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What attributes should a specialist in rehabilitation have? Seven suggested specialist Capabilities in Practice

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Abstract

Problem: Many services and professionals refer to themselves as providing rehabilitation. There is no agreed method for determining whether someone has specific expertise in rehabilitation. This makes it difficult for patients and payers to know whether professionals who claim to provide rehabilitation are specifically expert in rehabilitation.

Context: Doctors have a medical speciality of rehabilitation. The medical training curriculum gives attributes that differentiate a rehabilitation specialist from other doctors. Until recently, these attributes were competencies to undertake activities associated with specialization. Apart from nurses, who have at least one, unofficial, curriculum identifying specific competencies, other professions involved in rehabilitation do not have any way to show specialization in rehabilitation.

Capabilities in Practice: The U.K. General Medical Council accredits specialist medical training. It has moved from specifying multiple practical clinical competencies to specifying fewer high-level 'Capabilities in Practice'. Six are generic to all doctors, eight identify the trained doctor as having specialist rehabilitation skills. This article adopts this approach to put forward seven generic and seven specialist capabilities to identify any professional as having special expertise in rehabilitation. The seven specialist capabilities centre on the biopsychosocial model of illness and multidisciplinary teamwork. Four of them could be used to define a specialist rehabilitation team.

Conclusion: Seven capabilities identifying specialization in rehabilitation are put forward for discussion. They could form the basis of a formal recognition that any professional has additional expertise in rehabilitation. A validating authority would be needed to provide oversight and governance.

Keywords

Professional capability, rehabilitation capability, specialization, expertise

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Introduction

How should one signify that a healthcare worker has expertise in rehabilitation? Healthcare professional titles refer to the profession, such as nurse, psychologist, doctor and so on. Additional descriptors may identify a special area of expertise, usually based on a disease group, such as cardiologist or oncologist (for a doctor) or cardiac or oncological (for a nurse or therapist). Professional qualification is validated by an appropriate state-recognized authority. Use of descriptors is not controlled.

The medical profession has formalized what differentiates a doctor specialized in rehabilitation from other doctors; it is enshrined in specialist training curricula and examinations. Curricula have usually been framed in terms of competencies at particular tasks, together with an accumulation of experience in rehabilitation.[1] The Association of Rehabilitation Nursing (in the United States) has developed a set of 16 competencies shown in Box 1, defining specialization in rehabilitation nursing.[2,3] I am unaware of any other professional bodies setting out criteria which validate specific knowledge and skills in rehabilitation.

Those using or paying for rehabilitation need some way of knowing whether any person with some healthcare qualification has the rehabilitation expertise claimed, in addition to their validated professional qualification. This article suggests a mechanism which recognizes that many professions, including carers, may have or gain expertise.

Rehabilitation

Before discussing the attributes that might demonstrate that a clinician has expertise in rehabilitation, it is necessary to set out what rehabilitation is.

Rehabilitation refers to an educational, problem-solving process focused on disability with the goal of optimizing social participation, guided by the patient's preferences.[4–6] The process involves a multidisciplinary team[6–8] that may include any one of a very large number of professions. It happens in many settings, and is embedded in different organizations both within and outside healthcare.

Box 1. Nursing competencies in rehabilitation (Association of Rehabilitation Nursing).[2,3]

Competencies assessed:
- Autonomic dysreflexia
- Bladder function
- Bowel function
- Communication
- Disability
- Dysphagia
- Gerontology
- Musculoskeletal, body mechanics, functional transfer techniques
- Neuropathophysiology and functional assessment
- Pain
- Patient and family education
- Paediatrics
- Rehabilitation
- Safe patient handling
- Sexuality
- Skin and wound care

Rehabilitation interventions[7] (see Box 2) include:

- The following four generic components:
  - Exercise that increases cardio-vascular and muscular fitness.
  - Repeated practice of activities that are affected, to improve performance.
  - Education of the patient, especially about self-management.
  - Providing psychosocial support, to alleviate associated emotional difficulties.
- One personalized component, a set of interventions tailored to the person's needs and goals, which should be monitored for effectiveness.

