

ТЕРАПІЯ ТА РЕАБІЛІТАЦІЯ

EXPERIENCE UTILIZING THE CANADIAN OCCUPATIONAL PERFORMANCE MEASURE (COPM) IN THE DEVELOPMENT OF INDIVIDUAL REHABILITATION PROGRAMS FOR MIDDLE-AGED INDIVIDUALS WITH CHRONIC CALCULOUS CHOLECYSTITIS AFTER CHOLECYSTECTOMY

ДОСВІД ЗАСТОСУВАННЯ КАНАДСЬКОГО ІНСТРУМЕНТА ОЦІНКИ ВИКОНАННЯ ЗАНЯТЬ (COPM) У РОЗРОБЦІ ІНДИВІДУАЛЬНИХ РЕАБІЛІТАЦІЙНИХ ПРОГРАМ ДЛЯ ОСІБ СЕРЕДНЬОГО ВІКУ ІЗ ХРОНІЧНИМ КАЛЬКУЛЬОЗНИМ ХОЛЕЦИСТИТОМ ПІСЛЯ ХОЛЕЦИСТЕКТОМІЇ

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Abstracts

Objective is to describe the experience of using the Canadian Occupational Performance Measure (COPM) in the development of individual rehabilitation programs for middle-aged individuals after cholecystectomy; to determine the dynamics of the quality of life of middle-aged patients after cholecystectomy under the influence of the developed individual rehabilitation programs using COPM.

Material. Middle-aged patients aged 45 to 59 years with chronic calculous cholecystitis (CCC) after cholecystectomy (n=40) who underwent laparoscopic cholecystectomy were included. Patients in the main group (n=20) received rehabilitation according to our concept using a biopsychosocial individual approach and COPM, patients in the control group (n=20) received general recommendations on diet and exercise regimens. The mental and physical components of quality of life were assessed using the SF-12 questionnaire, in order to ensure client-centeredness when setting short-term goals in the process of developing and implementing individual rehabilitation programs aimed at occupational activity, the COPM was used. The article presents the results of assessing the quality of life at the acute stage of rehabilitation (initial examination), in the post-acute stage (one month after laparoscopic cholecystectomy (LCC)) and long-term stage (one year after LCC). Statistical methods: Shapiro-Wilk W-test, the mean ($\bar{x}$), standard deviation (S) and standard error of the mean (m) were calculated; Student's t-test, differences were considered statistically significant at $p < 0.05$.

Results. The results of the SF-12 quality of life survey in individuals with CCC indicate a level of life slightly below the average in the physical and mental components. This indicates that chronic calculous cholecystitis negatively affected these two important factors of quality of life. Analyzing the dynamics of quality of life according to the SF-12 questionnaire one month after LCC, no statistically significant ($p > 0.05$) changes in quality of life were found in any of the groups. The results of the dynamics of quality of life according to the SF-12 questionnaire in individuals with CCC one year after LCC indicate a statistically significant ($p < 0.05$) improvement in the control group compared to the previous examination. The results of the dynamics of the quality of life according to the SF-12 questionnaire in individuals with CCC one year after LCC indicate a statistically significant ($p < 0.05$) improvement in the representatives of the main group compared to the previous examination and compared to the control group one year later, which indicates a more positive dynamics in the quality of life in the physical and mental components.

Conclusions. COPM allows taking into account the personal factors of patients when developing individual rehabilitation programs aimed at restoring occupational activity in individuals after cholecystectomy and ensuring client-centeredness of occupational therapy intervention. The use of COPM in individuals after cholecystectomy increases their motivation to continue rehabilitation in long-term stages, directs interdisciplinary work to all areas of quality of life. It has been established that the use of COPM in the concept of restoring the quality of life of individuals after cholecystectomy leads to an improvement in its mental and physical components.

Key words: Canadian Occupational Performance Measure (COPM), occupation, occupational therapy, quality of life, individual rehabilitation program, cholecystectomy.

