives [ICM], 2014) and/or codes of professional conduct (American Physical Therapy Association [APTA], 2020; World Medical Association [WMA], 2015).

Each profession requires its members to demonstrate professionalism in their activities in health and social care services. This means that the individual works based on professional knowledge, values and skills and collaboratively with others (Cao et al., 2023; Eid et al., 2018; Ghadirian et al., 2014; Lecours et al., 2021). Professionalism in collaboration refers to the shared values which become visible and true during the collaboration between different professional groups and patients and clients (Frost et al., 2018; Hammer et al., 2012; Interprofessional Education Collaborative [IPEC], 2023). Effective and successful collaboration requires knowledge of the professional ethics and values of other professional groups. It is also important to respect the values of others. (Karam et al., 2018.) Despite the importance of the fundamental basis of ethics and professionalism, professionals have reported ethical issues in their daily work (Gágyor et al., 2019; Pavlish et al., 2015; Rainer et al., 2018).

Lack of knowledge of other professionals' values has challenged collaboration in health and social care services (Engel & Prentice, 2013; Kangasniemi et al., 2022). The focus on studies on professional values (Arnal-Gómez et al., 2022; Poorchangizi et al., 2019; Poreddi et al., 2021; Weis & Schank, 2000, 2009, 2017) and professionalism (Cao et al., 2023; Lecours et al., 2021; Reimer et al., 2019; Vincent, 2023), has been on individual professions. Due to the reform of health and social care services (Kallio et al., 2022; Karam et al., 2018; Nicholson et al., 2018), which has included changes to the roles of professionals and patients and clients in collaboration with each other (Baxter et al., 2018; Nummela et al., 2019), it is important to produce knowledge about how various professional groups assess their professional values, and how they implement these in their collaboration between each other. The aim of this study was to explore and describe ethics and professionalism in collaboration among health and social care workers and the related factors. The ultimate goal was to provide new knowledge of the topic to support health and social care workers in their work of providing person-centered care.

# 2 Review of the Literature

To establish the theoretical background for the phenomenon examined in this dissertation study, this chapter is based on previous literature, using scientific literature, textbooks, dictionaries, and international and national legislation and guidelines. Scientific literature for this theoretical background has been collected during the study process using the CINAHL, PubMed, Scopus and SocINDEX databases. The searches were limited to scientific peer-reviewed articles, published in English and with a focus on the studied phenomenon (Appendix 1.)

## 2.1 Professional collaboration in health and social care services

Professional collaboration between health and social care workers has been described as a strategy in integrated care to secure care and social services that are accessible, joint, seamless (Baxter et al., 2018; Hammer et al., 2012; Holtman et al., 2011; Nicholson et al., 2018; WHO 2016, 2018) and person-centered (Baxter et al., 2018; Kangasniemi et al., 2015; Nicholson et al., 2018). The goal is to provide high-quality treatment for clients and patients (Frost et al., 2018; Hammer et al., 2012; Holtman et al., 2011; IPEC, 2023). The overall goal is to work toward the optimal well-being, safety and health of the patients, clients and communities (Hammer et al., 2012; Holtman et al., 2011; Frost et al., 2018). Collaboration enables health and social care workers the help and support they need to attain their principal aim at the global and community levels as well as individual and group levels (IPEC, 2023; Wilhelmsson et al., 2012; World Health Organization, 2010). In this thesis, the terms 'collaboration among health and social care workers' and 'interprofessional collaboration' are used in parallel to describe professional collaboration in integrated care.

### 2.1.1 Integrated care toward person-centeredness

Integrated care, toward person-centeredness refers to interprofessional collaboration in health and social care services which supports ethical, joint and seamless working to meet patients' and clients' needs (Baxter et al., 2018; Minkman, 2016; Nicholson

et al., 2018; WHO 2016, 2018). Integrated care involves different levels of health and social care services coordinating and supporting collaboration between the care and cure sectors (Minkman, 2016; WHO, 2016 ) and patients and clients (Henderson et al., 2020; Valentijn et al., 2022; WHO, 2016). Integration between different stakeholders is required at the systemic, organizational, professional and clinical levels, also acknowledging the shared goals, values and support for integration (Valentijn et al., 2022).

The primary aim of integrated care is to improve the care and social service paths provided to patients and clients (Kallio et al., 2022; Karam et al., 2018; Minkman, 2016; Nicholson et al., 2018). The goal is to improve health care and social service outcomes, reduce care inequalities (Henderson et al., 2020; Nicholson et al., 2018), and ensure that patients can continue living in their own communities, such as home (Vaartio-Rajalin & Fageström, 2019) for as long as possible. In addition, the goal of integrated care is to increase the efficiency, safety, timeliness, and coordination of the service (Henderson et al., 2020; de Matos et al., 2024; Nicholson et al., 2018) by, for example, reducing duplication and avoiding unnecessary hospitalizations (Vaartio-Rajalin & Fageström, 2019).

Person-centeredness refers to a way of producing integrated care which is based on supportive, respectful and empowering relationships between health and social care workers, patients and clients and their significant others (Morgan & Yoder, 2012; Valentijn et al., 2022). Antecedents for person-centered care in organizations include a vision and commitment to supporting environmental culture, organizational behavior, positive attitudes and shared decision-making (Morgan & Yoder, 2012; Valentijn et al., 2022). Person-centeredness has enabled improving the quality of care and health outcomes and increasing satisfaction with integrated care (Morgan & Yoder, 2012).

Patients' and clients' roles and the mode of communication between them and health and social care workers in the process of integrated care are crucial (Cassidy et al., 2023; Nicholson et al., 2018; WHO, 2010). In this process of interaction, mutual honesty and trust are required (Banks, et al., 2010; IPEC, 2023). Patients' and clients' roles in the collaboration between professional groups have changed. Increasingly, patients and clients are expected to take responsibility for their own care by participating in decision-making regarding their treatments. (Castro et al., 2018; Nordin et al., 2017.) They are expected to be part of a team made up of members of different professional groups (IPEC, 2023; Lawless et al., 2020).

Patients and clients also have a wider awareness of their rights and possibilities to share decision-making related to their care (Chen et al., 2020; Kallio et al., 2022; WHO, 2010). They also have comprehensive expectations of proper communication, collaboration, and confidential relationships (Henderson et al., 2020), and the continuity of care, including treatment effectiveness and support for their self-care

(Lawless et al., 2020). Patients and clients find it important that the safety and rights of the individual as well as their families and significant others are taken into account (Lawless et al., 2020). Patients experience that integrated care provided in collaboration with different professions is related to their enhanced well-being, self-care, and overall quality of life (Henderson et al., 2020; Nurchis et al., 2022).

### 2.1.2 Interprofessional collaboration among health and social care workers

Interprofessional collaboration among health and social care workers is a term that has become more common recently to describe mutual action taken together to improve working outcomes. Multiple terms have been used for this, such as co-operation, multiprofessional collaboration and partnership. *Co-operation* refers to the most limited way of taking care of patients and clients together with others. Even though there is an agreed goal (Castañer & Oliveira, 2020), there is no cross-professional interface or negotiation (Schot et al., 2018). By contrast, a health and social care worker informs the other parties of the collaboration when the work has already been completed (Petrakou, 2009). *Multiprofessional collaboration* refers to workers from different professional groups working together side by side for a mutual goal when needed but there is no deeper integration between the workers and they remain separated, which has been described as operating in their respective silos. This results in a lack of knowledge and understanding of the roles and skills of other professionals in care processes. (Khalili & Orchard, 2020.) *Partnership* refers to different professional groups and their members engaging in long-term cooperation with each other (Kaiser et al., 2022), mostly based on inter-organizational relationships (Casey, 2008; Häggman-Laitila & Rekola, 2016). It includes, however, shared goals and purpose, participation, the provision of information and the sharing of decisions (Casey, 2008).

Interprofessional collaboration refers to a process in which different health and social care workers and professional groups collaborate to achieve the best possible result in patient or client care (IPEC, 2023; Reeves et al., 2017). It refers to finding ways of working together, in different environments, and between various service providers (Lindblad, 2021; Scholes & Vaughan, 2002; Schot et al., 2020), with a mutual understanding of the shared responsibility of care, where patients and clients are also involved (IPEC, 2023; Khalili & Orchard, 2020; Lutfiyya et al., 2019). Interprofessional collaboration aims to clarify the needs of patients and clients and respond to these needs together (Ministry of Social Affairs and Health, 2024c; Reeves et al., 2017; WHO 2016, 2018). It requires teamwork, in which different health and social care workers, patients and clients and their families and significant others are participating (Doornebosch et al., 2022; IPEC, 2023). It also requires

commitment to mutual goals and willingness to take part in joint collaboration (Doornebosch et al., 2022; Minkman, 2016). Successful interprofessional collaboration enables the views and expertise of all parties to be acknowledged for the benefit of patients' and clients' safe treatment and ethical, person-centered care (Vaseghi et al., 2023).

Interprofessional collaboration among health and social care workers is conducted in multiple settings (Auschra, 2018; Piquer-Martinez et al 2024; WHO, 2016), between individuals, different specialities in out-patient and in-patient care, and organizations (Piquer-Martinez et al, 2024), and multicultural teams (Chen et al., 2020; Egede-Nissen et al., 2019). The involvement of patients and clients (Castro et al., 2018; Nordin et al., 2017) is increasingly changing the environment where health and social care workers perform their daily work. Digital health and social care services (Guraya et al., 2021; Rukavina et al., 2021) as well as new technology (Guraya et al., 2021; Risling 2017; Rukavina et al., 2021) contribute to shaping work, enabling working in person and remotely (Terkamo-Moisio et al., 2021; Guraya et al., 2021). These contribute to the work carried out together with different professional groups but also to the work done alone, for example, in the care of older people, where the focus is on services provided at patients' and clients' homes (Ministry of Social Affairs and Health, 2024c; Vaartio-Rajalin & Fageström, 2019).

### 2.1.3 Competencies guiding interprofessional collaboration

Competencies for interprofessional collaboration are needed to fulfil the requirements of the collaborative work assigned to professional groups in integrated care. All workers need the knowledge of the entity of integrated care to ensure the continuity of patients' and clients' paths in services. Health and social care workers are required to have professional competencies directed by their own profession and generic competence shared by all professions. (Kangasniemi et al., 2018; Ministry of Social Affairs and Health, 2024c; Nummela et al., 2019.)

Collaboration between professions is based on professionals' own competence which consists of theoretical and practical knowledge and skills, self-efficacy and attitudes (Kangasniemi et al., 2018). Evidence-based knowledge and substance know-how ensure that patients' and clients' needs are recognized and properly assessed. They also make sure that the necessary care is provided in a timely manner. (Kangasniemi et al., 2018; Nummela et al., 2019.)

Generic competencies, shared by all professionals, consist of knowledge of how to work with patients and clients, how to develop work in integrated care, and how to work together with others (Barraclough et al., 2021, Kangasniemi et al., 2018). This includes knowledge of ethics and legislation, a person-centered orientation, expertise in development and research, as well the other topical expertise such as

new technology and sustainable development. Knowledge of ethics and legislation are seen as cross-cutting competence areas through other competencies. (Kangasniemi et al., 2018; Ministry of Social Affairs and Health, 2024c.)

Health and social care workers must advance their competence in four different competencies related to collaboration between other professions. These are: working according to the principles that lay at the core of working together in interprofessional collaboration; having awareness of the responsibilities and roles of various professional groups and professions; managing their teamwork skills; and managing working practices based on professional and shared values. (IPEC, 2023.) Health and social care workers also need knowledge from other professional groups as well as their skills and competencies (IPEC, 2023; Minkman, 2016). Together they need to improve their competencies on how to assess the needs of patients and clients in a person-centered manner, provide guidance of services from a holistic perspective, and ensure that the service path is individual for each patient or client (Ministry of Social Affairs and Health, 2024c; Nummela et al., 2019).

It is essential that workers have the competence and are capable of resolving conflicts and disagreements in a way that serves the best interest of the patient or client (Hammer et al., 2012; Vaseghi et al., 2023). Working together is based on good communication, where patients, clients, and workers interact with mutual trust and an open manner. Continuous structural changes to still improve the provided integrated care (Henderson et al., 2021) require the capability to react to changing job descriptions and tasks together with other professional groups (Barraclough et al., 2021; Stein, 2016).

## 2.2 Ethics in interprofessional collaboration in integrated care

Ethics in interprofessional collaboration in health and social care services consists of moral values and principles that guide how professionals interact with each other regarding the concepts of right and wrong (Thompson et al., 2006). It also includes the professionals' awareness of the duties and responsibilities involved in that collaboration. (Clark et al., 2007; Engel & Prentice, 2013; Thompson et al., 2006.)

### 2.2.1 Legislation guiding the professional work

Legislation guides the professions in integrated care where they have missions and roles defined for them by society, and laws and regulations (Lindblad, 2021; Scholes & Vaughan, 2002). Laws also govern the way work is done (Act on Organizing Healthcare and Social Welfare Services 612/2010; 612/2021; Data Protection Act, 1050/2018). Different stakeholders are guided on how these services should be

organized and who is responsible for them (Act on Organizing Healthcare and Social Welfare Services 612/2010; 612/2021). The law also defines who and with which qualifications may act as a professional in health and social care services (Act on Health Care Professionals, 559/1994; Act on Social Welfare Professionals, 817/2015).

In Finland, each individual has the right to sufficient health and social care services (The Constitution of Finland, 731/1999). Health and social care workers are guided to take into account the patients' right to decide on their treatments and make these decisions together. This also includes obligations to take into account the consent and opinions of patients as well as their rights to refuse treatments. All these require, that patients receive enough understandable information about their health situation, possible options for treatment, and the effects of treatment. (Act on the Status and Rights of Patients, 785/1992.) The use of patients' personal data must be appropriate and confidential. Patients have legal rights to have information on how and why their patient data is used. (Data Protection Act, 1050/2018.) Clients have a right to access social welfare services (Act on the Status and Rights of Social Welfare Clients, 812/2000) in which their individuality, dignity and privacy are respected (Ministry of Social Affairs and Health, 2024b).