Competencies to capabilities

Until recently, professional abilities were defined by competencies, the ability of the person to carry out some defined task or activity safely. The tasks are specific to the profession, and are relatively easily assessed as being present or not. Over time, the number of competencies has increased, leading to a practical difficulty in assessing the trainee. Competencies usually concern defined procedures. They do not assess more complex clinical

Box 2. An evidence-based description of effective rehabilitation.

Patients and places:
Rehabilitation may
- benefit anyone with a longer term disabling illness at any stage of that illness and
- be delivered in any setting

The outcome:
The goal is to optimize a patient's self-rated quality of life and degree of social integration through:
- optimizing independence in activities,
- minimizing pain and distress and
- optimizing the ability to adapt and respond to changes in circumstances

The structure:
Rehabilitation:
- requires an expert, multidisciplinary team, who:
  - use the biopsychosocial model of illness[9]
  - agree a formulation of the situation, covering all domains of the biopsychosocial model
  - set collaborative team-based goals
  - participate in close, collaborative working across all boundaries, professional, organizational and geographic
  - undertake ongoing monitoring of change and effects of interventions

The process:
Rehabilitation is:
- a problem-solving process,
- framed in the context of the holistic biopsychosocial model of illness,
- focused on a patient's functional activities,
- delivered in a person-centred way and

The interventions:
Rehabilitation will usually involve:
- the following general approaches to management
  - Repeated practice of functional activities
  - General exercise that increases cardio-respiratory work
  - Education, with an emphasis upon self-management
  - Psycho-social support (not well defined yet) and
- some specific actions tailored to the patient's priorities and needs,
  - covering (if necessary) all domains of the biopsychosocial model of illness and
  - being evaluated regularly for their benefits and harms, to determine whether they should be continued, changed or abandoned

performance, such as managing an outpatient clinic. Medical specialization has been defined by competencies in many countries.[10–13]

These considerations led the U.K. General Medical Council to move from assessing multiple competencies to assessing trainee doctors in their performance of complex professional activities. These are termed 'Capabilities in Practice'. Only a relatively small number is assessed. They cover performance of broad and complex clinical activities, which necessarily require competencies. For example, one capability for specialists in internal medicine is 'managing an acute unselected take',[14] being responsible for all the clinical and other problems that may arise during a spell 'on-take'.

Capabilities are difficult to measure. The standard used is being 'entrustable'; your colleagues would trust you to manage without supervision.[15–18] The evidence for entrustability is accumulated during postqualification training, a period of at least 9 years in medicine in the United Kingdom.

Generic capabilities

When developing specialist curricula, the General Medical Council recognized that all healthcare

Box 3. Six generic capabilities for secondary care doctors in training (General Medical Council).[19]

The six capabilities are:
- Able to function successfully within the National Health Service (NHS) organizational and management systems.
- Able to deal with ethical and legal issues related to clinical practice.
- Communicates effectively and is able to share decision making while maintaining appropriate situational awareness, professional behaviour and professional judgement.
- Is focused of patient safety and delivers effective quality improvement in patient care.
- Carries out research and manages data appropriately.
- Acts as a clinical teacher and clinical supervisor.

professionals needed a core set of generic capabilities, and that a specialist must have these in addition to specialist capabilities. They developed a framework of nine general professional capabilities,[9] which covered six capabilities and three professional characteristics: knowledge, skills and professional values and behaviours. Then, while developing training curricula, they identified six capabilities that all secondary care doctors had to have to practice independently (Box 3).

Although these generic capabilities were developed in relation to doctors, they should be relevant to all healthcare professions. This article has adapted them to be more applicable across professions and added one, to set out seven generic capabilities (Supplemental Figure 1). The capabilities are outlined below, highlighting the areas of particular importance within rehabilitation. They are expressed as: 'Having the capability to: . . .'