Мета – описати досвід застосування Канадського інструмента оцінки виконання занять (COPM) у розробці індивідуальних реабілітаційних програм для осіб середнього віку після холецистектомії; визначити динаміку рівня якості життя пацієнтів середнього віку після холецистектомії під впливом розроблених індивідуальних реабілітаційних програм із застосуванням COPM.

Матеріал. Включено пацієнтів середнього віку віком від 45 до 59 років із хронічним калькульозним холециститом (ХКХ) після холецистектомії ($n=40$), яким була проведена холецистектомія лапароскопічним способом. Пацієнти основної групи ($n=20$) отримували реабілітацію за нашою концепцією із використанням біопсихосоціального індивідуального підходу та COPM, пацієнти контрольної групи ($n=20$) отримували загальні рекомендації щодо дієти та рухових режимів. Оцінювали психічний та фізичний компоненти якості життя за допомогою опитувальника SF-12 з метою забезпечення клієнтоорієнтованості у разі встановлення короткострокових цілей у процесі розробки та впровадження індивідуальних реабілітаційних програм, спрямованих на заняттєву активність, застосовували інструмент COPM. У статті представлені результати оцінки якості життя на гострому етапі реабілітації (первинне обстеження), в післягострому (через місяць після лапароскопічної холецистектомії (ЛХЦ)) та довготривалому етапі (через рік після ЛХЦ). Статистичні методи: W-критерій Шапіро-Уїлка, обчислювали середнє ($\bar{x}$), стандартне відхилення (S) та стандартну похибку середнього (m); t-критерій Стюдента, статистично значущими вважали розходження при $p < 0,05$.

Результати. Результати опитування якості життя за опитувальником SF-12 у осіб із ХКХ вказують на рівень життя незначно нижче середнього рівня у фізичному та психічному компонентах. Це свідчить про те, що хронічний калькульозний холецистит негативно впливав на ці два важливі фактори якості життя.

Аналізуючи динаміку якості життя за опитувальником SF-12, через місяць після ЛХЦ не встановлено статистично значущих ($p > 0,05$) змін у якості життя у жодній із груп. Результати динаміки якості життя за опитувальником SF-12 у осіб із ХКХ через рік після ЛХЦ вказують на статистично значуще ($p < 0,05$) покращення у представників контрольної групи порівняно з попереднім обстеженням. Результати динаміки якості життя за опитувальником SF-12 у осіб із ХКХ через рік після ЛХЦ вказують на статистично значуще ($p < 0,05$) покращення у представників основної групи порівняно з попереднім обстеженням та порівняно з контрольною групою через рік, що свідчить про більш позитивну динаміку в якості життя у фізичному та психічному компонентах.

Висновки. COPM дозволяє врахувати особистісні фактори пацієнтів під час розробки індивідуальних реабілітаційних програм, спрямованих на відновлення заняттєвої активності у осіб після холецистектомії та забезпечити клієнтоцентричність ерготерапевтичного втручання. Застосування COPM у осіб після холецистектомії підвищує їхню мотивацію для продовження реабілітації на довготривалих етапах, спрямовує міждисциплінарну роботу на всі сфери якості життя. Встановлено, що використання COPM у концепції відновлення якості життя осіб після холецистектомії призводить до покращення його психічного та фізичного компонентів.

Ключові слова: канадський інструмент оцінки виконання занять (COPM), заняттєва активність, ерготерапія, якість життя, індивідуальна реабілітаційна програма, холецистектомія.

Introduction. Lifestyle modification is an emerging specialized area of practice in health-care in which certified health care providers focus on promoting health, preventing disease, and treating chronic conditions that arise primarily from unhealthy lifestyles and behaviors. Preventive lifestyle interventions should focus on

improving a person's health through nutrition, physical activity, healthy sleep and hygiene, emotional well-being, cessation of tobacco and alcohol use, weight management, and health and wellness education. Noncommunicable diseases caused by unhealthy lifestyles are the leading cause of morbidity and mortality worldwide and

the leading cause of years of life lost with disability [13; 37; 38].

