Commentary: Collaboration in Pediatric Primary Care: A Pediatrician’s View

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Over the past several decades, the definition of pediatric care has expanded markedly. Pediatricians have come to understand the boundaries of their professional responsibility to include not only children’s physical health but their success in the emotional, educational, and social domains as well. They now consider children, their parents, their families, and even the schools and communities that support them to be within the purview of pediatrics.

Unfortunately, we have yet to invent effective mechanisms to operationalize these more broadly conceived boundaries in pediatric practice. Surveys show repeatedly that 40% to 80% of parents have questions or concerns about the behavior and development of their children, but that they are not talking to their pediatricians about these issues (Lynch, Wildman, & Smucker, 1997; Richardson, Keller, Selby-Harrington, & Parrish, 1996; Young, Davis, Schoen, & Parker, 1998). Ample data demonstrate also that primary care pediatricians are not aware of many of their patients’ psychosocial and developmental problems (Costello, Burns, et al., 1988; Costello, Edelbrock, et al., 1988; Horwitz, Leaf, Leventhal, Forsyth, & Speechley, 1992; Lavigne et al., 1993; Richardson et al., 1996). Although quite satisfactory instruments exist for screening in the realms of cognitive, motor, and speech development, and with regard to behavioral, emotional, and social development (Stancin & Palermo, 1997), pediatricians are not using them systematically.

Barriers to Psychosocially Sophisticated Pediatric Care

There are a number of barriers to incorporating psychosocial issues into primary care practice. Pediatricians have had inadequate education and training in the knowledge and skills necessary to address developmental and behavioral concerns systematically and thus lack confidence in caring for children with psychosocial difficulties. Pressures of time and money are considerable and increasing with the market constraints imposed by managed care arrangements. Pediatricians may question the interest or value of learning about or addressing developmental and family difficulties in lieu of more clear-cut organic conditions. They sometimes question the acceptability to their patients of asking questions about children’s behavior or development or about the family’s interactions, though numerous investigations have documented that parents are not only willing but quite eager to discuss their observations and concerns. In addition, pediatricians have little support from colleagues for their efforts to elicit concerns and intervene about family and emotional difficulties. The broad range of potential concerns and difficulties, in the face of inadequate resources to provide appropriate intervention, is at best frustrating and may even challenge ethical boundaries (Perrin, 1998).

Referral to appropriate mental health colleagues

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may be frustrating to pediatricians. Financial and administrative barriers make it difficult for some families to gain access to recommended services, and the persistent stigma associated with psychological and family difficulties adds to families’ reluctance to make use of these services. Many pediatricians have had bad experiences with mental health colleagues because of poor communication, loss of control, and fragmentation of their patients’ care. Some pediatricians remain unconvinced of the value of many mental health interventions. In addition, there are insufficient services to address child and family mental health adequately in most communities.

The responsible practice of pediatrics requires attention to the mental health and cognitive, emotional, and social development of children and families, and the circumstances that may create risks to that development. Unfortunately, pediatricians must attend to many other responsibilities also in their all-too-brief office visits for child health supervision. They must treat acute and chronic ailments, screen for risks to the child’s safety, ensure that all immunizations and routine assessments are up-to-date, watch for signs of compromised physical health, and counsel families about the hazards to avoid in the interim ahead. As a result of market forces and the constraints imposed by managed care, the duration of the average office visit is now 14 minutes (Ferris et al., 1998). In order for pediatricians to meet the challenge of comprehensive biopsychosocial care, they must find ways to work in close partnership with other professionals who have the skills, training, and interest needed to participate in children’s care with them and to focus more directly on the contexts and challenges of children’s development.

Collaborative care in pediatric primary care practice consists (at a minimum) of a professional based in the practice along with the pediatrician(s), whose responsibilities are clearly defined as including screening, information gathering, and intervention in the realms of children’s and families’ psychological and social development and well-being. This kind of collaboration in the practice setting could be provided by individuals with training in psychology, social work, nursing, or education; for the purpose of this discussion, I will refer to these partners as psychologists. Various collaborative practice models and the essential elements of successful collaborations have been described (Drotar, 1995; Wertlieb, 1999). This model of integrated primary care practice is more familiar to practitioners of family medicine than of pediatrics and is the mission of the Collaborative Family Health care Coalition.1