1. Function within the healthcare and social support management systems.

All healthcare workers need to understand their healthcare system(s) and, increasingly, their social support system(s). This helps them work within their system, to negotiate access to appropriate resources for their patients both within and outside the healthcare system, and to explain matters to their patients.

Rehabilitation specialists specifically need to understand social care systems and non-statutory services, because many patients have to use these services to meet their needs.

2. Adapt actions to the social context of their patients.

All healthcare professionals must consider the patient's social context. Some aspects are very personal, such as family values or cultural rules, and some are very general, such as legally defined practices or local cultures.

Rehabilitation specialists need to pay particular attention to the common social contexts among their patient population, such as religious beliefs, attitudes towards disability, and local cultural norms, because almost all rehabilitation actions relate to a patient in their social context. Any decisions and suggested actions or goals must be concordant with the patient's social milieu.

3. Communicate effectively, including when sharing decision-making.

All healthcare professionals need to communicate effectively. This does not mean simply giving someone information. It encompasses active and empathetic listening, non-verbal communication, writing informative letters or referrals, use of various technologies such as phones and video conferencing, the style of interaction and so on. Failures in communication underlie many complaints and episodes of harm to patients.

Rehabilitation specialists additionally need to recognize when a patient has difficulties affecting communication as part of their illness, such as reduced hearing, language impairment (aphasia), cognitive losses, attentional difficulties, delusional beliefs and so on. Moreover, rehabilitation professionals must be skillful at communicating with people who have communication difficulties.

4. Focus on quality and safety, and participate in quality improvement systems.

All healthcare professionals should focus on the quality and safety of their own work, and also of the

service or team they work within. This concern means giving effective treatments and avoiding harm, and extends to many other matters affecting service quality, such as being respectful of others. There is also a responsibility to comply with and actively participate in any quality control and monitoring systems.

Rehabilitation specialists additionally need to consider activities and services occurring outside the local rehabilitation service and organization, including those outside healthcare. Patients will be in contact with many services which may be provided by social services, non-statutory, not-for-profit organizations, and commercial organizations. Much of the observed harm in rehabilitation arises from poor communication and collaboration between services. The potential for quality improvement through better collaboration, and the potential for harm from poor services and/or lack of collaboration, must always be recognized and acted on.

5. Understand and support research.

All healthcare professionals need some understanding of research and should be able to evaluate it. They should be able and willing to support research. Engagement with research should foster an attitude of curiosity, critical thinking, a willingness to change and adapt, and increased collaboration with others.

Much health research only considers outcome at the level of disease and physiological function. Rehabilitation specialists should particularly consider the functional and social outcomes of research and should encourage the use of patient-related outcomes whenever the opportunity arises.

6. Teach and supervise healthcare trainees.

All healthcare professionals have a responsibility to help teach and train others, even if only by supervising someone who has just started. Most people will also teach and train colleagues as a normal part of their day-to-day work; a few undertake more formal teaching.

Rehabilitation specialists should specifically teach training-grade professionals from outside their own profession. Effective teamwork depends upon each person having an awareness of the knowledge and skills of other team members.

7. Base all clinical practice on best available evidence, and on professional standards.

This encompasses (a) keeping up-to-date with relevant knowledge and skills, usually referred to as continuing professional development, (b) using and applying that to all aspects of clinical practice and (c) seeking out relevant evidence and using it when faced with a new problem or other uncertainty.

Rehabilitation specialists specifically need to participate in multidisciplinary learning with other professions, to enable better coordinated care. They also need training in multiprofessional teamwork, such as undertaking rehabilitation interventions with others and setting team goals. This requirement contrasts with the uniprofessional focus of most continuing professional development activities.