Laws, regulations and declarations (e.g. Act on the Status and Rights of Patients, 785/1992; Act on the Status and Rights of Social Welfare Clients, 812/2000; United Nations, 1948) require respect for human rights and dignity. This includes the freedom of choice and self-determination of patients (National Advisory Board on Ethics in Social and Health Care, ETENE 32, 2011).

### 2.2.2 Shared values in collaboration

Shared values in collaboration among health and social care workers have traditionally been rooted in respect for human dignity, wanting the best for the patients and the clients, avoiding causing them any harm and aiming to ensure integrity (Rider et al., 2021; United Nations, 1948). Shared values are based on the common goals of health and social care services to provide effective, safe and quality care (ETENE, 2001; Rider et al., 2021; WHO, 2015), as well as the values of individual professional groups (ETENE, 2001; Kangasniemi et al., 2015; WHO, 2015).

In integrated care, health and social care workers are also guided by their professional values and ethical principles (Kallio et al, 2022; Karam et al. 2018; Lindblad, 2021; Scholes & Vaughan, 2002). Professional values mean moral principles guiding workers to act professionally in their daily work (Beauchamp & Childress, 2013; Johnstone, 2016; Merriam-Webster Dictionary, 2024; Varkey, 2021). These values show them the starting points of work and what is important to

a professional group (Kangasniemi et al. 2015; WHO, 2015) as well as the core responsibilities, duties and rights of professionals (Kangasniemi et al., 2015; Varkey, 2021).

A fundamental part of the collaboration between professional groups and their members is promoting the value of patients' and clients' health, safety and well-being (Kallio et al., 2022; Karam et al., 2018). The shared values of respecting the human dignity, autonomy, equality, justice and privacy of the patients and clients (Beauchamp & Childress, 2013; Johnstone, 2016; Moyo et al., 2016; Varkey, 2021) guide and support them in pursuing this goal. Professional groups and their members are expected to acknowledge and support the self-determination of patients and clients in making decisions on their own care. They are expected to plan and implement care and treatments in a way that allows for avoiding harm while also promoting the interests and rights of patients an clients. Professional groups and their members are also expected to avoid causing pain and prevent suffering. Care and treatment are expected to be appropriate, equitable and fair. (Beauchamp & Childress, 2013; ETENE, 2001; Johnstone, 2016; Varkey, 2021.) Clients and patients may have multiple care needs (Cassidy et al., 2023; McGilton et al., 2018; Tahsin et al., 2023). In order to guarantee ethical person-centered care for even the most demanding and multimorbid patients and clients (Cassidy et al., 2023; McGilton et al., 2018; Tahsin et al., 2023), there must be a shared understanding of their privacy and dignity among professions (IPEC, 2023).

Professional values are connected to various factors. An increase in age has had an association with a stronger commitment to professional values and, simultaneously, longer work experience has a positive effect on a stronger professional value orientation. Individuals' ethnic backgrounds may affect their professional values and ethical points of view to care when they treat patients and clients with different cultural backgrounds. Female nurses perceive professional values as more important than their male colleagues. Also, workers with a higher education give greater importance to professional values. (Gassas & Salem, 2022; Poorchangizi et al, 2019.) The importance of professional values is described to be related to the good care of patients, patients' and clients' satisfaction with care, and the job satisfaction of health and social care workers (Kaya & Boz, 2019). Professional values are also considered to be meaningful in relation to the development of clinical competence (Skela-Savic et al., 2017) and professional identity (Fitzgerald, 2020), ethical decision-making (Chen et al., 2021) and the conduct of evidence-based practice (Skela-Savic et al., 2017).

### 2.2.3 Ethical issues in collaboration

Ethical issues related to collaboration among professional groups emerge in the health care and social services of patients and clients (Gágyor et al., 2019; Pavlish et al., 2015; Rainer et al., 2018). An ethical issue has been defined as an unsolved situation or problem between two or more persons or organizations, but one that has the capacity to be solved and decided upon (Beauchamp & Childress, 2013; Merriam-Webster Dictionary, 2024). Although different professional groups have been described as having a common goal (ETENE, 2014; Hammer et al., 2012; WHO, 2015), health and social care workers experience these ethical issues in their work daily (Engel & Prentice, 2013; Hollman et al., 2014).

Ethical issues in integrated care are usually considered among individual professions, such as nurses (Fithriyyah et al., 2023; Oh & Gastmans, 2024), physiotherapists (Ditwiler et al., 2022; Nyante et al., 2020; Sturm et al., 2023), and social workers (Juujärvi et al., 2020). Ethical issues are related to clients and their significant others (Juujärvi et al., 2020; Nyante et al., 2020) and the client's safety and surrounding special situations, such as a pandemic (Ditwiler et al., 2022) or certain contexts such as elderly care (Podgoriga et al., 2021).

Ethical issues in collaboration between different professions in health and social care services have concerned mainly nurses and other individual professions such as physicians, for example in surgery (Jeon et al., 2023), and in elderly care with physiotherapists and practical nurses (Arjama et al., 2024). Ethical issues are connected to patients' and clients' rights and self-determination (Podgorica et al., 2021) and relationships between professionals (Sturm et al., 2023). However, there is a lack of studies on the ethical issues among various professional groups. The ongoing revolution of health and social care services in Finnish society (Ministry of Social Affairs and Health, 2024a) and globally (Baxter et al., 2018; de Matos et al., 2024; Sandhu et al., 2021; WHO, 2016, 2018) is historic and requires making observations and identifying the role of ethics to secure patients' and clients' individual paths in integrated care.

## 2.3 Professionalism in interprofessional collaboration

Professionalism in interprofessional collaboration means that professionals in health and social care services have trust in the members of another professional group, and their involvement and contribution to the care of the patients and clients (Frost et al., 2018; Hammer et al., 2012; Holtman et al., 2011; IPEC, 2023). It also refers to the realization of shared values and ethical principles (Frost et al., 2018; Hammer et al., 2012; Holtman et al., 2011; IPEC, 2023). The basis of professionalism in interprofessional collaboration is altruism and ethical conduct of practice in

integrated care (Frost et al., 2018; Hammer et al., 2012; Holtman et al., 2011; IPEC, 2023). Professionalism is defined as workers' required competence and skills (Cao et al., 2023; Eid et al., 2018; Ghadirian et al, 2014; Lecours et al., 2021) where the focus is on the quality and efficiency of conduct. The synonyms of professionalism include competence and expertise (Merriam-Webster Thesaurus, 2024). Professionalism guides work based on the profession's knowledge base (Cao et al., 2023; Eid et al., 2018; Ghadirian et al, 2014; Lecours et al., 2021).

Professionalism in interprofessional collaboration between professionals is needed to acknowledge the ethics in health and social care services and secure the conduct of integrated, seamless, and high-quality care of patients and clients (Frost et al., 2018; Hammer et al., 2012; Holtman et al., 2011; IPEC, 2023; WHO, 2010). Professionalism in interprofessional collaboration aims to secure effective work for the best possible results of integrated care (Cao et al., 2023; Frost et al., 2018; Hammer et al., 2012; Holtman et al., 2011; IPEC, 2023; WHO, 2015). In addition, it ensurest that patients and clients receive equal treatment, taking into account their own opinions of care during decision-making and care. Collaboration between different health and social care workers requires protecting patients' and clients' rights to continuity of care and autonomy. (ETENE, 2011.) Simultaneously, a lack of professionalism in interprofessional collaboration may lead to undermining the rights of patients and clients and the quality of their care (Cao et al., 2023; ETENE, 2011; Hammer et al., 2012; Holtman et al., 2011; WHO 2015).

Within individual professions, education and professional training, as well as prior work experience, strengthen the professionalism realized at work (Azemian et al., 2021; Eid et al., 2018; Ghadirian et al., 2014; Lecours et al., 2021). The surrounding culture (Cao et al., 2023) and job satisfaction (Azemian et al., 2021; Cao et al., 2023; Ghadirian et al., 2014) are linked to stronger professionalism at work. A weaker interaction between health and social care workers and organizational culture (Eid et al., 2018), or poor guidance and support (Ghadirian et al., 2014) are related to inadequate and weak professionalism. The ethics of the working environment (Seo & Kim, 2022) is also linked to the perceived stronger professionalism. In addition, appropriate interactions between different health and social care workers have prevented situations where individuals are focusing only on the activities of their respective profession and its views (Ghadirian et al., 2014).

Professionalism in interprofessional collaboration among students of healthcare (Frost et al., 2018) and different health and social care workers (Hosseinpour et al., 2022; Keshmiri et al., 2022) shows fluctuating professionalism among professionals. In a hospital setting, professionalism in interprofessional collaboration is described as low (Hosseinpour et al., 2022; Keshmiri et al., 2022). At the same time, healthcare students show high scores for professionalism (Frost et al., 2018). Interprofessional interventions and education promote and develop professional collaboration

(Hosseinpour et al., 2022). Still, there is a further need to develop professionalism skills in collaboration (Keshmiri et al., 2022).

## 2.4 Summary of the literature

All professional groups in health and social care services have a duty to care assigned to them by society (Act on Organizing Healthcare and Social Welfare Services 612/2010; 612/2021; ETENE, 2011; WHO 2015). Health and social care workers are increasingly expected to collaborate with an interprofessional approach to produce integrated care toward ethical person-centeredness. They benefit from understanding the legal and ethical basis guiding their work. (ETENE, 2012; WHO 2015.) In interprofessional collaboration, health and social care workers must act based on professional ethical principles and shared values, simultaneously showing professionalism and acknowledging the contribution and expertise of other professional groups. In interprofessional collaboration, respecting patients' and clients' autonomy, engaging in open interaction and taking responsibility are central for each worker. (Cao et al., 2023; ETENE, 2012; Frost et al., 2018; IPEC, 2023; WHO 2015.) Values secure the fair treatment of patients and clients and ensure high-quality and seamless care as well as their well-being. This enables producing benefits for individuals and communities. (Frost et al., 2018; Hammer et al., 2012; Holtman et al., 2011). (Figure 1.)

As a professional, each individual must take responsibility for their professional development (Cao et al., 2023; Eid et al., 2018; Ghadirian et al., 2014; Lecours et al., 2021) and further the competencies needed in interprofessional collaboration (Kangasniemi et al., 2018; Ministry of Social Affairs and Health, 2024c; Nummela et al., 2019). This includes the knowledge and skills related to involving patients, clients and those close to them in genuine collaboration (Kangasniemi et al., 2018; Nummela et al., 2019). However, collaboration between different professional groups may be difficult and challenging. Sometimes working together with shared objectives may also be difficult (IPEC, 2023; Reeves et al., 2017). In addition, health and social care workers' perceptions of the conduct of ethical care and social services may differ and thus endanger the realization of high-quality person-centered care (Glaser & Suter, 2016; Kallio et al., 2022).

Despite the importance of professional and shared values to high-quality care for patients and clients, there has been less research on professionalism and professional values among different health and social care workers; instead, the focus has been on individual professions such as nurses (Asiandi et al., 2021; Azemian et al., 2021), occupational therapists (Lecours et al., 2021), physicians (Reimer et al., 2019) and nursing students (Poorchangizi et al., 2019; Venables et al., 2023). Collaboration among health and social care workers takes place in multiple settings (Auschra,

2018; Piquer-Martinez et al 2024; WHO, 2016), including the involvement of patients and clients (Castro et al., 2018; Nordin et al., 2017), and new technology (Guraya et al., 2021; Risling 2017; Rukavina et al., 2021) contributing to and shaping the work. In order to support health and social care workers in their interprofessional collaboration, it is relevant to explore what ethics is in today's health and social care services when different professionals, patients and clients are working together. Therefore, it was meaningful to investigate how ethics emerge in collaboration and identify ethical issues in their collaboration. It was also important to explore how health and social care workers evaluate their professional values and how the ethics of professionalism is carried out in their collaboration. This dissertation addresses these gaps in knowledge.

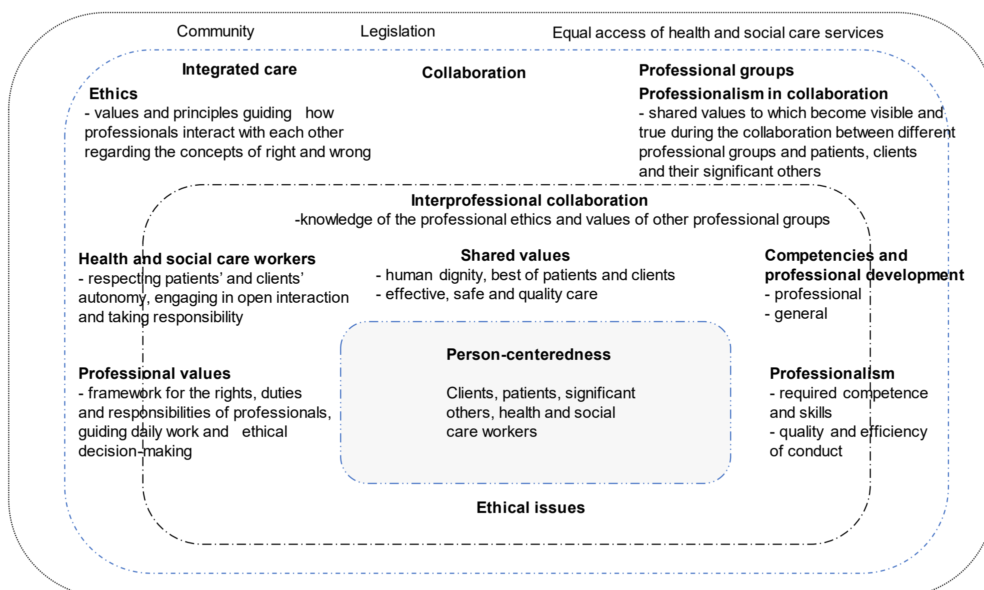


**Figure 1.** Ethics and professionalism in collaboration among health and social care workers.

# 3 Aims

The aim of this study was to explore and describe ethics and professionalism in collaboration among health and social care workers and the related factors. The ultimate goal was to provide new knowledge on health and social care workers' professional values and the realization of their ethics of professionalism in collaboration with each other. This new knowledge can be utilized to support health and social care workers in their work for integrated high-quality person-centered care.