Health management strategies that promote healthy behavior and help prevent and treat chronic noncommunicable diseases through a scientifically based approach to lifestyle modification should be a prerequisite for creating individual rehabilitation programs for people after cholecystectomy. Health management is one of the areas of human occupation. As an integral part of multidisciplinary rehabilitation teams, occupational therapists' scope of practice includes restoring occupational performance and engagement [1; 9; 20; 26].

Recovery of patients with laparoscopic cholecystectomy in the early postoperative and subsequent periods depends on many factors, namely: on the existing complications of the surgical intervention, or the patient's condition, age, existing concomitant diseases, physical activity and occupational engagement, personal factors. Rehabilitation measures should contribute to positive changes in the condition of the person, and their quality of life. In patients with chronic calculous cholecystitis, who underwent a planned cholecystectomy without comprehensive rehabilitation support, postoperative complications were recorded in 34% of cases. The presence of concomitant diseases significantly reduced the likelihood of favorable recovery, as instead of the expected improvement in the quality of life, people often faced an exacerbation of chronic pathology immediately after the intervention [14; 16].

The use of preoperative education, the creation and implementation of individual rehabilitation programs that take into account concomitant pathology, as well as the correction of eating behaviors, level of physical activity and lifestyle are key factors that can accelerate recovery, reduce the frequency of complications and subsequently shorten the period of disability. In this context health management as a tool of occupational therapy plays a leading role, as it involves systematic intervention process with all components that affect the quality of life: functional capabilities, level of activity and participation, psycho-emotional well-being, personal resources

and environmental conditions. The integration of health management into the rehabilitation process allows not only to optimize the restoration of physical functions, but also to increase the patient's ability to live independently, prevent recurrent complications and maintain long-term health. For a holistic assessment of health, including in individuals after cholecystectomy, it is currently advisable to use the International Classification of Functioning, which provides an assessment of the structure, function, activity and participation, and the person's environment, which constitutes a comprehensive approach to measuring quality of life [14; 15; 16].

To ensure inclusion of personal factors and individualized rehabilitation approach, the Canadian Occupational Performance Measure (COPM) is widely used by occupational therapists globally. The measure was developed in Canada in the late 1980s as part of a national quality program in occupational therapy practice. In 1988, the National Health Development Program of Canada, together with the Canadian Occupational Therapy Foundation (CAOT), initiated the creation of an outcome measure that should focus specifically on the patient's performance of key areas of occupation: self-care, productivity, and leisure. The main requirements for the new tool included: focus on personally important occupations; consideration of the environment, level of development, life roles, and motivation; universality – the need to be not specific to pathology; ease of use and numerical assessment; availability of reliability, relevance, and sensitivity to changes [30]. As a result, the first edition of COPM was published by CAOT in 1991. In community rehabilitation services, analysis showed that 60% of patients improved their performance on post-assessment, and 66% improved their satisfaction with performance of prioritized occupations after completing the program, regardless of age or condition [39].

In home rehabilitation of the elderly, the COPM tool has shown sufficient validity, adaptability, and sensitivity to change [36].

COPM is conducted in a semi-structured interview that allows the patient to independently identify the most important problems for him in

performing everyday activities [23]. However, in Ukraine, the use of this tool is not yet widespread [28]. Therefore, the experience of using the COPM in people after cholecystectomy can serve to popularize its use in occupational therapy practice.

The aim and objectives of the study – to describe the experience of using the Canadian Occupational Performance Measure (COPM) in developing individual rehabilitation programs for middle-aged individuals after cholecystectomy; to determine the dynamics of the quality of life of middle-aged patients after cholecystectomy under the influence of developed individual rehabilitation programs using COPM.