Rehabilitation speciality-specific capabilities

The General Medical Council then allowed each speciality to set out upto eight specialist 'Capabilities in Practice', that identified the areas of expertise associated with the speciality. The eight 'Capabilities in Practice' for the U.K. Rehabilitation Medicine curriculum[19] are shown in Box 4. These have been adapted and reduced to the seven capabilities suggested here for all rehabilitation specialists, shown in Supplemental Figure 2. Each is expressed as: 'Having the capability to: . . .'

1. Use the biopsychosocial model of illness in all areas of practice.

This encapsulates one of the central differentiating aspects of rehabilitation, the need to take a holistic view of a patient's situation. It requires anyone specializing in rehabilitation not only to know the biopsychosocial model,[20] but to use it in all spheres of work: direct patient care activities; academic activities such as teaching and researching; management activities such as monitoring the quality of services and improving them; financial activities such as quantifying and justifying

Box 4. Specialist capabilities for rehabilitation medicine (in United Kingdom).[19]

There are eight 'Capabilities in Practice':

- Able to formulate a full rehabilitation analysis of any clinical problem presented, to include both disease-related and disability-related factors.
- Able to set out a rehabilitation plan for any new patient seen with any disability, this plan extending beyond the consultant's own specific service.
- Able to work as a full and equal member of any multidisciplinary rehabilitation team.
- Able to identify and set priorities within a rehabilitation plan.
- Able to diagnose and manage existing and new medical problems in a rehabilitation context.
- Able to recognize need for and to deliver successfully specific medical rehabilitation treatments.
- Able to work in any setting, across organizational boundaries and in close collaboration with other specialist teams.
- Able to make and justify decisions in the face of the many clinical, sociocultural, prognostic, ethical, and legal uncertainties and influences that arise in complex cases.

resources; and bureaucratically, such as organizing clinical records or information.

A rehabilitation specialist obviously will not be personally and directly responsible for the use of the model in all these different areas. On the contrary, good managers and organizations design systems around the needs of clinicians and so the rehabilitation specialist has the opportunity to promulgate the use of the model when system design or change is happening. In clinical practice, patient formulations and planning should be based on this model, notes and documents should be set in this framework, and intra-team communication should be based on it. A rehabilitation professional should use the model at all times, not just 'when needed'.

2. Develop (with others) a rehabilitation plan for the patient.

Using the biopsychosocial model requires a willingness and ability to consider how all the patient's identified needs may be met, including those needs well outside the expertise of the professional or team. The professional (and team) should identify and refer patients to the resources needed to meet other needs. Their responsibility is to ensure all needs are met, not to meet all needs themselves. A rehabilitation professional should contribute to this broader activity, thinking well outside their specific professional area of knowledge and skills. Identifying priorities among the many possible actions and goals is another important characteristic.

This capability is particularly important when the professional is the patient's first contact with rehabilitation. The rehabilitation professional should be able to identify the main interventions or further assessments likely to be needed and to form an outline plan. Rehabilitation specialists must avoid being 'a man with a hammer, who sees everything as a nail' and, instead, acknowledge that 'no problem is an island entire of itself; every person's problem is a piece of a greater whole'. Then they need to develop a plan for the whole patient, not just the part the professional knows most about.

3. Work as a full and equal member of any multidisciplinary team.

Rehabilitation problems are complex, and collaborative teamwork of people with many different areas of knowledge and skills is the best approach to any complex problem.[8] It requires individuals to relax the boundaries around their unique professional training, sharing their expertise, helping other team members to acquire relevant skills to support their interventions, and being prepared to help other team members with their interventions.[8]

Teamwork requires each team member: to give positive attention to achieving good teamwork; to show commitment to the team, treating others with respect; to be prepared both to lead and to be led; to appreciate the knowledge and skills of other members of the team, so that they can develop and then work jointly on agreed goals; and to support interventions designed by others, especially the common ones.[7]

4. Work across organizational and geographic boundaries, collaborating with other professionals and teams.

It will be rare that a particular rehabilitation professional, team or service can resolve all patient problems without any input from others. Transferring responsibility to another team is also common. Teams and team members need to be willing to work closely with others outside their own service, sharing information and work. Often this will involve training others, professionals and family/friends, how to help or support the patient.