The research questions of the study were:

- How ethics in interprofessional collaboration in clinical practice is described in previous studies? (Paper 1)
- How do health and social care workers describe the importance of their professional values and the realization of their professionalism in collaboration? (Papers 2, 3, Summary)
- How are professional value orientation and professionalism in collaboration associated with each other and with the personal characteristics of health and social care workers? (Papers 2, 3, Summary)

# 4 Materials and Methods

This study used mixed methods (Anguera et al., 2018; Creswell 2022; Morgan, 1998), utilizing quantitative and qualitative approaches to achieve new knowledge of ethics and professionalism in collaboration among health and social care workers, and answer the research questions posed. Quantitative research enabled exploring the perceptions of several different professional groups on the examined phenomenon. Qualitative methods allowed the participants of the study to express their thoughts on the phenomenon in their own words and thus deepen the knowledge produced by this research. While former research on the phenomenon was limited, meta-synthesis (Paper 1) was used to gain previous knowledge on ethics emerging in interprofessional collaboration in clinical practice. Meta-synthesis (Noblit & Hare, 1999) was chosen due to its suitability for identifying and synthesizing earlier knowledge because the material contained qualitative and theoretical papers. The first sub-study (Paper 1) provided the starting point for the second phase of this doctoral research. It showed gaps in the knowledge of ethics and professionalism in collaboration among health and social workers.

In the empirical phase of this study (Papers 2, 3 and Summary), a decision was made to use a quantitative cross-sectional survey study. New knowledge was needed on how health and social care workers assess the importance of their professional values in daily work and the implementation of ethics of professionalism in their work with others. The use of a cross-sectional survey was justified to reach various professionals (Polit & Beck, 2013) working in health and social care and answer the research questions broadly from the point of view of different professional groups. The survey was supplemented with qualitative open-ended questions to enable participants to share their views in their own words regarding their positive and critical experiences (Anguera et al., 2018; Creswell 2022; Morgan, 1998) related to professionalism behavior in collaboration among different health and social care workers. The purpose was to provide knowledge on different points of view of the phenomenon (Anguera et al., 2018; Creswell 2022; Morgan, 1998), thus enriching the study results. (Table 1.)

**Table 1.** The aims, methods, designs, publications, samples, settings, time, data collection and analysis of the study.

<table>
<tr><td colspan="3">The aim of the study: To explore and describe ethics and professionalism in collaboration among health and social care workers and the related factors. The ultimate goal was to provide new knowledge on health and social care workers’ professional values and the realization of their ethics of professionalism in collaboration with each other. This new knowledge can be utilized to support health and social care workers in their work for integrated high-quality person-centered care.</td></tr>
<tr><th></th><th>Synthesis of previous research</th><th>Empirical phase</th></tr>
<tr><td>Methods</td><td>Qualitative</td><td>Quantitative and qualitative</td></tr>
<tr><td>Design</td><td>Meta-synthesis (Paper 1)</td><td>Cross-sectional survey (Papers 2, 3, Summary)</td></tr>
<tr><td>Aims</td><td>- To synthesize and describe how ethics has emerged in interprofessional collaboration in clinical practice</td><td>- To describe the importance of health and social care workers’ professional values and realization of professionalism behavior in collaboration between health and social care workers<br>- To explore how a professional value orientation and professionalism in collaboration are associated with each other and with the personal characteristics of health and social care workers</td></tr>
<tr><td>Sample, settings, and time</td><td>- Qualitative (n=6) and theoretical papers (n=3)<br>- 2018–2020</td><td>- Health and social care workers (n=2,609) and 13 professional trade unions (Paper 2, Summary)<br>- Health and social care workers (n=2,675) and 15 professional trade unions (Paper 3, Summary)<br>- 2020–2024</td></tr>
<tr><td>Data collection</td><td>Systematic literature searches:<br>- CINAHL, PubMed, Scopus, Soc-INDEX</td><td>- Finnish version of Nurses’ Professional Values Scale-3 (F-NPVS-3), 28 items<br>- Finnish version of Interprofessional Professionalism Assessment (F-IPA), 26 items, two global items<br>- Seven open-ended questions of positive issues and issues that needed to be improved in professionalism in collaboration</td></tr>
<tr><td>Data analysis</td><td>Four phases of analysis:<br>- Analyzing, comparing, interpreting, and creating a synthesis of previous knowledge</td><td>- Descriptive statistics: frequencies and percentages<br>- Inferential statistics: Spearman’s correlation, the Kruskal–Wallis H test, Mann–Whitney U test, Dunn’s Test with Bonferroni correction, linear regression analysis, ANOVA with Tukey’s Test<br>- Inductive content analysis</td></tr>
</table>

## 4.1 Meta-synthesis on previous knowledge (Paper 1, Summary)

A seven-phase method of meta-synthesis (Noblit & Hare, 1999) was used to synthesize previous knowledge of ethics in nurses' interprofessional collaboration (Paper 1).

### 4.1.1 Data collection

To begin with, in the first phase, preliminary literature searches were conducted to get a sense of the research questions (Kangasniemi et al., 2012; Noblit & Hare, 1999). Second, the CINAHL, PubMed, Scopus and Soc-INDEX databases were used for data collection. Both electronic and manual searches were conducted. The search terms used were ethics, interprofessional, health and social care, and they were combined with various modifications. The time frame of January 2013–December 2019 was applied. A supplementary literature search was conducted for data published between January 2020 and January 2024. No other limitations were used. Papers were chosen based on the inclusion criteria of scientific and peer-reviewed papers with abstracts, a focus on nurses and, at the very least, one other profession in the field of health and social care, and ethics in their collaboration. Studies focusing on students or patients as informant groups were excluded. No limitations on the language of publication were imposed.

The electronic searches yielded 4,763 original articles and, based on inclusion and exclusion criteria (Kangasniemi et al., 2012; Noblit & Hare, 1999), eight studies were selected for the review. Manual searches with the same criteria were conducted in the journals *BMC Medical Ethics, Health and Social Care in the Community, Interprofessional Care, Interprofessional Education and Practice, and Nursing Ethics.* This search resulted in one study. Next, the quality of the selected paper was evaluated based on the method-specific checklists of the Joanna Briggs Institute (Lockwood et al., 2015; McArthur et al, 2015). The independent criteria-based evaluations were conducted by two members of the research group. Subsequently, based on mutual discussion, the papers were given scores. No studies were excluded from the analysis on the basis of the quality review because the quality and information were good. (Paper 1.) The supplementary search included the same databases and journals for the manual search, search terms, limitations, and inclusion and exclusion criteria as the original literature search (Table 2.). No new studies were included based on it.

**Table 2.** Selection of previous literature for meta-synthesis (modified from Paper 1).

| Years | 2013–2019, *n* | 2020–2024, *n* |
|---|---|---|
| **Electronic searches** | **4,763** | **2,236** |
| -CINAHL | 797 | 845 |
| -PubMed | 1,719 | 75 |
| -Scopus | 1,857 | 1035 |
| -SocINDEX | 390 | 281 |
| **Accepted based on titles** | **75** | **23** |
| -CINAHL | 24 | 4 |
| -PubMed | 24 | 1 |
| -Scopus | 22 | 9 |
| -SocINDEX | 5 | 9 |
| **Accepted based on abstracts** | **26** | **3** |
| -CINAHL | 7 | 0 |
| -PubMed | 10 | 0 |
| -Scopus | 8 | 0 |
| -SocINDEX | 1 | 3 |
| **Accepted based on full texts** | **9** | **0** |
| -CINAHL | 2 | 0 |
| -PubMed | 5 | 0 |
| -Scopus | 1 | 0 |
| -SocINDEX | 0 | 0 |
| -Manual search | 1 | 0 |
| **Selected papers** | **9** | **0** |

### 4.1.2 Analysis and synthesis of the papers

In the third phase of the meta-synthesis (Noblit & Hare, 1999), after the literature selection, the selected papers were read multiple times (Kangasniemi et al., 2012; Noblit & Hare, 1999). The country, year, and research questions of the papers were tabulated. The details and descriptions of the papers that corresponded to the research questions, and the professional groups that were described in the papers were entered into the table. As a fourth phase, the relationships between studies were examined and determined by comparing their key metaphors, accounts and concepts. This created new themes which were also investigated in relation to each other. (Kangasniemi et al., 2012; Noblit & Hare, 1999.) In this phase, features of ethics were recognized in the nurses' interprofessional collaboration and presumed relationships between the papers were identified for the first time. Next, the fifth phase was carried out and involved formulating a shared conceptual framework and studies were translated into one another (Kangasniemi et al., 2012; Noblit & Hare, 1999). This meant that the central metaphors and interactions found in and between papers were compared. In the sixth phase, all translations were abstracted and an interpretative synthesis (Kangasniemi et al., 2012; Noblit & Hare, 1999) of ethics in

nurses' interprofessional collaboration in clinical practice was formulated. The seventh and final phase consisted of reporting the results. (Paper 1.)

## 4.2 Survey for health and social care workers (Papers 2, 3, Summary)

A cross-sectional survey was conducted in collaboration with Finnish trade unions in the spring of 2022 to examine health and social care workers' perceptions of the importance of their professional values (Paper 2) and the realization of professionalism behavior in their collaboration (Paper 3). Two instruments, the Nurses' Professional Values Scale-3 (NPVS-3) (Weis & Schank, 2017) and the Interprofessional Professionalism Assessment (IPA) (Frost et al., 2018; Interprofessional Professionalism Collaborative, 2018) were cross-culturally adapted. Descriptive and inferential statistics were used for data analysis. Inductive content analysis was conducted with data from open-ended questions.

### 4.2.1 Instruments

Data were collected (Papers 2 and 3) using two instruments, the *Nurses' Professional Values Scale-3* [NPVS-3] (Weis & Schank, 2017*)* and the *Interprofessional Professionalism Assessment* [IPA] (Frost et al., 2018; Interprofessional Professionalism Collaborative, 2018). The aim of the NPVS-3 (Weis & Schank, 2017) is to measure the importance of professional values. It consists of three factors with 28 items. It includes a five-point Likert scale for responses with options ranging from not important (1) to the most important (5). Higher mean scores indicate a more developed professional value orientation (Weis & Schank, 2017). (Table 3.) The aim of IPA (Frost et al., 2018; Interprofessional Professionalism Collaborative, 2018) is to measure professionalism behavior in collaboration among health and social care workers and students. It consists of six domains with 26 items, two global items, and seven open-ended questions. Due to the exploratory factor analysis (Watkins, 2018), the Finnish version of F-IPA includes five domains (Paper 3). A six-point Likert scale was included for responses ranging from "strongly agree" to "strongly disagree". Professionalism behavior in collaboration was considered to be realized frequently or well if participants either strongly agreed or agreed with items. Meanwhile, when they strongly disagreed or disagreed, this was considered to mean that professionalism behavior had been not at all or poorly achieved. Scores were constructed as excellent 4.1–5.0, good 3.1–4.0, moderate 2.1–3.0, and low 1–2 (Paper 3). Also, the options of "neither agree nor disagree" and "not possible to assess in this environment" were used. Higher mean scores indicated more developed professionalism behavior in collaboration (Frost et al., 2018). (Table 3.)

**Table 3.** Instruments used in the study.

| Domain/Factor | Content, reflecting: | Response options |
|---|---|---|
| **Nurses' Professional Values Scale 3 (NPVS-3),** three factors: 28 items, scale range 28–140. | | |
| **Caring**<br>10 items<br>Scale range 10–50 | - professional's fundamental commitment to providing equal care for patients and clients as individuals, families, groups, communities or populations. | 1=not important<br>2=somewhat important<br>3=important<br>4=very important<br>5=most important |
| **Activism**<br>10 items<br>Scale range 10–50 | - professional's duties in activities that advance their profession and its responsibilities to the public | |
| **Professionalism**<br>8 items<br>Scale range 10–40 | - responsibility for the work environment and practice | |
| **Interprofessional Professionalism Assessment (IPA),** six domains: 26 items, scale range 26–130**,** 2 global items and 7 open questions. | | |
| **Communication**<br>5 items<br>Scale range 5–25 | - comprehensive and understandable communication, considering the needs of other health and social care workers. | 1=strongly disagree<br>2=disagree<br>3=neither agree nor disagree<br>4=agree<br>5=strongly agree<br>6=not possible to assess in this environment |
| **Respect**<br>5 items<br>Scale range 5–25 | - understanding the culture, values, and the roles and responsibilities of other health and social care workers/professions in care. | |
| **Altruism and caring**<br>4 items<br>Scale range 4–20 | - considering the needs of patients and other professionals with empathy and compassion. | |
| **Excellence**<br>4 items<br>Scale range 4–20 | - responsibilities and own contribution to the care process, considering coordination and documentation of care to ensure quality care. | |
| **Ethics**<br>4 items<br>Scale range 4–20 | - addressing collaborative work to ensure ethical practice. | |
| **Accountability**<br>4 items<br>Scale range 4–20 | - taking responsibility for one's own work, preventing and addressing the possible care-related disadvantages. | |
| **Global item 1** | Level of professionalism in interprofessional interaction in general | 1=weak<br>2=satisfactory<br>3=good<br>4=very good<br>5=excellent |
| **Global item 2** | The implementation of interprofessional collaboration on a general level, taking into account all aspects of the work | |
| **Open-ended questions** | Commenting on approaches related to:<br>1 Communication<br>2 Respect<br>3 Altruism and caring<br>4 Excellence<br>5 Ethics<br>6 Accountability<br>7 General observations of professionalism in collaboration<br>Including the approaches receiving positive feedback as well as those that need to be improved. | |

The instruments were cross-culturally adapted to Finnish health and social care workers (Papers 1 and 2). The five phases of Beaton et al. (2010) were followed, first, by translating the original instruments from English to Finnish by a qualified translator. Second, the research group and translator formulated a consensus of the used concepts in relation to the studied phenomenon. Third, another qualified translator produced back translations into English for both instruments. Fourth, the researcher and the entire research group reviewed both instruments in relation to the Finnish context of health and social care, its culture and language. In the case of IPA, several members of the Interprofessional Professionalism Collaborative (2018) evaluated the back-translated version for its equivalency to the original instrument as a part of the cross-cultural adaptation process (Beaton et al., 2010).

