Collaborating With Medical Professionals: A Guide for Educators

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Schools are increasingly committed to providing comprehensive educational, psychological, and health services to all children, given evidence that improved mental and physical health play a large role in improving educational outcomes. In addition, concerns about uninsured and underinsured families in the United States and access to healthcare in Canada make schools important entry points for improving the current and future health of society. Because many children currently are prescribed medications or have chronic illnesses that affect school performance, collaborating with medical professionals is a fundamental activity in schools. However, despite the potential to help improve student outcomes, collaboration between medical personnel and educators does not take place as often or as effectively as it could. To a large degree this is due to the systemic barriers and differences in culture between the two professions. These barriers and differences can be overcome through understanding and the skillful use of collaboration.

BARRIERS TO COLLABORATION WITH MEDICAL PROFESSIONALS

Differences in diagnostic systems and approaches to decision making interfere with effective collaboration across medical and school systems, necessitating interdisciplinary teamwork.

Diagnostic Systems

Efforts to collaborate are hindered by the different diagnostic systems used in medical versus education settings. For example, a physician diagnoses a learning disability, yet educators find that the same child is not eligible for the learning disabilities classification within the special education system. Or perhaps a physician requests educational assistance for a child with attention deficit hyperactivity disorder (ADHD), yet educators do not believe that special education services are appropriate because there is limited evidence that the child’s academic performance is impaired by ADHD. Who is right? Actually, both are. Physicians make diagnosis and treatment recommendations based on medical criteria such as the International Statistical Classification of Diseases and Related Health Problems (ICD-10) or the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), and subsequently recommend a medical approach to treatment. Educators use state and federal special education criteria contained within the Individuals with Disabilities Education Improvement Act (IDEA 2004) for disability classification and follow appropriate regulations and safeguards for determining an effective educational treatment plan.

Decision Making

Primary care physicians and many specialty care physicians in independent practice most often make diagnoses independently, although there are exceptions. Educators, by law, determine special education eligibility and service needs through team decision making. Physicians are not mandated to use prereferral interventions or to consider least restrictive environments in making diagnostic or treatment decisions. Educators rarely consider family history, neurological findings, or lab results in determining eligibility for services. The educational and medical models contain enough similarities to create confusion and enough differences to create conflict. Yet both seek the same goals.
**Interdisciplinary Teamwork**

How can professionals using two entirely different diagnostic systems and cultures of decision making work together? The first step is for both professionals to understand that there are two equally legitimate and valid systems in place that can be complementary. The second step is to appreciate that in many cases neither physicians nor educators can provide effective services to children in isolation. Teamwork is a requirement and not simply a nicety or refinement.

**MODEL FOR EFFECTIVE COLLABORATION**

Effective interdisciplinary collaboration requires mutual respect for professional boundaries, an openness among all parties to collaborate, effective communication, efficient presentation of information, training in collaboration, and the appropriate use of liaisons between systems.

**Respect for Professional Boundaries**

The first stage of collaboration is to respect the formal boundaries of the medical and educational professions as established by state certification and licensure laws. Physicians legally must refrain from dictating school educational placement decisions or educational techniques. Schools must legally refrain from making medical diagnoses or medication decisions. However, information can easily go across formal boundaries. For example, a teacher may state, “Since Jane started taking her medication, she has begun falling asleep in class.” Or a physician may state, “Since Jacob started in the gifted program, he has chronic abdominal pain with no known medical origin.” Although working to support the same student by sharing information, each teacher or physician must use his or her best professional judgment to make decisions about educational or medical treatment.

**Openness to Participation**

Although respect for formal boundaries is important, there must also be informal efforts to reach across any barriers. There are few activities that serve to develop interdisciplinary relationships as much as a physical presence. When teachers take time out of their busy schedules to accompany children to a pediatrician visit, they demonstrate a significant commitment to working as a collaborative team member. When a physician takes time to attend an IEP team meeting in a school, the commitment to collaboration is equally clear. Clinic schedules and logistics make personal appearances by physicians difficult. Taking the initiative to invite other professionals to contribute to and review documents, receive timely information, and share responsibilities are the best ways to collaborate without the time and logistical demands of a personal appearance. For example, teachers should be involved in the evaluation of the efficacy and unintended effects of medical management of behavior. The pediatrician should be asked to review the IEP for any activities that may be medically contraindicated.