The rehabilitation specialist will actively identify and work with other professionals outside their own service needed to help their patient. The specialist will liaise, teach others anything needed to help the patient, and will pass over all relevant information, within the rules governing confidentiality. Failure to pass on information poses a significant risk to the patient, and wastes resources.

5. Recognize, accept and manage uncertainty and complexity, with long-term commitment to the patient if needed.

Patients needing rehabilitation often have problems that are complex and may last for years or for life. There is usually uncertainty both about the future in general, and about whether or not an intervention will help. Some patients are overwhelmed by and lost in the myriad of different people and services involved. Over time the patient will meet hundreds of people and many services, and each will usually undertake a small specific input and then discharge the person. Frequently, no one takes responsibility for ensuring that all problems are identified and managed, or for maintaining a continuing rehabilitation-professional interest.

The rehabilitation specialist needs to acknowledge this complexity and uncertainty, and to explain the uncertainty to the patient and others clearly. The biopsychosocial model is useful in demonstrating the many factors influencing outcome. The rehabilitation specialist also should recognize when a patient and, often, their family are struggling with the multitude of people and services. After discussion with others, they should be prepared to provide long-term rehabilitation support, not limited to their own professional expertise.

6. Support the common, generic rehabilitation interventions.

Successful rehabilitation uses many of the same interventions across all conditions and settings,[7] shown in Box 2.

While the specialist in rehabilitation will not be expert in all these interventions, each and every rehabilitation specialist must have some familiarity with them, sufficient to provide basic input and, with support and training from others, to support more specific interventions safely. Conversely, the rehabilitation specialist should help other professionals to support their own interventions.

7. Use profession-specific expertise to help the patient and assist team processes.

Each team member will have a body of knowledge and skills not held by others within the team. Blurring of boundaries does not require complete loss of uniprofessional expertise. Indeed, maintenance of unique expertise is vital.

The professional with rehabilitation specialism will be expected to undertake a more detailed assessment of factors relating to their specific professional expertise, and then to explain the significance and impact of their findings in the context of all other information. They should contribute to the analysis and understanding of the patient's situation.

The professional with rehabilitation specialism will also be expected to give a more accurate prognosis for matters within their area of expertise, and to identify what profession-specific interventions might assist and how, and what suggested interventions will not assist, and why. In this way they should help develop a comprehensive rehabilitation plan. They need the knowledge and skills to explain and justify decisions about their own professional treatments, to explain risks and benefits, to deliver them, and to know when an intervention is not helping or should be stopped.

Discussion

Rehabilitation has no professional body to set out what it does, what knowledge and skills define it

and how expertise is to be demonstrated. This leaves it open for anyone to define themselves as experts – with the only exception being medical doctors. Some people assume that some professions, such as physiotherapists, occupational therapists and speech and language therapists, are automatically experts in rehabilitation.

This lack of an over-arching authority leads to a difficulty for those who commission or pay for rehabilitation. How can an individual or organization paying a service or a professional person for rehabilitation be satisfied that the person or team members have expertise in rehabilitation, rather than just in their own professional activities?

The article has developed seven specialist capabilities that might be used to classify someone as being a 'rehabilitation specialist' within their profession. As is shown in Supplemental Figure 2, it has also, and incidentally, developed at least four features that identify a team as being an expert rehabilitation team:

- Using the biopsychosocial model of illness in all areas of practice,
- Developing a comprehensive rehabilitation plan,
- Working across organizational and geographic boundaries, collaborating with other professionals and teams,
- Accepting and managing uncertainty and complexity, including making a long-term commitment to the patient if necessary and

These capabilities are put forward to stimulate discussion about what it means to be a professional with additional expertise in rehabilitation. This process cannot be taken much further until and unless a professional body representing rehabilitation (and not just a limited set of professions) is set up within the country.

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