Materials and methods. Inclusion criteria: middle-aged patients aged 45 to 59 years with chronic calculous cholecystitis (CCC) after cholecystectomy (n=40), who underwent laparoscopic cholecystectomy (LCC) in the surgical department of Ivano-Frankivsk Central City Clinical Hospital in 2019–2020. Patients in the main group (n=20, of which 16 women and 4 men) received rehabilitation according to our concept using a biopsychosocial individual approach and participated in the COPM interview, patients in the control group (n=20, of which 17 women and 3 men) received general recommendations on diet and physical activity regimens. Exclusion criteria: presence of neuropsychiatric pathology in patients; refusal of patients to participate in the study. The mental and physical components of quality of life were assessed using the SF-12 questionnaire, in order to ensure client-centeredness when setting short-term goals in the process of developing and implementing individual rehabilitation programs aimed at occupational activity, the COPM was used. The article presents the results of assessing the quality of life at the acute stage of rehabilitation (initial examination), in the post-acute (one month after LCC) and long-term stage (one year after LCC). The study is simple, randomized, with blinding of assessors. All individuals included in the study provided written informed consent to receive rehabilitation care. The research methods used do not contradict the terms of the 2008 Declaration of Helsinki

and were approved by the ethics committee of the Ivano-Frankivsk National Medical University (IFNMU) when planning a scientific study on the topic: “Theoretical and methodological foundations of physical therapy of patients after laparoscopic cholecystectomy” (state registration number 01119 U 2951). Six people dropped out of the study (3 from each group). Statistical methods: input data were checked for normality of their distribution, for this purpose the Shapiro-Wilk W-criterion was used, since the data corresponded to a normal distribution, the mean ($\bar{x}$), standard deviation (S) and standard error of the mean (m) were calculated; in order to assess the significance of the difference compared to the previous examination and compared to the control group, the Student’s t-test was used; differences were considered statistically significant at $p < 0.05$.

Research results. During all rehabilitation stages, the development of individual rehabilitation plans in the main groups took place according to a certain protocol developed by us. Assessment of the structure and function of internal organs and body systems, activity, and participation of the person was formed on the basis of objective research (laboratory, instrumental, physical) questionnaires, special tests, and valid assessment tools. The results of the initial examination and assessment according to the ICF made it possible to apply a problem-oriented approach. After the identified problems, a rehabilitation prognosis was determined, goals were set, and an individual rehabilitation plan was drawn up for each person. The selection of rehabilitation intervention tools was discussed with each person individually, taking into account the wishes and available resources. Also, when developing an individual rehabilitation plan (IRP), it is imperative to take into account the occupations and participation of each person (activities of daily life, instrumental activities of daily life, rest and sleep, education, work, leisure, social participation), the presence of harmful habits, etc. To restore occupational participation the COPM was used. It should be noted that agreeing on goals with individuals and selecting means to solve them, taking into account the person’s opinion

and expectations, provides good feedback and increases the person's motivation and interest in continuing rehabilitation. An important factor in a person's decision about the need for rehabilitation intervention is the announcement of a rehabilitation diagnosis, which was based on the results of the initial examination and anamnesis. Measurements of intermediate results of rehabilitation interventions were discussed with the person, and the IRP was adjusted if necessary. Client-centered approach embodied in the inclusion of patients' preferences, roles, and target occupations made it possible to individualize the rehabilitation process and increase motivation. In particular, it was the focus of the entire rehabilitation process on the patients' occupation that allowed setting a long-term goal that was meaningful to the individual, and all other short-term goals were aimed at achieving this goal [11].

The use of the ICF for individuals after LCC has facilitated a common understanding of functioning and communication between members of the multidisciplinary rehabilitation team [2]. Personal factors (PF) of individuals after cholecystectomy were taken into account when setting goals for the development and implementation of the IRP. It is known that taking into account personal factors, occupations of the individual and motivation is an important predictor of rehabilitation intervention [2; 17].

We used the Canadian Occupational Performance Measure (COPM) to identify the individual's current problems and needs. This tool allows us to reliably assess the client's subjective opinion of the effectiveness of the intervention [27; 28].

The main points of the COPM approach are illustrated in Fig. 1:

Each of the main areas of occupation is divided into subgroups:

- self-care: personal care, functional mobility, community mobility.
- productivity: paid or unpaid work, house-keeping.
- leisure: rest, active recreation, socialization.

