

Editorial

Can “occupations” become leaders in the multidisciplinary rehabilitation team?

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Description

Evidence-based practice in experimental studies on rehabilitation is quite difficult to achieve because of a number of variables, including blindness to treatment, placebo cohort, quantification of results and follow-up. However, objective and standardized quantification of the effects of rehabilitation is mandatory for recognition of efficacy by public health systems. The issue is further complicated in Italy, where 8 different disciplines (Physiotherapist, Occupational Therapist, Podiatrist, Speech Therapist, Pedagogue, Orthoptist, Psychiatric Technician, Neurodevelopmental Disorders Therapist) have been identified by the National Health System [1], with rather diverse methodologies, approaches and outcome measurements.

At present, very few rehabilitation studies have been performed according to a recognized scientific approach. The majority of efforts applied “pathology vs. profession” paradigm, i.e., measurement of outcomes related to a specific discipline of rehabilitation in subjects affected by a specific disorder. Although this approach is useful for designing relatively simple protocols, it limits the identification of potential efficacy of multidimensional rehabilitation paradigms [2]. Since year 2001, the International Classification of Functioning, Disability and Health (ICF) centered the biopsychosocial process of rehabilitation on activity of the individual [3]. Consequently, the process of rehabilitation should primarily focus on ensuring patients with dignified life rather than specific tools of rehabilitation.

As of today, occupational therapy (OT) is the discipline of rehabilitation mostly endorsed on subject’s lifestyle. OT is indeed, a client-centered health profession oriented on promoting health

and well-being through occupation. The primary goal of OT is to enable people participating in activities of daily living. Occupational therapists achieve outcomes by working with individuals or communities to enhance ability in engaging in occupations they want to, need to, or are expected to, and by modifying occupation or environment to help supporting the occupational engagement [4]. Given these premises, the question raises of whether OT may represent the leading discipline for adaptation of rehabilitative process to evidence-based practice.

The term “occupation” refers to everyday activities that people engage with as individuals, in families and/or communities to occupy time with meaning and purpose of life [4]. Obviously, occupations cannot be standardized, being unique to each individual. However, statistical methods may help identifying similarities of single traits among cohorts, aimed at designing discrete protocols applicable to large number of subjects. Thus, the identification of occupations more frequently requested by clients suffering from a specific disease, and solutions that may be introduced within the rehabilitative protocol may drive biopsychosocial reasoning within the scientific study to obtain verifiable and reproducible data. These, in turn, may help reconsidering the cost-effectiveness of treatments through the “evidence-based practice”, in particular with respect to chronic-progressive neuropsychiatric disorders such as Parkinson’s disease, Alzheimer’s dementia or schizophrenia [5].

We acknowledge that methodological and practical difficulties may hamper this approach: first, health professionals belonging to different disciplines should be trained to work in rehabilitation as a team, objectives being based on occupations and performances identified by statistical analyses and relatively rigid protocols of rehabilitation. For each defined objective, disciplines should reciprocally interact to potentiate outcomes by means of teamwork activity carried out with a problem-solving approach. For instance, if the case of a client (let’s call him Charles) admitted in teamwork rehabilitation for gait difficulties limiting his daily activity to walk,

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the Physiotherapist will focus on the modulation of sequences of muscle contraction optimizing kinematic of steps, whereas the Occupation Therapist will concentrate on occupational performances (i.e., the social relevance of walking as a tool to allow Charles meeting a close friend of him hospitalized at a different floor of the same rehabilitation clinic). As such, while sharing data on the progress of the client, team members might plan ahead to ensure the two friends will meet somewhere in between their original locations if the total distance would be too long for the walking possibility of Charles at the beginning of treatment, and progressively encourage Charles to walk the entire distance according to progression of benefit from treatment. Beyond this simple example, such methodology should be adopted when managing more complex disabilities and more problematic health scenarios. A similar approach is, indeed, fundamental for designing and interpreting experimental studies on rehabilitation, assuming standardization of methods and objectives is reached. Further issues will deal with statistical analysis of different occupational activities with specific disease/disorder and the setting of rehabilitative protocols utilizing tools and evaluation measures shared by all members of the rehabilitation team. Thus, setting of a rehabilitation record and program centered on the patient as

a client bearing decision power as to what to do on his/her life and body, and including evaluation tools as measures commonly utilized by health professionals, together with robust knowledge of the neurophysiological bases of rehabilitation, may help defining correct therapeutic strategies and identifying efficacy of the results.

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