In the final, fifth phase, the instruments of the Finnish versions of NPVS-3 [F-NPVS-3] and IPA [F-IPA] were pilot-tested by twenty health and social care workers (nurses, public health nurses, practical nurses, a physiotherapist, a Bachelor of Social work, and medical students) from the field. The participants of the pilot study were reached by purposeful sampling by the researcher (Polit & Beck 2013; Waltz et al., 2010). They were asked to evaluate the clarity of the survey comprising of F-NPVS-3 and F-IPA, its instructions, items, response options, and questions for background information. The pilot participants were also asked to provide feedback and suggestions to clarify the survey items or response options if they found these unclear in some way (Beaton et al., 2010; Polit & Beck, 2013; Waltz et al., 2010). In the case of F-NPVS-3, the pilot study resulted in minor corrections to the spelling of items which were corrected by the research group to enhance clarity. In relation to F-IPA, no corrections were needed based on the pilot study. The respondents were asked about their age, sex, ethnicity, and other education and work-related characteristics (n=20) as background information (Table 4). The data from the pilot study were not included in the final study. (Papers 2 and 3.)

**Table 4.** Personal, education and work-related characteristics of the study participants.

| **Personal, education and work-related characteristics of the study participants** | |
|---|---|
| **Personal characteristics**<br>3 items | - age, ethnicity, gender |
| **Education-related characteristics**<br>5 items | - education level<br>- professional degree<br>- interprofessional studies in the most recent professional education<br>- professional ethics training in the previous 5 years<br>- interprofessional ethics training in the previous 5 years |
| **Work-related characteristics**<br>12 items | - work experience in health and social care<br>- work experience in current work<br>- employment sector<br>- position at work<br>- form of employment<br>- interprofessional collaboration in own work<br>- remote patient/client work in own work<br>- multiculturalism in the work community<br>- support for ethical practice by superior<br>- support for ethical practice by organization<br>- multi-professional ethical reflection at work<br>- satisfaction with work |

### 4.2.2 Recruitment of study participants and data collection

The participation criteria for the target groups were that the study participants needed to have a degree in health or social care or be students in the field. They needed to have work experience in health and social care. They were also required to have a trade union membership at the time of the data collection. The convenience sampling method (Pollit & Beck, 2014; Waltz et al., 2010) was used to reach as many respondents representing different professional groups as possible.

A total of 120,332 health and social care workers were contacted in collaboration with 15 professional trade unions and associations. One trade union represented professions in the field of social care and two physicians. Eleven trade unions represented various health professions, including care assistance, nursing, oral health and rehabilitation. One represented workers in care and assistive tasks and nursing in childcare and youth work. An information letter concerning this study was sent to the trade unions. The contact persons sent an invitation to participate in the study to their members by email, a newsletter or a closed professional social media group. This invitation included information about the study, data processing, data protection, and a link to the online survey. Between one and two reminder letters were sent to trade union members by contact persons. Data collection was conducted in Finland from February to May 2022. (Papers 2 and 3.)

### 4.2.3 Data analysis

Statistical and qualitative methods were used to analyze the data. Descriptive and inferential statistics were used to analyze the quantitative survey data. Inductive content analysis was conducted with qualitative data from the survey. Quantitative analysis was conducted using the R software program version 4.0.2 (The R Foundation). (Papers 2 and 3, Summary.) For analysis purposes, the participants' work experience in current work was categorized as < 2, 3–10, 11–20, and >20 years, and general work experience in health and social care was grouped as < 5, 6–15, 16–25, and > 25 years. The variable of remote work was categorized as yes and no, instead of the five original options. The professional degrees of the participants (n=31) were categorized into professional groups (n=8) and one group of students (Papers 2 and 3). To investigate the total and factor and domain sums among professional groups, the Kruskal–Wallis H test (Kruskal & Wallis, 1952) was carried out with data from both instruments (Papers 2 and 3).

Correlations between the professional value orientation and background characteristics of the study participants were investigated with Spearman's rank correlation test (Spearman, 2010) and the Mann–Whitney U test (Mann & Whitney, 1947). Pairwise comparisons of the importance of professional values were explored with Dunn's test with Bonferroni correction (Midway et al., 2020). To establish how personal characteristics explained differences in professional value orientation among study participants, a linear regression analysis (Yan & Sun, 2009) was conducted. (Paper 2.)

Associations between the F-IPA total and its two global items and five domains were investigated with Spearman's correlation test (Spearman, 2010). To explain the variation between study participants' background characteristics and the study variables of professionalism, linear regression analysis with model selection by genetic algorithm with the Akaike information criterion (Akaike, 1974) was conducted. This included testing various models for F-IPA and its five domains. Pairwise comparisons between professional groups were conducted with an ANOVA with Tukey's Test (Tukey, 1949). (Paper 3.)

To investigate possible associations between health and social care workers' professional value orientation and professionalism in collaboration, a Spearman's correlation test was carried out. During analyses, groups of childcare and youth workers and students were excluded from the regression analysis of professional value orientation, and a group of students were excluded from the analysis of professionalism in collaboration because of the low number of participants. Groups of childcare and youth workers, physicians, and students were removed when conducting correlation tests between the data of F-NPVS-3 and F-IPA. Data over 30% of incompleteness were excluded, and the confidence level was set to 95%. To ensure the internal consistency of the Finnish versions of NPVS-3 (Weis & Schank,

2017) and IPA (Frost et al., 2018; Interprofessional Professionalism Collaborative, 2018), Cronbach's alpha (Cronbach, 1951) was calculated.

Open-ended questions in the survey enabled study participants to tell in their own words about the positive issues and development areas in the realization of professionalism behavior in the collaboration between different professional groups or related needs for improvement. Responses to the seven open-ended questions in F-IPA were analyzed with qualitative content analysis (Elo & Kyngäs, 2008). Qualitative data was separated from the survey Excel data manually and transcribed to 88 pages of written material, with the Times New Roman font, size 12, line spacing 1.5. First, the written data was read multiple times to get an overview of it (Elo & Kyngäs, 2008). Second, it was transferred and managed with the NVivo14 software.

Original expressions (Elo & Kyngäs, 2008) based on the open-ended questions of the survey were extracted from the data in the form of phrases and sentences as the units of analysis. These expressions were then grouped into sub-categories according to their similar content. The sub-categories were grouped further and abstracted into general categories, simultaneously moving the analysis to a higher level. Finally, the main categories were formed for the issues that were positive or needed to be improved related to professionalism in collaboration between different health and social care workers.

# 5 Results

This chapter first describes ethics in interprofessional collaboration in clinical practice based on previous knowledge synthesized in a meta-synthesis (Paper 1). Next, the results of the cross-sectional survey are described, including the personal background characteristics of the study participants and health and social care workers' perceptions of their professional values and professionalism in collaboration between the professional groups (Papers 2 and 3). This chapter presents unpublished material, in the form of associations between health and social care workers' professional value orientation and professionalism behavior. Also, a synthesis is presented of workers' perceptions of positive behaviour and those behaviours that need to be improved related to professionalism in collaboration.

## 5.1 Previous knowledge of ethics in interprofessional collaboration (Paper 1)

The meta-synthesis (Paper 1) included nine studies (Table 2), of which six were qualitative and three were theoretical papers. The research settings of the qualitative papers were mainly hospitals (n=4). Qualitative studies reached their participants from conferences, universities and round table groups. Three theoretical papers were focused on ethics between nurses and other professional groups working in health and social care. The studies were conducted in the US (n=2), Sweden (n=2), Australia (n=1), Botswana (n=1), Canada (n=1), Canada and the US (n=1), and in the Netherlands (n=1). (Paper 1; Table 1.)

Based on synthesis, ethics in interprofessional collaboration in clinical practice was related to professionals' understanding of the role of the patients and other professionals in the care process. The professionals did not always know what the patient's own will was or whether this should have been taken into consideration in the shared decision-making. They also occasionally disagreed with the patient. In some cases, patients' own will and desires were ignored. There were also different perceptions of whether or not the patient should be told the truth. Professionals disagreed on the amount and accuracy of information given, as well as the manner in which the information was given to the patient. They also did not agree on how to identify the patient's pain and their need for pain relief. Ethical conflicts occurred if

no pain relief was given at all, if it was not given in time, or if different methods were used. (Paper 1.)

Different roles of professionals in interprofessional collaboration were based on the primary aims of their professions, caring versus curing, which caused ethical conflicts in relation to shared decision-making for the patient's best care. An inbalance of power caused ethical conflicts in collaboration especially if not all professional groups were consulted and heard in the care process. A feeling that the professional group was not included and listened to in decision-making was common among nurses and other health and social care workers. Ethical conflicts also emerged when physicians expected other professionals to base their decisions on evidence, but they did not necessarily do the same themselves. Ethical conflicts occurred if different health and social care workers did not commit to common practices and values in their daily work and in the organization. Instead of looking for a shared consensus, some individuals preferred to act according to their own views and methods. Professionals had problems taking part in mutual ethical discussions and dealing with ethical issues in their daily work. They also had differing views on the reasons for the lack of ethical discussions. If ethical issues were not addressed in time, it threatened patients' care quality or their rights. (Paper 1.)

## 5.2 Health and social care workers' perceptions of professional values and professionalism in collaboration (Papers 2, 3, Summary)

A total of over 2,600 health and social care workers filled out the survey on the importance of their professional values and professionalism in collaboration between different professional groups (Papers 2 and 3). The analysis covered 1,823 completed responses to the F-NPVS-3 and 1,769 to the F-IPA instrument. Over 90% of the study participants were women of Finnish ethnicity. The respondents' mean age varied from 47.52 ± 11.46 (Paper 2) to 48 ± 11.59 (Paper 3) years. The study participants reported various degrees (n=31) which represented nine professional groups. The degrees had been completed in upper secondary education, universities of applied sciences, and universities. Work experience among the participants varied from 1 to 52 years in different contexts of health and social care. Some of the study participants had completed further training in professional ethics and interprofessional ethics after their graduation. (Papers 2 and 3.)

### 5.2.1 Importance of professional values (Paper 2)

Health and social care workers assessed the importance of their professional values as high (117.06 ± 14.52 out of 140), both in total and in relation to different factors (Paper 2). A comparison of professional groups showed that nurses considered the values to be more important compared to nurses in diagnostic care ($p < 0.001$) and social workers ($p < 0.05$). Additionally, care assistants ($p < 0.05$) and childcare and youth workers ($p < 0.05$) rated the importance of professional values higher than diagnostic care nurses (Paper 2; Table 6). These differences were statistically significant.

*Caring*, reflecting professionals' fundamental commitment to providing equal care for patients and clients, was assessed as the most important factor (45.14 ± 4.80 out of 50). Values deemed especially important included those that addressed protecting patients' and clients' rights, the safety of individuals and the public, and trustworthiness and respect. (Paper 2; Table 4.) When the professional groups were compared, statistically significant differences were found between childcare and youth workers ($p < 0.05$), nurses ($p < 0.01$), and nurses in diagnostic care, as the first two groups regarded caring as more important (Paper 2; Table 6).

*Activism*, reflecting professionals' duty to advocate for their professions and their responsibilities in society, was assessed as the least important factor (38.41 ± 6.84 out of 50). Less importance was given to the values that highlighted influencing at the societal level to decrease health disparities or to promote health globally. (Paper 2; Table 4.) There were statistically significant differences between nurses in diagnostic care, nurses and care assistants, as the latter two reported activism as being more important ($p < 0.01$, $p < 0.01$, respectively) (Paper 2; Table 6).

*Professionalism*, reflecting professionals' responsibilities for their work environment and practices, was assessed as important (34.04 ± 4.45 out of 40). This was true, especially in relation to recognizing boundaries between different professions and professionals' responsibilities to take care of their own well-being. The responsibilities to enhance their working environments were assessed as less important. (Paper 2; Table 4.) Statistically significant differences were found between nurses, nurses in diagnostic care ($p < 0.01$) and social workers ($p < 0.001$), as the first found professionalism more important (Paper 2; Table 6).

### 5.2.2 Realization of professionalism in collaboration (Paper 3, Summary)

The health and social care workers assessed the level of realization of professionalism behavior in collaboration as excellent (Paper 3; Table 2). In a comparison of professional groups, social workers generally gave professionalism in collaboration lower scores than care assistants ($\beta$ 0.43, 95% CI 0.11 to 0.75),

childcare and youth workers (β 0.30, 95% 0.05 to 0.56), and nurses (β 0.42, 95%) who scored it higher (Paper 3).

*Ethics and accountability*, which focus on the demonstration of joint work to secure ethical practice, was achieved well based on the participants' assessments (Paper 3; Table 2). This included the prevention and observation of treatment failures in care, and professionals showing responsibility for their own work. Similarly, professionalism behavior in collaboration was reported to be realized well in the context of shared discussions on ethical issues related to shared decision-making or when reporting unethical or unprofessional actions. The health and social care workers also reported that other professionals provided information on unclear issues at an excellent level. In comparison, 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) and nurses in diagnostic care (β 0.46, 95% CI 0.06 to 0.86) and in oral health (β 0.51, 95% CI 0.06 to 0.96) gave professionalism in collaboration statistically significantly higher scores than social workers. (Paper 3; Table 4.)

*Communication*, reflecting extensive and understandable communication, was assessed to have been realized at an excellent level with the highest scores of the six domains (Paper 3; Table 2). Communicating with respect, considering other's needs and responding to questions comprehensibly were assessed to be particularly excellent. The comparison between professional groups did not yield any statistically significant differences.

*Respect* for other professions' cultures, values, responsibilities and roles, especially in connection with sharing work and expertise in care and services, was also found to be realized at an excellent level (Paper 3; Table 2). There were no statistically significant differences between professional groups in relation to the respect domain.