The main method of obtaining information was interviewing, which included several steps:

1. Identification by the person of the types of activities that they want or need to perform, and recording the difficulties and degree of importance of each occupational performance issue.
2. Assessment of the importance of each occupational performance issue using a visual numerical scale from 1 to 10.
3. Assessment of performance and satisfaction with performance of the most important occupational issues using a scale (maximum 10).
4. Reassessment, identification of new prioritized occupations and further consultations of occupational therapist or physical therapist regarding next steps [27; 28].

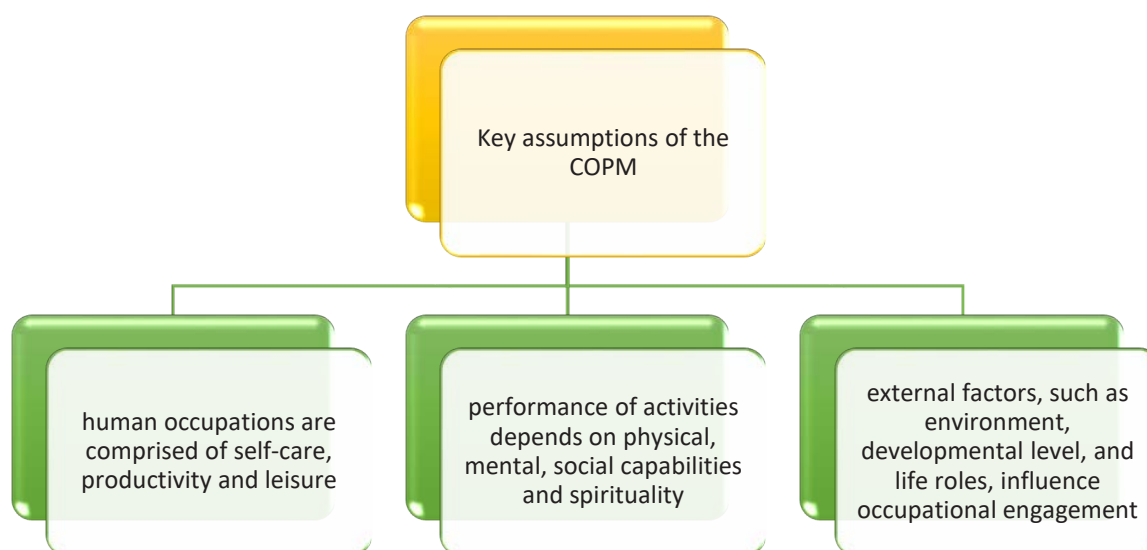


Fig. 1. Key assumptions of the COPM

The Canadian Model of Occupational Performance and Engagement (CMOP-E) [22; 18] includes the spiritual and physical activities of a person whose self-esteem, productivity, leisure and work depend on physical, cultural and social factors. The main attention in CMOP-E is focused on the performance of occupations, which was the result of the dynamic interaction between the components of the model: person, occupation and environment. These components were the main interest in occupational therapy. In practice, sessions were aimed at meaningful activities and participation for a person and their occupations, the implementation of which required therapeutic intervention. The application of CMOP-E in the process of implementing intervention strategies for restoring the quality of life of people after LCC allowed the establishment of goals that are meaningful to the person, which, in turn, contributed to the motivation of the person to participate in rehabilitation.

CMOP-E has been used in inpatient and outpatient settings. Most of the developed therapeutic intervention strategies were directed in the acute rehabilitation period to the elements of self-care (dressing, hygiene, care and selection of individual aids), in the post-acute period – to the elements of productivity (fulfillment of certain roles, responsibilities, return to work), and in the long-term period – to social participation and leisure. However, it should be noted that occupational therapy intervention aimed at managing the health of a person after cholecystectomy was needed at all stages of rehabilitation.

