Acquiring Medical Duties of Care

Teachers' Perspectives

by Sean Cousins

Over the past four decades, teachers have increasingly acquired duties of care that were once the exclusive specialization of health professionals (Kirchofer, Telljohann, Price, Dake, & Ritchie, 2007). Some are handed responsibilities to perform medically invasive procedures (Olsen, Seidler, Goodman, Gaelic, & Nordgren, 2004), while others carry out first-aid functions as part of their school's emergency response plan or whenever such need arises (Closs, 2013). These commonplaces aside, teachers across Canada attend to the health and safety of students in ways that blur traditional boundaries distinguishing health care provider and classroom educator.

In assuming such paramedical responsibilities, teachers often learn how to do so through trial and error and from informal conversations with colleagues and parents. These findings come from a study I recently conducted that offers insight into the contemporary challenges faced in delivering medical services at school and teachers' particular contributions to these services.

The qualitative study used individual interviews and a demographic questionnaire (10 participants) to probe teachers' views regarding their participation in the medical care for students with diabetes, as well as what particular strategies they considered most useful in supporting these students' health and wellbeing. Study participants were full-time grade 1 to 8 teachers, purposefully drawn from three school districts: two from Southeastern Ontario and one from West-central New Brunswick. They were mostly female and uniformly distributed by educational attainment, grade level taught, and years of teaching experience. Most of them taught in urban schools, with only a couple having taught in rural schools, reflecting the geography of the school districts.

How do teachers conceptualize the medical health needs of these students? According to the interviewees, students of medical services have perceived developmental, social and cognitive challenges, all of which were documented in official health plans and requiring the teachers to accommodate through performance of medical care and scaffolded instruction. In the words of one teacher: "The plan acts like we provide a flotation device, like, you know, helping them keep swimming, not drowning."

Other commonly cited sources informing the teachers' perception of these students were consultations with parents, school personnel, nurses and students, either individually or collectively and at one time or periodically across the school year, diabetes management training sessions, and "independent research," such as visiting websites or contacting pediatricians on one's own. A few teachers recalled having experienced a family member or close relative needing help to manage their diabetes, while the majority shared memories about having personal friends, neighbours, or some other social network outside of the school who were involved in the life of someone with diabetes. While teachers described their students' medical health needs occasionally using clinical terms (e.g., "monitoring glucose levels," "insulin injections," and "health data management,"), most of the time they added further insight using language that reflected their everyday experience (e.g., "it's time for a check-up," "it looks like we need a picnic," and "make sure to record the results in your journal").

When asked about their role in addressing the medical health needs of their students, teachers frequently described the need to maintain continuity and coordination among a varied network of service actors and health services. New Brunswick teachers spoke about serving as proxies for absent or unavailable school nurses in the province, while Ontario teachers detailed the purpose and organization of health services meetings, which often revolved around planning for building safety and social awareness in the classroom environment. These circumstances aside, the teachers expressed a strong focus on preventing health emergencies in their care, and highlighted a small cluster of health-infused strategies used to accomplish this purpose: charting within and out-of-range blood glucose levels, building peer support in the classroom, arranging for unlimited student access to emergency food rations, participating in telephone case management with parents, and exercising direct supervision over students' health and wellbeing.

Apart from these methods of service delivery, the teachers spoke about the impact of performing medical care had on their professional outlook and teaching. Most felt having experienced a fundamental shift in perception about the meaning of being a teacher. As one teacher summarized:

"It's no longer just standing up there and telling the students what to do. … I became a doctor and a nurse … I became a coach and a counsellor. I am not just a teacher anymore, I am so much more."

Not only is teaching about delivering important lessons to students, they told us, but it is also a highly idiosyncratic practice that attempts to instil fundamental skills, knowledge and values useful for individual health promotion. Specifically, teachers pointed out several factors that shaped their teaching practice in acquiring their medical duties of care: the student's health plan; personal and classroom health literacy, the student's psychosocial characteristics, school policies around inclusion, grade level taught, and years of teaching experience. Not one of these factors was reported more significant than another; rather, teachers emphasized that their quasi-medical teaching practice was a blend of both clinical management and educational outreach. The exact form their execution took ultimately depended, according to the teachers, on the situation at hand.

Relating our study's results to the research literature, the teachers' reported contributions to

medical care at school provide strong reason to believe that they are, like other general and special education teachers before them (Nabors, Little, Akin-Little, & Iobst, 2008), often called on to address important facets of students' medical health needs. The teachers' accounts serve to challenge the view that educators must practise a "hands-off" approach when it comes to the care for their students (Piper & Smith, 2003). For example, our findings suggest that the teachers interviewed adapted their teaching practice in ways applicable to the administration of medical services, especially to the contributions of health and safety support. They made sense of and followed through on medical, hygiene and safety protocols, as well as monitored students' behaviours from an educational-health viewpoint.

Like the teachers reported about in Clay, Cortina, Harper, Cocco and Drotar (2004), the participants felt "moderately" to "very responsible" in addressing the medical health needs of students in their care. Accordingly, they openly called for further preparedness training in dealing with issues of chronic illness: workshops based on adult learning principles, professional certification courses, mandatory first-aid training, and teacher-friendly resources on topics such as diabetes, asthma and allergies, among other high-incidence chronic health conditions. Given these findings, the medical health needs of students appear to hold more than eclectic or passing interest among these educators, helping to fuel further speculation about how best to respond to this reality affecting classrooms today.

References

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