*Excellence* in collaboration was given the lowest scores but was still considered to have been realized well (Paper 3; Table 2). It reflected each professional's contribution and responsibility in care and services to secure quality care. These good scores were assessed especially in relation to obligations related to familiarization with patient record entries made by other professionals. The realisation of participation in decision-making without hierarchy or boundaries between professions was assessed to be at the same level. Statistically significant differences were found between care assistants and social workers, of which the former gave the excellence domain statistically significantly higher scores (β 0.45, 95% CI 0.89 to 0.01) (Paper 3; Table 4).

*Altruism and caring* reflect empathy and compassion with the needs of patients, clients and other professionals. Health and social care workers gave the realization of professionalism behavior in relation to honest and reliable communication and interaction between other professionals high scores indicating this as excellent

(Paper 3; Table 2). Based on their assessment, other professionals' or patients' and clients' needs were taken well into account. Care assistants gave statistically significantly higher scores to altruism and caring than rehabilitation workers (β –0.28, 95% CI –0.53 to –0.04) and social workers (β –0.40, 95% CI –0.68 to –0.12). In addition to this, childhood and youth workers assessed this domain with statistically significantly higher scores than social workers (β –0.40, 95% CI –0.73 to –0.07) (Paper 3; Table 4).

### Barriers and enablers of professionalism in collaboration

The analysis of the qualitative data yielded altogether 1,110 health and social care workers' original expressions of behaviours that need to be improved and positive behaviours in professionalism in collaboration.

The issues that need to be improved related to professionalism in collaboration between different professional groups were described as barriers to the realization of professionalism behavior in collaboration (Table 5).

**Table 5.** Categories of the barriers and enablers of professionalism in collaboration.

| Main categories | Generic categories | Sub-categories |
|---|---|---|
| Barriers to the realization of professionalism in collaboration | Imbalance of power between professional groups | Hierarchy between professionals |
| | | Differences between generations |
| | Health and social care workers' inactive commitment to the collaboration | Dependence on individual persons and units |
| | | Lack of shared policies and operational guidelines |
| | | The lack of flow of information between professionals |
| | Ignorance of the primary aims of the professions | Challenges in knowing and valuing others' work and roles |
| | | Challenges in recognizing patients' and clients' interests in care |
| | Lack of support from interprofessional leadership and organization | Time-related challenges |
| | | Ineffective collaboration between professions |
| | | Lack of support for multi-professional collaboration |
| Enablers of professionalism in collaboration | Recognizing the shared goal of collaboration | The mutual goal of providing high-quality care to patients and clients |
| | | Multiprofessional leadership and organization supporting shared discussions and training in professionalism |
| | Recognizing each other's role in mutual communication | Active and practical communication |
| | | Feedback on the success of the care process |

The health and social care workers reported an *imbalance of power between professional groups* during collaboration as a barrier to professionalism in collaboration. This meant a hierarchy between professionals and differences between generations in collaboration among workers. The hierarchy was connected to higher education of some professionals and the use of professional jargon in mutual interactions which was difficult for the other party to understand. The hierarchy was described to be present between physicians and nurses, but also to emerge in collaboration between rehabilitation workers and nurses, between in-patient and out-patient care workers, and between health and social sectors. The health and social care workers noted that the opinions of the representatives of professional groups with a lower level of education were not listened to and not always even asked for their opinion. These workers described that they worked closely with patients and their significant others and thus had a lot of important information about their patients' condition and had, therefore, something to contribute to shared decisions. (Table 5.)

"*Some employees feel that higher levels of education justify arrogant or otherwise inappropriate communication with people with lower levels of education.*"

Different generations were reported to mean younger generations and new professionals in health and social care. Younger generations were reported to behave less hierarchically. New professionals did not get their opinions or ideas for development heard in the work community based on the justification that:

"*This has always been the case here.*"

*The health and social care workers' inactive commitment to collaboration* was described as being dependent on individual persons and units and connected to the lack of shared policies and operational guidelines of the units. The health and social care workers reported that being unfamiliar with their collaborators and representatives of other professions could cause a barrier to collaboration. For example, the flow of professional communication was challenged if a colleague known as a good co-worker was absent and replaced by a person acting unprofessionally. The health and social care workers also noted that there were differences in professional interaction between health and social care units. Proper communication and treatment of patients and clients were said to be prevented because the professionals did not follow common instructions or there were none. They also felt that it was necessary to develop shared policies and operational guidelines for communication in their own unit and between different units. These

should also be taken into account by different service providers, such as public and private practitioners. (Table 5.)

> "*Communication in the workplace should be developed with regard to the awareness and development of treatment practices, as everyone seems to have specific practices and perceptions of treatment implementation.*"

The lack of flow of information between professionals (Table 5) was identified as a barrier to professionalism behavior in collaboration because there were no uniform models for communication, units were located far apart or patient record systems were disconnected. Some health and social care workers longed for natural face-to-face contact. The lack of flow of information was reported to prevent the realization of professionalism both between specialized medicine, primary healthcare and social care, but also between units. Data protection was also described to prevent the natural exchange of information to ensure patients' and clients' care and services. The flow of information was also reported to require professional language between professionals. The use of professional jargon was considered to be occasionally linked to risking patient safety, due to the information recipient's difficulty in understanding what was meant by it.

> "*Sometimes unknowingly, and sometimes even intentionally, jargon or abbreviations are used, which weakens the transmission of information.*"

*Ignorance of the primary aims of the professions* (Table 5) was related to unsuccessful professionalism behavior in collaboration. Challenges in knowing and valuing others' work and roles in collaboration were described to have emerged when the tasks of other workers were unclear to professionals, and this made it difficult for them to interact. Neither did they always know who to ask about unclear issues in patients' care. A lack of knowledge of others' work was seen to cause unnecessary expectations and conflicts between professional groups. The participants described a gap between health and social care workers. The social care workers felt that their skills were insufficiently recognized. Similarly, the health care workers noted that the representatives of the social care sector did not take their expertise and opinions into account when planning clients' care. The health and social care workers also described a similar dichotomy in healthcare between specialized medicine and primary healthcare.

> "*One does not always know or understand the job description of another profession and thus does not understand all decisions and actions. Not being*

*aware of the responsibilities or obligations of another profession, which leads to not understanding why the other professional acts the way they do.*“

Challenges in recognizing patients’ and clients’ interests in care (Table 5) were described as a barrier to the realization of professionalism behavior in collaboration. The health and social care workers reported that conflicts emerged if the health and social care workers had different ideas about what was best for the patient. On the other hand, based on the descriptions, not everyone involved in the collaboration always remembered that the work was done for patients and clients. One health and social care worker described that patients’ and clients’ needs may also at times differ from what would be perceived as ethically correct. The health and social care workers had differing views on whether the interests of patients and clients should be put ahead of those of the professionals. A conflict was considered to emerge in the promotion of health and social care workers’ well-being if they had to consider whose best interest had to be put first.

*A lack of support from interprofessional leadership and organization* was described as a barrier to proper professionalism behavior in collaboration (Table 5). The realization of professionalism behavior in collaboration had time-related challenges. The health and social care workers noted that having to rush daily practice tasks could make interactions between professionals disrespectful and rude, sometimes even impossible. Due to this urgency, the health and social care workers were unfamiliar with the records kept by other professionals in patients’ treatment plans. On the other hand, mutual discussions on near-miss situations and incidents were also considered incomplete or at times completely absent, due to a lack of time.

“*If the conditions are good, the interactions can be excellent, but hurry and pressure can turn the situation aggressive and conflictory, which, even when information is transmitted, can leave you with a bad feeling and may have a negative effect on the implementation, etc.*”

The health and social care workers noted that a lack of interest among leadership and in the organization in the collaboration between professional groups hampered the inclusion and visibility of different professional groups in the work community. A lack of support also affected the commitment of the entire work unit or team to professionalism behavior and communication in collaboration, as ineffective collaboration between professions. (Table 5.)

*Recognizing the shared goal of collaboration.* An issue promoting professionalism behavior in collaboration, the health and social care workers noted that the mutual goal of providing high-quality care to patients and clients was a contributing factor. They pointed out that mutual collaboration for a shared goal had

promoted quality and competence in the care of patients and clients. Multiprofessional leadership and organization supporting continuous shared discussions and training contributed to the success of professionalism. The workers reported that these means were significant in increasing competence in shared discussions of professionalism behavior between workers. Support for multiprofessional work from the leadership and organization enabled addressing patients' issues ethically and interprofessionally. The workers addressed the topic of their leaders' abilities and courage to intervene in unprofessional activities at work communities. (Table 5.)

> "*There is a lack of courage and knowledge to intervene in unprofessional and unethical activities in an ethically sustainable manner. This is a very big, very complex, very wide-ranging problem.*"

*Recognizing each other's role in mutual communication.* The health and social care workers noted that professionalism in collaboration was promoted by active and practical communication between professional groups and individuals. As an issue promoting professionalism in collaboration, they noted that effective communication had lowered the threshold for collaboration between different professional groups. Furthermore, an issue promoting professionalism in collaboration identified by the health and social care workers was feedback on the success of the care process which further contributed to the collaboration between health and social care workers**.** Regular joint meetings around common issues were reported to have contributed to and improved collaboration, interaction and understanding of the work of others. (Table 5.)

> "*Learning from others and sharing knowledge, with the common goal of working with the client, are positive.*"

### 5.2.3 Associations between personal characteristics, professional values and professionalism in collaboration (Papers 2, 3, Summary)

#### Associations between professional values and personal characteristics

Participants who had worked in health and social care for less than five years gave statistically significantly higher mean scores to the importance of professional values in relation to *activism* ($p < 0.05$) and professional values in general ($p < 0.05$) than those who had worked over 15 years. Participants who had trained in professional ethics gave statistically significantly higher scores on the importance of professional

values in general ($p < 0.05$), and in the context of *activism* ($p < 0.05$) and *professionalism* ($p < 0.05$) than participants without training in professional ethics. (Paper 2; Tables 5 and 8.)

Based on a linear regression analysis, the education- and work-related background characteristics of health and social care workers were associated with the importance of professional values. Education at the university level indicated statistically significantly more developed professional value orientation related to *caring* (β 1.09, $p < 0.05$). Participants employed in healthcare services attributed statistically significantly less importance to *caring* than those who worked in social care services (β -1.03, $p < 0.01$). Those workers who experienced more satisfaction at their work scored professional values higher in general (β 1.46, $p < 0.05$), and in relation to *the* factors of *caring* (β 0.67, $p < 0.01$), and *professionalism* (β 0.42, $p < 0.05$). Those who received more support for their ethical practice from their organization rated the importance of professional values higher in general (β 1.34, $p < 0.05$), and related to *caring* (β 0.51, $p <0.05$). These differences were statistically significant. (Paper 2; Table 8.)

### Associations between professionalism in collaboration and personal characteristics

Older participants assessed professionalism behavior in collaboration with statistically significantly higher scores (β 0.01, 95% CI 0.00 to 0.02) in general and in relation to the respect domain (β 0.01, 95 % CI 0.01 to 0.02). Participants who had completed a degree from a university of applied sciences rated professionalism statistically significantly higher compared to participants with a university degree (β –0.27, CI –0.45 to –0.09), in general and in relation to all five domains. Health and social care workers with professional degrees assessed professionalism in relation to respect, ethics and accountability with statistically significantly higher scores than students (β –0.38, 95 % CI –0.58 to –0.17; β 0.24, 95 % CI –0.48 to –0.00, respectively). Participants who had not completed training in interprofessional ethics during the last five years assessed professionalism behavior in general (β –0.17, 95 % CI –0.29 to –0.04) and in relation to respect (β – 0.21, 95 % CI –0.35 to –0.07), excellence (β – 0.23, 95 % CI –0.40 to –0.06), and ethics and accountability (β – 0.20, 95 % CI –0.36 to –0.04) with statistically significantly lower scores than those who had completed training. (Paper 3; Tables 4 and 5.)

Health and social care workers who had 26–50% interprofessional collaboration in their work assessed professionalism behavior in collaboration with statistically significantly higher scores, in general (β 0.13, 95 % CI 0.02 to 0.23), and in the contexts of excellence (β 0.28, 95 % CI 0.13 to 0.44), and ethics and accountability (β 0.18, 95% CI 0.04 to 0.32) than those with less than a 25% share of

interprofessional collaboration in their work. Participants who had not engaged in mutual ethical reflections in their daily work assessed professionalism behavior in general (β – 0.15, 95% CI –0.24 to –0.07) and in relation to excellence (β – 0.12, 95% CI –0.24 to –0.00), ethics and accountability (β – 0.21, 95% CI –0.33 to –0.10), communication (β – 0.12, 95% CI –0.20 to –0.04), respect (β – 0.11, 95% CI –0.22 to –0.01), and altruism and caring (β – 0.19, 95% CI –0.18 to –0.01) with statistically significantly lower scores than those with experience of mutual ethical reflections.

Health and social care workers who were more satisfied with their work (β 0.16, 95% CI 0.08 to 0.23) and received more support for their ethical practice from their organization (β 0.14, 95% CI 0.05 to 0.22) assessed professionalism behavior with statistically significantly higher scores in general than those who were not satisfied or did not receive support. This was also true in relation to most of the domains. No statistically significant differences in the assessments of professionalism in collaboration were identified in the domains of remote work with patients and clients, or the multicultural work environment. (Paper 3; Table 5.)

### Associations between professional values and professionalism in collaboration

The professional value orientation (*F-NPVS-3 total*) and professionalism behavior in collaboration (*F-IPA total*) between different health and social care workers were statistically significantly associated ($p < 0.0001$) (Table 6). The general professional value orientation was statistically significantly associated with F-IPA *ethics and accountability* ($p < 0.001$) and *communication* ($p < 0.0001$) in collaboration. Health and social care workers' professional value orientation was statistically significantly associated with *respect* in collaboration ($p < 0.05$), however, this correlation was weak. There were associations between general professional value orientation and professionalism behavior related to F-IPA *excellence* ($p < 0.001$) and *altruism and caring* ($p < 0.0001$). These associations were statistically significant.