As part of health management, the occupational therapist provided recommendations on eating habits, diet, nutritional and energy components of consumed food, as well as methods of heat treatment in order to prevent complications from both the gastrointestinal tract and the prevention of dyslipidemia, obesity and other conditions associated with the presence of harmful eating habits, keeping a food diary, modification of physical activity, daily routine, and leisure.

The results of the dynamics of quality of life according to the SF-12 questionnaire of middle-aged people with CCC are presented in Table 1.

The results of the SF-12 quality of life survey in individuals with CCC indicate a slightly below average level of quality of life in the physical and mental components, indicating that CCC negatively affected these two important factors of quality of life [2; 13–16].

Analyzing the dynamics of quality of life according to the SF-12 questionnaire one month after LCC, no statistically significant ($p > 0.05$) changes in quality of life were found in any of the groups. The results of the dynamics of quality of life according to the SF-12 questionnaire in individuals with CCC one year after LCC indicate a statistically significant ($p < 0.05$) improvement in representatives of the control group compared to the previous examination. The results of the dynamics of quality of life according to the SF-12 questionnaire in individuals with CCC one year after LCC indicate a statistically significant ($p < 0.05$) improvement in representatives of the main group compared to the previous examination and compared to the control group one year later, which indicates a more positive dynamics in quality of life.

Table 1
Results of the dynamics of quality of life according to the SF-12 questionnaire in middle-aged people with CCC

Group	Life quality component			
	Physical, points		Mental, points	
	$\bar{x}$	S	$\bar{x}$	S
Initial assessment				
Control group	48.99	2.54	48.79	2.78
Main group	47.29	3.02	50.01	3.04
One month after LCC				
Control group	49.62	2.56	50.40	2.90
Main group	48.55	3.08	50.72	3.15
One year after LCC				
Control group	58.42*	2.96	59.45*	3.34
Main group	64.88*°	4.07	67.61*°	4.15

Note 1. * – statistically significant difference compared to the previous survey at $p < 0.05$

Note 2. ° – statistically significant difference compared to the control group at $p < 0.05$

Discussion. A systematic review by M. Karhula, S. Saukkonen et al. has shown that personal factors play a significant role in rehabilitation. They play a role in supporting the person-centered rehabilitation process and are important in planning rehabilitation and in documenting information about functioning. Taking into account and understanding personal factors can contribute to key components of person-centered rehabilitation, such as respect for values, beliefs, experiences and context, and family involvement. It has also been argued that person-centered care can positively influence rehabilitation outcomes, although it has not yet been fully implemented in rehabilitation settings [2; 21; 40].

The rehabilitation process combines two theoretical frameworks: treatment theory, which provides tools for how a particular factor can be changed, and facilitation theory, which recognizes that functioning is complex and determined by many factors, and which seeks to model these complex interrelationships [2].

The importance of personal factors in motivation is also noted by a number of researchers, who came to the conclusion that they must be taken into account when planning rehabilitation, returning to work and setting realistic goals in rehabilitation. In particular, literature suggests that the ICF allows for a comprehensive analysis of experience and needs in health care (physical, mental, social) for a comprehensive understanding of the health and functioning of people with chronic diseases. However, researchers have reported some limitations of its use and the need to classify the “personal factors” component [25].

The use of the ICF in individuals after cholecystectomy, most of whom have comorbidities, encourages a biopsychosocial and person-centered approach to health care and is a useful tool to guide clinical assessment and encourage clinicians to consider the multiple factors that led to cholecystectomy, its consequences in terms of rehabilitation prognosis, and the impact on health, which requires individualization of rehabilitation focused on the needs of each individual. Such research results were also reached by scientists V.M. Alford, S. Ewen et al. who also argue that the use of a common framework that

can be understood across all health care disciplines can improve interdisciplinary communication and collaboration, improving the delivery of health care and overall health outcomes for the population [6].