The History of Collaborative Care

Pediatricians and psychologists have a long history of collaboration in the academic context (Drotar, 1995). Research collaborations began as early as 1930 when John Anderson described the potential contribution of psychology to pediatrics in understanding individual variation in children’s development. Many early research institutions were directed jointly by pediatricians and psychologists—for example, the Fels Research Institute and the Yale Child Study Center. The Society for Research in Child Development was founded in 1930 with the explicit intent to establish and promote interdisciplinary research and policy efforts. Robert J. Haggerty introduced the concept of a “new morbidity” in 1975, stating that “many of these difficulties lie beyond the boundaries of traditional medical care” (Haggerty, Roghmann, & Pless, 1975). His recognition of the value of greater collaboration among pediatricians, psychologists, and other behavioral scientists led to creative initiatives (especially while he was president of the W. T. Grant Foundation) that have fostered interdisciplinary research.

In pediatric education also, new partnerships have developed between pediatricians and behavioral scientists. As the acceptable boundaries of pediatric care have broadened, the knowledge and skills of sociology, anthropology, and of both developmental and clinical psychology have been integrated increasingly into medical school and postgraduate pediatric education.

In pediatric practice, collaboration between a pediatrician and a psychologist has succeeded in several communities but has never become accepted as a standard component of primary care. The former Surgeon General Julius Richmond has long recognized and promoted the importance of psychological expertise in the provision of pediatric care. In 1967 he wrote, “We stand on the threshold of achieving the best health record for children

1Collaborative Family Health care Coalition (CFHcC), 40 West 12th Street, New York, New York 10011; 212-675-2477; staff@CFHcC.org; www.CFHcC.org.
the world has ever known. Whether we cross this threshold will depend upon the imagination, industry, and resourcefulness with which we expand and apply our knowledge of child development.”

The Promise of Collaborative Care

Pediatricians and psychologists should be natural collaborators in the context of child health supervision and care. Their goals are broadly similar: to assist families in creating a context that will support children’s growth and encourage them to feel competent, safe, and valued. Four models of working relationships between pediatricians and psychologists have been described (Drotar, 1995). In the first, still the most common, the psychologist is an independent specialist, getting referrals from pediatricians and providing direct services to children and their families. In this referral model, there is a danger of fragmented, duplicated, or conflicting opinions. The second, or consultation, level has the psychologist and the pediatrician as educational consultants for each other. They provide information and advice about particular children and families who are cared for by one or the other of them. The third level is a truly collegial one: the pediatrician and the psychologist are colleagues, each with unique responsibilities related to their training and skills, and they share in the care of particular children and families. This model has had notable success in the care of children with chronic medical conditions and psychosomatic disorders and in helping children to cope with acute and chronic pain and invasive procedures. The fourth level, collaboration, operates at the level of the practice rather than of individual children and families. In this model, the pediatrician and psychologist consider the particular needs of their community and work out together appropriate ways to respond to them.

Because of the differences in their training, pediatricians and psychologists bring differing knowledge, skills, and resources to this common goal. Pediatricians are equipped by their training and the style of their usual professional interactions to observe and monitor children’s and families’ development over time; psychologists are trained to select, administer, and interpret systematic screening instruments and to evaluate in depth children’s developmental and emotional status. Pediatricians understand and observe the complex interplay between children’s physiologic functioning and their developmental progress and challenges. Psychologists have more training and expertise in helping children and families to recognize, address, and correct the difficulties that trouble them and to mobilize community resources to support them. Pediatricians and psychologists have familiarity with and access to differing sources of additional expertise. Pediatricians frequently have available networks with child psychiatrists, child neurologists, and with surgical and pediatric subspecialists, while psychologists may have an easier time creating effective linkages with school personnel, parent education and support groups, and community mental health agencies.

As a result, a psychologist who is an integrated member of the primary care team will have the job of identifying and monitoring children at special risk, including children with chronic health or developmental problems or with distressed families. He or she will take responsibility for systematic screening regarding children’s emotional, social, and academic development and will assess family issues such as parental mental health, marital stability, substance abuse, child care arrangements, and potential violence. A pediatric practice organized on this kind of collaborative model will have more incentive to do systematic screening because the pediatrician will no longer be the sole resource for gathering further information and for intervening when screening reveals a concern or a difficulty.