The professional value orientation of *caring*, reflecting professionals' fundamental commitment to providing equal care for patients and clients, was statistically significantly associated with general professionalism behavior in collaboration (F-IPA total) between health and social care workers ($p < 0.0001$). The same was true for all five F-IPA domains. Statistically significant association was also found between the F-NPVS-3 domain of *activism*, reflecting professionals' duties in advancing their professions and their responsibilities for society, and professionalism behavior in collaboration, ($p < 0.001$). Statistically significant associations were found between F-NPVS-3 *activism* and the four F-IPA domains of *ethics and accountability*, *communication*, *excellence*, and *altruism and caring*. The professional value orientation of the *professionalism* factor, reflecting professionals'

responsibilities for their work environment and practices, had positive statistically significant associations with professionalism behavior in collaboration, in general ($p < 0.0001$), and in relation to all F-IPA domains. (Table 6.)

**Table 6.** Associations between professional value orientation and professionalism in collaboration among Finnish health and social care workers.

| | *p* value, r | *p* value, r | *p* value, r | *p* value, r |
|---|---|---|---|---|
| | F-NPVS-3 total | Caring | Activism | Professionalism |
| F-IPA total | < 0.0001 (0.10) | < 0.0001 (0.10) | < 0.001 (0.08) | < 0.0001 (0.11) |
| Ethics and accountability | < 0.001 (0.08) | < 0.01 (0.07) | < 0.01 (0.07) | < 0.0001 (0.10) |
| Communication | < 0.0001 (0.10) | < 0.0001 (0.11) | < 0.01 (0.07) | < 0.0001 (0.12) |
| Respect | < 0.05 (0.06) | < 0.01 (0.06) | 0.0944 (0.04) | < 0.01 (0.07) |
| Excellence | < 0.001 (0.10) | < 0.001 (0.09) | < 0.01 (0.08) | < 0.001 (0.09) |
| Altruism and caring | < 0.0001 (0.15) | < 0.0001 (0.15) | < 0.0001 (0.13) | < 0.0001 (0.14) |

## 5.3 Summary of the study results

The main results of the study are illustrated in Table 7. Ethics in interprofessional collaboration was related to the roles of patients and different professionals in the care process. The importance of professional values and the realization of professionalism in collaboration among health and social care workers were consistent between different professional groups. Professional values and professionalism in collaboration were strengthened by support from the workers' organization for ethical practice in their daily work and job satisfaction.

**Table 7.** Summary of the study results.

<table>
<tr><td colspan="2">Previous knowledge of ethics in interprofessional collaboration: Meta-synthesis (Paper 1)</td></tr>
<tr><td colspan="2">- Ethics in interprofessional collaboration in clinical practice was related to professionals' understanding of the role of the patients and other professionals in the care process. Ethical conflicts were connected to:</td></tr>
<tr><td>- The meaning of patients' wishes<br>- Telling the truth to patients<br>- Recognizing and treating patients' pain</td><td>- The primary aim of professions<br>- The balance of power among professions<br>- Commitment to collaboration</td></tr>
<tr><td colspan="2">Health and social care workers' perceptions of professional values and professionalism in collaboration: Survey for health and social care workers (Papers 2, 3, Summary)</td></tr>
<tr><td colspan="2">- Based on the findings of the cross-sectional survey, professional values and professionalism in collaboration were highly consistent among professional groups.</td></tr>
<tr><td colspan="2">Importance of professional values F-NPVS-3 (n=1823):</td></tr>
<tr><td colspan="2">- Caring was the most important value (45.14 ± 4.80 out of 50) - reflecting professionals' fundamental commitment to providing equal care for patients and clients<br>- Activism was the least important value (38.41 ± 6.84 out of 50) - reflecting professionals' duty to advocate for their professions and their responsibilities in society<br>- Professionalism was an important value (34.04 ± 4.45 out of 40) - reflecting professionals' responsibilities for their work environment and practices</td></tr>
<tr><td colspan="2">Realization of professionalism in collaboration F-IPA (n=1769):</td></tr>
<tr><td colspan="2">- Ethics and accountability were achieved well (4.10 ± 0.84 out of 5) - focusing on the demonstration of joint work to secure ethical practice<br>- Communication was realized at an excellent level, with the highest scores (4.34 ± 0.73 out of 5) - reflecting extensive and understandable communication<br>- Respect was realized at an excellent level (4.26 ± 0.84 out of 5) - respecting other professions' cultures, values, responsibilities and roles<br>- Excellence was realized well, with the lowest scores (4.00 ± 0.91 out of 5) - reflecting each professional's contribution and responsibility in care and services to secure quality care<br>- Altruism and caring were realized at an excellent level (4.26 ± 0.69 out of 5) - reflecting empathy and compassion for the needs of patients, clients and other professionals</td></tr>
<tr><td colspan="2">Health and social care workers' perceptions regarding the barriers and enablers (n=1,110) of professionalism in collaboration:</td></tr>
<tr><td colspan="2">Barriers to the realization of professionalism in collaboration:<br>- Imbalance of power between professional groups<br>- Health and social care workers' inactive commitment to the collaboration<br>- Ignorance of the primary aims of the professions<br>- Lack of support from interprofessional leadership and organization</td></tr>
<tr><td colspan="2">Enablers of professionalism in collaboration:<br>- Recognizing the shared goal of collaboration<br>- Recognizing each other's role in mutual communication</td></tr>
<tr><td colspan="2">Associations between personal characteristics, professional values and professionalism in collaboration:</td></tr>
<tr><td colspan="2">- Workers who received support for their ethical practice from their organization and experienced work satisfaction had statistically significantly stronger professional values and scored higher than others in professionalism in collaboration.</td></tr>
<tr><td colspan="2">Associations between professional values and professionalism in collaboration:</td></tr>
<tr><td colspan="2">- The professional value orientation (F-NPVS-3 total) and professionalism behavior in collaboration (F-IPA total) between different health and social care workers were statistically significantly associated ($p < 0.0001$).</td></tr>
</table>

# 6 Discussion

The aim of this study was to explore and describe ethics and professionalism in collaboration among health and social care workers and the related factors. In this chapter, the main results of the study and suggestions for further research are discussed. Additionally, the validity and reliability of the study are assessed, and the ethics of the study is considered. Last, the practical implications are presented.

## 6.1 Discussion of the study results

This study produced new knowledge about the ethics and professionalism of interprofessional collaboration in different fields of health and social care services. In previous studies, the focus has been on individual professions and students in the field (Arnal-Gómez et al., 2019; Frost et al., 2018; Sturm et al., 2023; Weis & Schank, 2017) and mostly on hospital settings (Frost et al., 2018; Hosseinpour et al., 2022; Keshimiri et al., 2022). Even though the professional value orientation and professionalism in collaboration were highly consistent among professional groups, to ensure person-centered health and social care services, the study results indicate the need to consider them in relation to *health and social care workers' comprehension of the roles of patients' and clients' positions in integrated care* as part of that collaboration*, ethical conflicts in interprofessional collaboration,* and *leadership supporting ethics and professionalism in collaboration* between professional groups in integrated care.

### Health and social care workers' comprehension of patients' and clients' positions in integrated care

Finnish health and social care workers' values are particularly strongly related to protecting patients' and clients' rights, the safety of individuals and the public, and taking care of trustworthiness and respect in care processes (Paper 2). These findings are in line with previous studies, which reported that caring, as a professional value, was placed the highest value (Gassas & Salem, 2022; Weis & Schank, 2017; Paper 2). Based on this, health and social care workers have good starting points for collaboration in integrated care and person-centeredness. This is important among

patients and clients who are in an especially vulnerable position in their care, such as older people. Protecting and respecting their dignity, human rights and respective worldviews is fundamental (Kristensen & Peoples, 2019), acknowledging also the new kinds of living environments, such as smart homes (Zhu et al., 2022).

A meaningful part of the professional value orientation of different health and social care workers is the mutual understanding of other professionals and their shared values, which will lead to integrated care with a person-centered focus. (Venables et al., 2023.) The essential aspects of integrated care include prioritising the needs of people using the services and providing health and social care services in an ethical and person-centered manner responding to individuals' needs (Kallio et al., 2022; Karam et al., 2018; Minkman, 2016; WHO, 2016). Future research should therefore explore precisely in collaboration how health and social care workers protect and respect patients and clients and their human dignity, rights and different worldviews related to their individual needs. In addition, it is meaningful to investigate how the structures of integrated health and social care services support this.

Overall, professionalism in collaboration between Finnish health and social care workers (Paper 3) was assessed to be excellent. It had been realized through honest and reliable communication with respect and consideration of the needs of others, respect for other professions' work input and expertise in health and social care services. These results contradicted those of previous studies (Hosseinpour et al., 2022; Keshmiri et al., 2022) which indicated that communication was the least frequently demonstrated behavior. Proper communication is beneficial to organizations in providing integrated care, as successful communication prevents and removes overlaps and gaps in integrated care (Schot et al., 2020). Mutual communication is essential (Kangasniemi et al., 2018; Ministry of Social Affairs and Health, 2024c; Nummela et al., 2019) to the shared responsibility for a comprehensive integrated plan of care for patients and clients (Ministry of Social Affairs and Health, 2024c). Despite these positive results, health and social care workers (IPEC, 2023) as well as employers in different organizations must still promote their competencies related to communication through various means. Additionally, successful communication requires not only structural integration but also technological solutions (Ministry of Social Affairs and Health, 2024c), such as shared information systems, so that all parties involved have access to up-to-date patient data (Piquer-Martinez et al., 2024; Sandhu et al., 2021). That is why in future studies, it is important to determine what are the most effective ways to conduct interprofessional training and support successful communication between health and social care workers. In this context, it is vital to acknowledge the increasing need for multiple digital solutions to enhance interaction between different stakeholders and organizations.

Based on the principle of interprofessional collaboration, patients, clients and their significant others are also recognized and included (IPEC, 2013; Reeves et al., 2017). In the current integrated care and social services, patients and clients have increasingly challenging needs and diverse diseases, which require excellence from various professional groups (McGilton et al., 2018; Tahsin et al., 2023). Patients and clients expect to be heard in connection with the decisions that concern their well-being and health (Kuosmanen et al., 2021; Todd et al., 2021). To achieve the best care and treatments, health and social care workers, patients and clients need to engage in highly developed, integrated collaboration. In this context, professional groups need to work together in a coordinated manner between different organizations and at different levels, such as health and social care services and different organizations in their community (Lindblad, 2021; Scholes & Vaughan, 2002; Schot et al., 2020). This collaboration must take place between organizations and between different disciplines and workers (Lindblad, 2021; Scholes & Vaughan, 2002; Tiirinki et al., 2022). More research is needed to determine whether this term of *interprofessional collaboration* is suitable for integrated care. As a written concept (e.g. Reeves et al., 2017), it describes the collaboration between professionals precisely and could be considered to exclude patients and clients. Patients or clients are less commonly understood as being on par with professionals, even though they are experts in their own care and social services. Thus, their roles may not be strongly recognized in this form of collaboration. As a result, a question for future research is whether this form of collaboration should be called out as *integrated* (Nooteboom et al., 2021) or *multi-actor* (Ryan et al., 2024) collaboration rather than interprofessional collaboration, to ensure patients' and clients' active roles in person-centered care. Therefore it would be meaningful to explore, if ethics and professionalism in collaboration were studied with these concepts, the extent to which the results would be different.

### Ethical conflicts in interprofessional collaboration

According to the meta-synthesis, the ethical conflicts emerging in interprofessional collaboration between professional groups were related to health and social care workers' different understanding of patients' and clients' roles in integrated care. This included the patients' and clients' autonomy and rights, their integrity during interreactions, decision-making, and treatment. (Paper 1.) This led to the ethical conflicts that arose in collaboration among different health and social care workers. The conflicts emerged in communication, treatment situations, and decision-making related to treatment in the care process. It is also noteworthy that in processing the ethical conflicts related to patients' and clients' care process, they were not described as having active agency. (Paper 1.) The findings of other authors (Kristensen &

Peoples, 2019; Ulrich et al., 2010) were similar, as vulnerable patients were at risk of the violation of their right to informed consent and autonomy. Considering the basic task of professional groups (Lindblad, 2021; Scholes & Vaughan, 2002) to produce integrated, seamless and high-quality person-centered care in a sustainable way (Kallio et al., 2022; WHO, 2016), they should take into account the role of patients and clients (IPEC, 2023; Reeves et al., 2017). Patients and clients have the role of active experts in what is best for them with a right to be heard as a part of the shared decision-making with different professional groups. (Castro et al., 2018; Chen et al., 2020; IPEC, 2023; Nordin et al., 2017.) Therefore, in the future, it will be crucial to address and reinforce the clinical value and ethical principles of patient participation in collaboration among health and social care workers (Paper 1). There is a need to investigate how patients, clients and those significant others understand and observe how their rights are being taken into account in relation to ethical issues and professionalism in collaboration among health and social care workers during their health and social care service processes. A meaningful point of view to explore is how health and social care workers are engaging the patients, clients and their significant others in discussions of ethical issues during their care processes. In addition, there is a need to consider whether the role of patients, clients and their significant others will be highlighted strongly enough in the measures discussed in the present study. It would be beneficial to explore the impact of the hierarchy between professional groups on whether the patients and clients are actively involved in decision-making regarding their care. This would allow ensuring that the expertise of all professions and their members is made visible and that their voices are heard.

In addition, the ethical conflicts in interprofessional collaboration between professional groups were related to the different caring roles of health and social care workers (Paper 1). Ethical conflicts were related to the different values and power relations between the professional groups, which led to ethical conflicts. Based on other studies, different values have also been identified between professional groups earlier (Dennis et al., 2014; Rämgård et al., 2015). In the studies, some health and social care workers demonstrated limited awareness of the professional values held by others. Successful collaboration among different professional groups is challenging because they have to know of the values of others and possible conflicts of value in relation to others (IPEC, 2023; Reeves et al., 2017), simultaneously acknowledging the skills and knowledge of other professions (Entel & Prentice, 2013; IPEC, 2023). All health and social care workers need to be supported to recognize the meaningfulness of transparency, but such discussion requires them to be able to trust each other. In these discussions, it is also meaningful to understand the differences in competencies and enable everyone to participate as well as bring their specific expertise to care processes. (Entel & Prentice, 2013.) Ethical conflicts are, however, good in that they show how health and social care workers value their

respective professional values. This could be key to having the ability to address difficult issues. On the other hand, these values may already guide different professionals' work so strongly that it makes it hard to recognize them. Health and social care workers could jointly encourage each other to engage in interprofessional collaboration and listen to each other during it. More research is needed on the caring roles of the professionals related to ethical conflicts in interprofessional collaboration.