**Effective Communication**

The basics of professional communication are important. Return phone calls in a timely manner. Make yourself available. Write jargon-free reports and letters. Ensure that parents have completed all appropriate release forms and understand the nature of the collaboration before it begins. Most parents believe that such an interdisciplinary relationship can only help their child. However, some parents choose to keep medical and educational issues entirely separate. The parents’ right to such a separation must be honored.

**Present the Facts**

There will also be times when professionals will be expected to present results of evaluation and recommendations for treatment. Here a medical model of case presentation often serves to help organize large quantities of information according to the basic issues that need to be addressed. In other words, leave out all judgments and extra information that may be important, but not central, to the provision of support to the student through school or healthcare providers. The presentation of information by either physician or educator should include:

- The student’s name, age, ethnic group affiliation, sex, and reason for referral.
- All relevant historical findings (e.g., birth trauma, history of brain injury, academic progress over time, placement in a special educational curriculum).
- The student’s relative strengths and weaknesses as determined by observations and compared to other children in the classroom.
- Behavior, cognitive, social, and academic requirements and expectations in the classroom.
- The top three or four recommendations that serve as the immediate plan for helping the child given the evaluation results. There will likely be more than three or four recommendations in the final report, but the main goal is to communicate interventions that need to be addressed by health and/or school personnel.

**Training**

Many medical and educational training programs are engaging in interprofessional training that encourages future doctors, teachers, and other professionals to collaborate on basic issues in service delivery.
Professionals do this via collaborative problem solving in basic courses and field experiences that provide opportunities to work with experienced interdisciplinary teams.

**Liaisons**

Because the medical and educational systems have different vocabularies and cultures, it may be wise to use a medical–educational liaison as a translator so that the two professional groups understand each other. Hospital-based teachers, school nurses, social workers, school psychologists, and others with training in both medical and educational environments are good choices.

**ADHD: AN EXAMPLE OF PHYSICIAN/EDUCATOR COLLABORATION**

ADHD is one of the most common problems that requires interdisciplinary collaboration. The behaviors of ADHD are most commonly observed in the classroom, where the demands for attention, concentration, and behavior inhibition are greatest. The use of pharmacological treatments is managed by physicians. Therefore, teachers may be in the best positions to report on children's behavior in the classroom to the physician.

Variability in their response to a particular medication and dose, teachers may be called upon to make several observations of behavior over a period of weeks. The purpose is to document real change in response to dose and medication prescribed. In addition, unintended effects such as sleepiness, appetite problems, headaches, and other common reactions need to be observed and reported. Some physicians prefer to not inform teachers of the use or change of medications. Although this may be scientifically useful, such secrecy may have a negative impact on collaboration and will do little to develop a sense of trust.

Teachers, in collaboration with parents, are in the best position to develop behavioral interventions in the classroom and at home. The plans for behavioral interventions and their outcomes will need to be shared with physicians, as these strategies may influence decisions regarding dosage and timing of medications, as well as determination of the effectiveness of medical treatment.

**SUMMARY**

Collaboration between educators and physicians can be an exciting, productive, and rewarding experience. When all players within the team work together, children ultimately benefit. Educating all parties as to the roles of various professionals and building strong working relationships based on mutual respect and clear communication will help to improve the overall quality of children's health and learning.

**RECOMMENDED RESOURCES**


Resources for families and educators working with medical personnel and health concerns.

Developmental and Behavioral Pediatrics: [http://www.dbpeds.org](http://www.dbpeds.org)

Aimed at professionals interested in child development and behavior, especially in the medical setting.


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