The psychologist will develop effective systems for communication with schools regarding individual children and will serve as a consultant for both families and pediatricians who have concerns about particular children or families. Because the psychologist and the pediatrician will be sharing the same space and office hours, families on any given visit might meet entirely with the pediatrician, entirely with the psychologist, or with both in varying proportions.

The stigma associated with receiving psychological services will be considerably diminished when they are based in the pediatric office, as will the complexity of access to them. The psychologist might arrange for short-term counseling and organize various psychoeducational groups for children and for parents in particular circumstances—for example, children whose parents are divorced or divorcing, parents of toddlers, children with difficulty toilet training, children with ADHD, parents of children with ADHD, or parents who are depressed.
And if a referral to a community-based developmental or mental health professional is needed, the office-based psychologist will help to facilitate it.

**Making It All Work**

This kind of collaborative pediatric practice is actually not such a new idea. Smith, Rome, and Freedheim first described such a model in 1967. Carolyn Schroeder has described a successful collaborative practice arrangement in North Carolina (Kanoy & Schroeder, 1985; Schroeder, 1979; Schroeder, Gordon, Kanoy, & Routh, 1983), and there have been other similar reports over the past decade (Hurley, 1995; Morrison, 1976). The Healthy Steps project (Zuckerman, Kaplan-Sanoff, Parker, & Young, 1997), currently under development and evaluation, is a variant on the same theme.

Fundamental system change requires attention to considerations of administrative organization, professional boundaries, and financial accountability. The participants must be committed to the value of both their own and each other’s expertise and of the added value of the collaboration. They must have a way to define responsibilities clearly, identify difficulties, get information, and communicate regularly. Resolution of the pressures of time, space, and multiple competing responsibilities, complex funding and reimbursement patterns, and adequate back-up resources are essential to success.

Putting these ideas into practice is a challenge, made still greater in the face of escalating medical care and cost “management” efforts. Two practices in the Washington, DC, area have experimented recently with a collaborative model of care (Eggbeer, Littman, & Jones, 1997). In one, a master’s level early childhood educator and in the other, a clinical social worker, were the pediatricians’ partners. One practice was a middle-class suburban pediatric group, while the other was a staff-model HMO serving primarily low-income urban families. These programs were supported by grant funds for their initial two years of development. In both settings, the child development specialist, the pediatrician, and an overwhelming majority of the families surveyed were extremely pleased with the additional services that this collaborative arrangement allowed the practice to offer. Nevertheless, at the end of the external funding period, neither practice found a way to continue the collaboration.

**Training Considerations**

In addition to these difficulties, some intrinsic differences in the training and assumptions of professionals in different disciplines help to make collaborations across disciplines challenging. Among these differences are disparate underlying paradigms and expectations about the appropriate scope, pace, and scheduling of care. Psychologists typically meet with clients for 45 to 60 minutes multiple times over an extended period of time. Pediatricians’ visits are typically much shorter, perhaps 10 to 20 minutes, and far less frequent (especially after the first year of life). On the other hand, pediatricians meet with children and at least one parent regularly, even in the absence of an identified problem, while visits with a psychologist generally center around a particular concern. The professional style or orientation differs as well. Pediatricians in general assume an “expert” stance, providing expertise and information that they think families need. They generally take the initiative to direct the encounter actively. Interactions between psychologists and their clients tend to focus on the development of the relationship and to be more reflective; shared information is more subtle and often inferred rather than explicit. Even the goals of the professionals’ encounters are somewhat different. Pediatricians seek primarily to determine that children and families are within the broad range of normality in terms of their physical and emotional well-being and to intervene if necessary, whereas psychologists focus more on understanding the processes at work in children’s and families’ development and interactions.

When psychologists and pediatricians get involved in joint training, they will become familiar with the principles and practice of each other’s work and have experience in developing collaborative relationships (McDaniel & Campbell, 1997). The message will be reinforced that successful collaboration does not require that either partner become just like the other, but rather that both partners value each other’s wisdom and use it to inform their own thinking, attitudes, and actions.

**Summary**

Although neither pediatricians nor psychologists can provide alone for the vast needs of children and families in our increasingly complex society, these
needs can be met through effective collaboration. An ideal model for collaboration would exist if pediatricians and psychologists worked together in practice teams, for which developmental-behavioral pediatricians might serve as consultants. Together, these professionals could take responsibility for professional education, expanded clinical care, liaisons with schools and other community-based resources for children and families, and research that addressed questions about the development, coping, and correction of children’s and families’ difficulties.

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