Professional value orientation (Paper 2) was strong and consistent among different health and social care workers. This finding indicates a strong commitment to producing care and social services that are equal for all. Previous studies conducted among individual professionals (Gassas & Salem, 2022; Weis & Schank, 2017) underlined similar findings as the professional value orientation of nursing professionals was described as strong. This is highly meaningful in patient and client groups, for example in elderly care, which typically involves collaboration between health and social care workers. In this context, it is key that those involved respect the human dignity and rights and worldviews of one another. (Venables et al., 2023.) Professional values are usually described as related to individual professions' professional ethics (International Council of Nurses [ICN], 2021; International Federation of Social Workers [IFSW], 2018). In the future, however, it is necessary to investigate why ethical conflicts emerge if everyone considers caring as the highest value, and/or if some other values are simultaneously considered more important in integrated care.

This study revealed contradictions between the quantitative and qualitative results. In the survey, the respondents rated the importance of professional values and the realization of professionalism in collaboration as excellent (Papers 2 and 3). At the same time, in their open-ended answers, the health and social care workers described that their ability to provide person-centered care in their daily work was hindered by hierarchical structures, imbalances of power, and a lack of commitment to collaboration among professional groups (Summary). This finding was also underlined in the meta-synthesis (Paper 1). In line with previous study, the hierarchy between different health and social care workers may substantially compromise the patients' and clients' safety if it, for example, prevents workers from sharing their views even in situations where patients or clients have been guided incorrectly, or if this could prevent or interrupt incorrect treatments (Green et al., 2017). This might mean that there has not been awareness of how those values will work in collaboration in practice.  It poses a question about the need to further develop the chosen instruments to take into account how the professions and their environments, as well patients and clients have been shaped by time and society. Thus, future studies need to acknowledge the possible tensions between professions and their effects on integrated care that aims at true person-centeredness. Therefore, diverse

research methods should also be applied to better understand the reality of the daily work in integrated care.

### Leadership supporting ethics and professionalism in collaboration

The understanding of professional values and professionalism in collaboration between professional groups varied depending on work contexts and especially in relation to the existing organizational support for ethical conduct in one's work (Papers 2 and 3). Leadership was needed to support interprofessional collaboration and solve time-related challenges and ineffective collaboration between different health and social care workers (Summary). This was also supported by the meta-synthesis (Paper 1). Organizational support for ethical practice and work satisfaction were associated with stronger professional value orientation and professionalism behavior in collaboration among different health and social care workers (Papers 2 and 3). Similarly, in line with a previous study (Poikkeus et al., 2018), supporting work carried out according to professional values in practice strengthened workers' ethical competence and job satisfaction was connected to individuals' professional values (Yarbrough et al., 2017).

Mutual reflection was also related to stronger professional values and professionalism in collaboration, but only a minority of health and social care workers had experienced these in their work (Papers 2 and 3). In interprofessional collaboration, the role of leadership and organization is to ensure mutual reflection and to consider job satisfaction and related factors. This allows for strengthening mutual open discussions and increasing the understanding of shared values and different professions (Koskinen et al., 2022). It is meaningful for future studies to explore the supporting organizational structures and processes, and to determine which of these would be the most effective. It is also important to consider and examine whether those structures are recognized by different health and social care workers. Additionally, it is valuable to further explore the relationships between job satisfaction, professional value orientation and professionalism in collaboration in more detail to gain knowledge of which of these support one another.

Commitment to collaboration varied between individual workers. Health and social care workers' inactive commitment to the collaboration was due to person and unit dependence connected to a lack of common policies and operational guidelines. (Summary.) This was also supported by the meta-synthesis (Paper 1), as acting based on one's personal thoughts and desires instead of committing to what was mutually agreed upon was connected to ethical conflicts in interprofessional collaboration. It might be that the individual did not value or acknowledge the role of other stakeholders in integrated care processes, or respect their shared values of working together for the benefit of the patients and clients. In line with previous studies,

organizations may enhance commitment to collaboration by forming processes, clear resources and leadership which support interprofessionalism (Doornebosch et al., 2022). Also, collaborative management (Moore et al., 2023) has been presented as critical for ensuring true relationships in collaboration. It would be important for future studies to explore what are the factors preventing different health and social care workers from committing to shared values. It is also meaningful to find new ways to develop and support commitment to collaboration between different professional groups, patients and clients, and their significant others through leadership and organizational structures.

Professional value orientation was weaker in relation to the workers' duties to take an active part in wider society, promote the health and well-being of people in the community and globally, and promote the profession and its duties in society. The same was related to the development of practice and work environment. (Paper 2.) Previous studies have also addressed this simultaneously among individual professions (Gassas & Salem, 2022; Skela-Savic et al., 2017). The involvement of professional groups in the decision-making and discussions at the societal level is crucial for the development of integrated care (Alabdulaziz et al., 2022; Nurchis et al., 2022; Poreddi et al., 2021; Scela-Savic et al., 2017), both locally and globally. Changing the practice culture and having competence on how to influence societal decision-making has traditionally played a less substantial role among professions. However, according to a previous study, participatory governance has empowered professionals' involvement in decision-making and the development of practices in organizations (Kanninen et al., 2019). Therefore, it is essential to integrate a clarification of professional values related to responsibilities for the work environment, promoting practice, and societal engagement into education in leadership and ethics.

Health and social care workers value their own well-being as a highly meaningful part of their professionalism, as well as taking into account their professional boundaries (Paper 2). In previous research, the new generation of employees working in health and social care services is placing more emphasis on their well-being (Drennan & Ross, 2019; Hult et al., 2022). Traditionally and in keeping with the calling of health and social care workers to the profession, the workers have been known to put the needs of patients and clients above everything else. Health and social care workers have been expected to forget about their own health and well-being, and thus dissolve their professional boundaries. (Hult et al., 2022; Kallio et al., 2022.) However, major events such as the COVID-19 pandemic have challenged this tradition related to health and social care workers' own health and well-being (Ditwiler et al., 2021; Turale et al., 2020). Setting professional boundaries and taking care of oneself has helped them to cope with a new kind of daily practice at work (De Kock et al., 2021). Additionally, different ways of

leadership have affected health and social care workers' well-being (Niinihuhta & Häggman-Laitila, 2022). Health and social care workers should take care of their own well-being, although ensuring patients' and clients' well-being remains the primary task of health and social care services. Different stakeholders need to have open discussions on the welfare of employees and patients and clients as well as how to reconcile these. Discussions must occur at both organizational and societal levels and without placing any blame.

Collaboration among different health and social care workers seemed to occur very harmoniously (Papers 2 and 3). This would lead to the expectation that working together is easy. In line with previous studies, while integrated collaboration between professions can have significant benefits, such as better patient outcomes (Baxter et al., 2018; Frost et al., 2018) and lower costs (de Matos et al., 2024; WHO, 2016), its implementation can nonetheless be challenging (Auschra, 2018; Henderson et al., 2021; Kangasniemi et al., 2021; Nurschis et al., 2022). The results of this study provided knowledge about the multifold areas of the necessary competence in ethics to enable professionalism in collaboration (Kangasniemi et al., 2018; Nummela et al., 2019), that are required from different professional groups and their members in integrated care. The quality and position of professional values need to be evaluated regularly to meet the objectives set for the professional groups. This evaluation needs to acknowledge the surrounding society and time, and the different generations involved. (Kangasniemi et al., 2015; Weis & Schank, 2000, 2017.)

## 6.2 Validity and reliability of the study

This study aimed to conduct in a reliable, honest, respectful and accountable manner in accordance with principles of research integrity (All European Academies, 2022; TENK, 2023). To increase the validity and reliability of the study, mixed methods (Anguera et al., 2018; Creswell 2022; Morgan, 1998) were utilized. This section describes the trustworthiness of the meta-synthesis and the validity and reliability of the cross-sectional survey study.

### Trustworthiness of the meta-synthesis (Paper 1)

The trustworthiness of the meta-synthesis included in this study will be described according to the literature search process, study selection, quality appraisal of selected data, data analysis and synthesis, interpretation of data, and reporting of the study results. The formation of research questions and search terms and clauses was preceded by familiarisation with previous literature (Kangasniemi et al., 2012; Noblit & Hare, 1999). In determining the search terms, the aim was to take into account not only the right and suitable words but also their synonyms. In the

formation of the search clauses, the university's information specialist was consulted. The final keywords and clauses were formed based on a shared discussion in the research groups and between the group and the information specialist. We could have identified more papers related to the research phenomenon if we had omitted 'nurse' from the search terms. The purpose of the study, however, was to study ethics in interprofessional collaboration between nurses and other professional groups, as nurses are one of the largest professional groups in health and social care services (Statistics Finland, 2021) collaborating with many different professions in various contexts. (Paper 1.)

One researcher performed searches in predetermined databases. Two researchers worked separately and selected papers to be included in the review based first on titles, then on abstracts and full texts. Between each stage, the researchers discussed their choices and together decided which papers to choose for the next stage. To increase trustworthiness, one of the inclusion criteria was that all papers had to be peer-reviewed scientific papers. It is possible that in selecting the studies, some suitable papers may not have been identified. In this review, grey literature was not utilized, but a manual search was conducted to hinder any bias of publications. To prevent language bias, language limitations were not used in the database search process. The trustworthiness of the meta-synthesis was also increased by a quality appraisal (Lockwood et al., 2015; McArthur et al., 2015) with suitable methods for qualitative and theoretical papers. The average score of the qualitative papers was eight (scores ranging from six to nine out of ten). The theoretical papers all scored five out of six. All papers were included in the meta-synthesis. (Paper 1; Table 1.)

Trustworthiness in the analysis and synthesis phase was ensured by taking notes and carefully recording them in a table, taking other separate notes and having continuous shared discussions in the research group (Kangasniemi et al., 2012; Noblit & Hare, 1999). Attention was also paid to ensuring the careful handling of the heterogeneous concepts of the studied phenomenon; however, these may have affected the interpretation of the material as a whole. The trustworthiness of the interpretation was thus secured by close mutual collaboration and discussions between all members of the research group until a shared understanding was achieved. (Kangasniemi et al., 2012.) All selected papers were published in the English language, which improved the understanding of the papers, thus strengthening the trustworthiness of the interpretation. The meta-synthesis was reported according to the seven phases of the developers (Kangasniemi et al., 2012; Noblit & Hare, 1999). (Paper 1.)

### Validity and reliability of the cross-sectional study (Papers 2 and 3)

The validity and reliability of the cross-sectional survey included in this doctoral study were taken into consideration in the selection and cross-cultural adaptation process of the instruments, the recruitment and representativity of the study participants, the response rate of the study, data analysis, and the reporting and general applicability of the study results.

*Selection of the instruments.* To increase content validity, the researcher, together with the research group, examined the content of the selected instruments and ensured they were suitable and sufficient to measure the desired phenomenon among Finnish health and social care workers. In addition, to increase the credibility of the research, the professional values and ethical guidelines of the different professions were compared with each other and in relation to the NPVS-3 instrument (Weis & Schank, 2017). This led to the conclusion that there were no major differences from the point of view of cultural adaptation (Beaton et al., 2010).

*Cross-cultural instrument adaptation.* To increase research validity, a proper cross-cultural instrument adaptation process (Beaton et al., 2010) was conducted. The goal of this process was to ensure that the Finnish versions of the instruments measure the same things as the original instruments. The items of the instruments contained multi-conceptual contents, including the use of the words and/or or two issues in a single item which is not recommended according to previous literature (Pollit & Beck, 2014; Waltz et al., 2010). This may make it difficult for the participant to respond to the statement, and thus potentially distort the results. However, it was not possible to eliminate these elements without substantially changing the content of the items and thus the examination of the phenomenon as a whole. Based on the records of the translation process made at the different stages of the process (Beaton et al., 2010), the research group conducted a comprehensive equivalence assessment for both instruments in relation to the original instruments and the studied phenomenon in the context of Finnish society. Semantic equivalence was observed to ensure that the words had the same meaning in the target culture and context, prevent the statements from being understood in more than one way, and fix any grammatical challenges in translation (Beaton et al., 2010). In this study, the definitions, instructions, items and response options of the instruments were examined in relation to the Finnish culture and, as a result, changes were made to wording and sentence structures, which included changing the items into first-person statements. There was no direct translation of the concept of "interprofessional professionalism" into Finnish, and the translation solutions made had to be approved by the research group. Idiomatic equivalence (Beaton et al., 2010) was observed, acknowledging that translating possible colloquial or other established expressions can be challenging. In this study, the content of all the items could be applied to the Finnish culture and context. Experiential equivalence (Beaton et al., 2010) is

observed by conveying the experiences described in the items to the target culture. In this study, the content of all items could be experienced in the Finnish culture and context. In order to ensure conceptual equivalence (Beaton et al., 2010), the research group made sure that the concepts used had the same conceptual meaning in the source and target culture. In this study, a decision was made to replace the word "family" with the term "significant others" during the equivalence review. *Face validity* (Beaton et al., 2010) was then ensured in a pilot with a group of Finnish health and social care professionals and students corresponding to the target group of the study as a follow-up phase of the cross-cultural adaptation process of instruments.