Over the past 20 years, the ICF has become the accepted biopsychosocial framework for rehabilitation. By providing a common conceptual framework and a common frame of reference, the ICF has transformed the practice and statistics used to assess functioning and disability. The ICF includes a wide range of categories to describe body functions and structures, activities and participation. In addition, environmental factors, which are one component of contextual factors, can be identified as barriers or facilitators to functioning. Although the ICF does not classify personal factors, they are nevertheless important in rehabilitation interventions, as they include resources, means of achieving goals, education and patterns of behavior. Aligned with ICF, using the COPM when developing and implementing IRPs for people after cholecystectomy helped us to understand how people feel, what their expectations are, how they evaluate and understand their own situation, what they hope for and how they cope with problems in their daily lives. Taking into account personal goals and motivation for occupational engagement as a part of personal factors has generally not been considered at all in the medical approach. It is the consideration of personal factors that allows the individual to manage the rehabilitation process and make it patient-centered [2; 21].

For example, age and gender, occupations, roles of a person are also personal factors that we took into account when developing an IRP. In the post-acute and long-term stages of rehabilitation, personal and environmental factors have become even more relevant, especially when choosing means for physical activity. To name a few, we need to consider patient’s local community, availability of resources and occupations, the length of time to get to the rehabilitation department, experience of independent sessions, self-discipline, motivation, social attitudes, environment, level of education, functioning and participation in society, degree of social integration

and commitment to rehabilitation while planning a rehabilitation intervention. In general, these factors and their consideration when developing rehabilitation programs have not been classified to date, however, as researchers note, they are very important and can have a significant impact on the results of implementing rehabilitation programs and on the quality of life [2; 7; 21; 32].

Taking into account personal factors in the assessment of functioning, development and implementation of individual rehabilitation programs has to be mandatory, and the use of the COPM offers a practical and sustainable way to implement the holistic approach to rehabilitation aligning with ICF. Without personal factors as the key element of the ICF, the functioning model remains narrow and reduces the status of the individual to that of a disease, devoid of autonomy, subjectivity and humanity, and thus ignores the entire life context of the individual. Scholars argue that without personal factors, the ICF is a dehumanized model [12; 19]. Researchers have concluded that inclusion of personal factors creates resources and prevents frustration in rehabilitation and therefore promotes an optimistic attitude and commitment of the individual to rehabilitation [33].

The positive impact of COPM on client-centered occupational therapy services has been proven with patients from different nosological groups. In particular, COPM has been successfully used to establish client-centered and occupation-focused goals of an individual rehabilitation plan for people with rheumatoid arthritis [34], geriatric clients living at home [35], people with chronic obstructive pulmonary disease [29], various mental disorders [31], and traumatic brain injury [8] at different stages of the rehabilitation continuum. Both occupational therapists and clients and their families have confirmed the importance of clients setting meaningful goals to increase motivation, focus on expected outcomes, and organization in the rehabilitation process [2; 8]. The process of identifying issues with performance of daily activities during the administration of the COPM has been shown to positively influence the development of a partnership between the occupational therapist and

the client, as well as the client's awareness of their own needs, motivation, cooperation, and responsibility during subsequent rehabilitation [10; 24; 27; 28].

The Canadian Occupational Performance Measure (COPM) is an assessment tool recommended by the Ministry of Health of Ukraine (MOH, 2024) [5]. The new official translation of the COPM into Ukrainian was successfully used with 84 occupational therapy clients, demonstrates sufficient content validity, and can be recommended for use in Ukraine [27]. Recent local research on the use of the COPM by Ukrainian occupational therapists confirms that the COPM can increase the client-centeredness and occupational focus of occupational therapy [4]. Accordingly, the results of previous studies justify the use of the COPM for our study.

Conclusions.

1. COPM allows taking into account the personal factors of patients when developing individual rehabilitation programs aimed at restoring patients' occupations after cholecystectomy and ensuring client-centeredness of occupational therapy interventions.

2. The use of COPM in people after cholecystectomy increases their motivation to continue rehabilitation in long-term stages, and directs interdisciplinary work to all areas of quality of life.

3. It has been established that the use of COPM with the goal of restoring the quality of life of individuals after cholecystectomy leads to an improvement in their mental and physical functioning.

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