*Recruitment and representativity of the study participants*. The data collection was not separately aimed at the professional trade unions of the private sector. This may have affected the validity of the study if it led to obtaining a fewer number of respondents from the private sector. However, there was a preconception that the chosen trade unions covered professionals working with different service providers, such as public, private and third-sector operators. As professional trade unions were used to reach potential study participants, it is possible that everyone with interest in the present study may not be a member of the chosen trade unions and has thus not been able to participate in the research. However, the data was collected together with 15 trade unions, which increased the potential of reaching a large sample to represent the target group. Among the respondents, the representativeness of professions did not match the proportions of different professions in the Finnish health and social care context (Statistics Finland, 2021). Nevertheless, the group of respondents was comprehensive, representing a total of 31 degrees. Of these, it was possible to meaningfully form eight professional groups and a group of students. It is also worth pointing out that the proportion of female respondents was particularly high, thus causing bias in the data. However, this is also traditionally the case in the Finnish health and social care environment (Statistics Finland, 2021).

*The response rate of the study.* Over 100,000 health and social care workers were sent an invitation to participate in the study from their professional trade unions and associations. The number of participants in the study was closer to 3,000 but fewer than 2,000 of them completed the survey in a way that made it fit for statistical analysis. It is possible that some of those contacted did not receive the invitation email because of a changed email address, did not open the email or had no interest in a study concerning ethics (Suhonen et al., 2011). Probability sampling, instead of convenience sampling, could have improved the response rate (Pollit & Beck, 2014; Waltz et al., 2010), but the survey was intended to enable the participation of as many professionals and different professional groups as possible. At the time of contacting potential participants, the global COVID-19 pandemic was still ongoing and there was a national nurses' strike in Finland, both of which may have caused

overwhelming pressures at work, thus potentially preventing interest and participation in the survey and resulting in a response rate of just over 2%. Reminders to participate in the study were sent, but these had no significant impact on increasing the final number of respondents.

*Data analysis.* To increase the credibility of the data analysis of this survey study, the validity of the instruments was assessed, and the research data was deconstructed and analyzed using statistical methods in collaboration with a statistical expert (Parahoo 2006; Polit & Beck, 2013). One of the aims of the statistical analyses was to produce information on the psychometric properties of the instruments after the linguistic and cultural adaptation process. The validity of the instruments was tested with Factor Analysis. In conventionally reused instruments, a Confirmatory Factor Analysis [CFA] is traditionally used to demonstrate validity. (Watkins, 2018.) In this study, however, Exploratory Factor Analysis [EFA] was used for both instruments, due to the inclusion of various professional groups as a new respondent population instead of a traditional nurse population, as in the Weis and Schank's (2017) study or a group of students, as in the study of Frost et al. (2018). EFA showed that F-NPVS-3 produced a factor structure similar to the original instrument of Weis and Schank (2017) (Paper 2). For F-IPA testing, the developers did not get enough respondents for all domains, which is why they performed their analysis on four domains. In the present study, with a suitable number of study participants, EFA produced five domains (Paper 3), as *ethics and accountability* were combined into one domain.

*Trustworthiness of the qualitative content analysis*. Open-ended questions were included in the survey to allow study participants to reflect on professionalism in collaboration between different health and social care workers and provide information about possible positive issues and issues that need to be improved in more detail. The analysis process has been described carefully to increase credibility and transferability as well as to enable other researchers to understand and repeat the analysis process. The reliability of the qualitative part of the study may have been weakened by the fact that only one researcher conducted the inductive content analysis. However, the reliability of the qualitative content analysis was reciprocally increased by the researcher's in-depth familiarity with the studied phenomenon which improved the understanding of the data. Additionally, the researcher reflected on her own starting points and perspectives in relation to the phenomenon throughout the analysis process. (Elo & Kyngäs, 2008; Pollit & Beck, 2014; Waltz et al., 2010.)

*Reporting and general applicability of the study results*. To enhance the validity of the study, the STROBE checklist was used to report the study results (Papers 2 and 3). Self-assessment in surveys has been considered a poor way to gather information about the studied phenomenon. It has been noted that respondents' answers to items and questions may be more positive than the reality of the issue.

(Polit & Beck, 2013.) On the other hand, self-assessment is perceived as a way of asking those concerned directly about issues, thus being a valid approach (Waltz et al., 2010). This study had a particular aim to find out how professionals assess the importance of their own professional values and how they perceive professionalism to be realized in collaboration. Therefore, the use of self-assessment as a method was justified. In addition, it is important to consider the generalizability of the results of empirical research. The results might be different if the research was carried out in culturally more heterogeneous working contexts (Chen et al., 2020; Frost et al., 2018).

### *Reliability of the cross-sectional survey*

The purpose was to ensure the reliability of the instruments and thus the reliability of this cross-sectional survey study was verified during the pilot and testing phases. The internal consistency of the instruments was considered with Cronbach's alpha in the adaptation phase of the pilot study, to then proceed to the testing phase of the instruments. The objective was to reach Cronbach's alpha close to the corresponding statistical value of the original instruments in order to demonstrate the appropriateness of the cross-cultural translation process (Beaton et al., 2010).

The internal consistency (Cronbach's alpha) of the original NPVS-3 was .942 (Weis & Schank, 2017), and for three factors .799 – .912. Internal consistency by Cronbach's alpha for the original IPA (Frost et al., 2018) was .96, and for the four domains .890 – .920. The internal consistency of instruments in the present study was calculated both in the pilot and testing phases. In the pilot study, the alphas for the F-NPVS-3 and F-IPA were .934 and .951, respectively. In the survey study, the alpha for the F-NPVS-3total scale was 0.929, and for caring 0.878, activism 0.912, and professionalism 0.865. (Paper 2.) Similarly, the alpha for F-IPA was 0.964 for the total scale, and 0.837–0.912 for the five domains. (Paper 3.)

## 6.3 Ethical considerations (Papers 1, 2, 3, Summary)

Ethics and professionalism in collaboration are the foundation of high-quality person-centered care in integrated health and social care services. However, this is a little-studied phenomenon between different health and social care workers, which justifies the research process. The entire research process was conducted according to the responsible conduct of research (All European Academies, 2023; Medical Research Act 488/1999; TENK, 2023). The mixed research methods used were carefully studied and their basic principles were respected (Anguera et al., 2018; Creswell 2022; Morgan, 1998; Noblit & Hare, 1999).

In the meta-synthesis (Paper 1), ethical perspectives were taken into account across the research process, from the selection of the study subject to the presentation of the results (All European Academies, 2023). During the literature searches, special attention was paid to the correctness of the keywords and the searches were carried out with special accuracy. At each stage of the analysis, special attention was paid to ensuring a continuous common understanding, and the data was processed with respect to the original research and authors. The researcher and other authors respected the work of others and paid particular attention to citations of previous research and related perceptions. There was no need to obtain separate ethical permission for this kind of research as it consists of previous research. (All European Academies, 2023.)

In the adaptation process of the international instruments to measure professional values (Paper 2) and professionalism in collaboration (Paper 3) among health and social care workers, permission for their use and the backward translation process to the Finnish context was obtained and received from the developers.

In the cross-sectional survey study phase (Papers 2 and 3), permissions for the study were applied for and granted by 15 Finnish professional trade unions and associations. Informed consent was required from the study participants before enabling access to the survey. The health and social care workers were informed of the voluntary nature of the study and had the right to withdraw their participation at any stage of the study. They also received information about the anonymity, confidentiality and privacy of the study. (TENK, 2023.) The participants in the study were informed about the processing of their personal data by means of a separate privacy notice (EU 2016/679). The topics of professional values and professionalism in collaboration between different health and social care workers may be considered sensitive. However, no separate ethics committee approval was required, because all participants had professional degrees and were all adults, thus over 15 years old and legally competent. Participation in the survey did not deviate from the principle of informed consent. The research results were written and published in a way that ensured no study participants could be identified. During the publication processes of the cross-sectional study results (Papers 2 and 3), great care was taken in making reference entries to the original publications and authors. The data of the sub-studies were handled carefully and reported honestly. (All European Academies, 2023; TENK, 2023.)

In accordance with the data management plan, the researcher was responsible for the proper management and preservation of the material (All European Academies, 2023). In the empirical phase of the study, the electronic platform of Research Electronic Data Capture [REDCap] (Harris et al., 2009, 2019) hosted at the University of Turku was used to conduct the online survey, which recorded the participants' responses anonymously on the university's own secured server. During

the statistical analysis, the collected data was stored anonymously on Seafile, a secure cloud server maintained by the University of Turku. The research data was only available to the researcher and the research group, with personal identifiers. The data will be disposed of five years after the completion of the research.

## 6.4 Practical implications

Based on the findings of this study, this chapter presents practical implications for health and social care workers, leadership and organizations in the integrated practice of health and social care services.

Patients' and clients' active roles in integrated care need to be supported. This can be enabled by strengthening the ethics of interprofessional collaboration, by taking into account patients' and clients' own will and right to receive accurate information about their health situations and treatment in all phases. It is also necessary to involve patients and clients and their significant others in decision-making in case ethical conflicts arise during their integrated care.

Ethical issues concerning interprofessional collaboration may be avoided by concentrating on ensuring that different professional groups and all of their members have a mutual understanding of shared values. This can be justified by the fact that everyone has the same goal, good care and social services for the patients and clients. This needs to involve discussions of the different roles of professional groups in collaboration. Each health and social care worker can enhance trust and transparency in these mutual discussions by providing encouragement to others in collaboration and listening to one another as an ethical duty of the profession. Mutual ethical discussions are needed to guide and support how professional groups may identify, handle and reflect the ethical conflicts in integrated care. Professional groups will benefit from such if these shared discussions of ethical conflicts in collaboration are interprofessional, regular and made easy to participate in.

Ethics and professionalism in interprofessional collaboration can be supported by leadership and organizational structures. Different stakeholders in integrated care would benefit from solving and providing the structures for ineffective communication, inactive commitment, and time-related challenges in collaboration and integrated care. Knowledge of other professions' work and primary aims can enable reducing the hierarchy between health and social care workers. Mutual and guided discussions can be used to influence the power relationships between professional groups and thus promote equal work environments. This also requires, however, new skills and competence from the leadership. Leaders can be supported by organizations and continuous professional training that promotes competence in organizing mutual ethical reflections, supporting the professional and shared values of different health and social care workers and encouraging employees to act

according to them. Leaders can also be supported by encouraging them to utilize different leadership practices that enable them to promote the well-being of health and social care workers in their collaboration with each other. Organizations and leadership should work together with health and social care workers to determine the factors that affect the employees' well-being and satisfaction at work and how to ensure these.

# 7 Conclusions

Ethics and professionalism in collaboration among health and social care workers form the foundation of integrated care. This study produced new knowledge on health and social care workers' professional ethics and professionalism in collaboration. This new knowledge can be utilized to develop leadership and organizational structures to support health and social care workers in their work for integrated high-quality person-centered care.

Finnish health and social care workers' comprehensions of patients' and clients' positions in integrated care were very consistent. They involved placing great value on protecting patients' and clients' rights, the safety of individuals and the public, and ensuring trust and respect in the processes of care and social services. This provides a meaningful basis for collaboration that aims at person-centeredness in integrated care where patients and clients may have multimorbid needs. Still, open questions arise related to professionalism in collaboration, as the different power dynamics and hierarchies between professional groups, and also a lack of commitment and hearing of all parties involved in collaboration.

Ethical conflicts in interprofessional collaboration were connected to patients' and professionals' roles in the care processes. These were related to patients' and clients' autonomy, integrity and rights during communication, decision-making, and treatment. The different values and power relations between professional groups were also related to ethical conflicts. In ethical conflicts, there is a risk that patients and clients will not have an active agency in their own care process. There is good reason to strengthen the competence of different health and social care workers to reflect, solve and handle ethical conflicts in interprofessional collaboration, simultaneously considering all parties involved.

Professionalism in collaboration between professional groups enhances the achievement of the shared goal of empowering, respectful and supportive relationships between patients, clients and their significant others, and different health and social care workers in integrated care. Leadership and organization play a key role in guiding and supporting professional groups in their communication and commitment to collaboration, as well as well-being and satisfaction at work. Leadership needs to be recognised as a value-based and social assignment in the

development of integrated care. However, there is a need to clarify what kind of leadership would benefit collaboration in integrated care, and what kind of leadership supports truly person-centered care.

In order to support health and social care workers in their work for person-centered care, more attention should be paid to ensure continuous professional training in professional and interprofessional ethics, enabling regular mutual ethical discussions to courageously and openly process and prevent ethical issues together, and supporting work satisfaction.

To support ethics and professionalism in collaboration among health and social care workers, future studies need to explore the patients' and clients' and their significant others' perceptions of ethics and professionalism in collaboration in integrated care. There is also a need to investigate the most effective organizational structures and leadership for this kind of integrated collaboration. In addition, more research is needed to determine whether some form of collaboration other than interprofessional collaboration would be more suitable for integrated care.

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# Appendices

**Appendix 1.** The search terms used for collecting scientific literature in electronic databases and in manual search.

| Study phase and content | Search terms and combinations |
|---|---|
| Paper 1: Ethics in interprofessional collaboration in clinical practice | Ethic* AND (interprofession* OR multiprof* OR multidiscipline* OR interdisciplin* OR discipline* OR collaboration* OR co*operation* OR teamwork* OR partnership* OR cross-prof*) AND (healthcare OR "health care" OR "social work" OR "welfare service*" OR "social service*") |
| Paper 2: Professional values among health and social care workers | ("prof* values" OR "prof* ethic*" OR "shared values") AND (health and social care workers" OR "healthcare workers" OR "health care workers" OR "social care workers" OR "social workers" OR "healthcare prof*" OR "health care prof*" OR "social care prof*" OR "social welfare" OR "health and social care") |
| Paper 3: Professionalism in collaboration between health and social care workers | ("professionalism in collaboration" OR "interprofessional professionalism") AND (health and social care workers" OR "healthcare workers" OR "health care workers" OR "social care workers" OR "social workers" OR "healthcare prof*" OR "health care prof*" OR "social care prof*" OR "social welfare" OR "health and social care") |
| Summary: Ethics and professionalism in collaboration among health and social care workers | (Ethic* OR professionalism OR "interprofessional professionalism") AND ("collaboration" OR interprofessional collaboration") AND (health and social care workers" OR "healthcare workers" OR "health care workers" OR "social care workers" OR "social workers" OR "healthcare prof*" OR "health care prof*" OR "social care prof*" OR "social welfare" OR "health and social care" OR "integrated care") |

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