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No. 4
COLLEGE HEALTH SERVICES IN THE UNITED STATES

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FOREWORD

This century has seen a remarkable burgeoning of knowledge in almost all fields of human endeavor. In two fields in particular there has been a revolutionary revision of ideas and concepts. These are, of course, physics and human psychology. In the one we have begun to explore outer space, and in the other we have begun to glimpse something of our own human "inner space."

Increasing knowledge and understanding of human development and psychology has led to the creation of the specialties of child and adult psychology. Starting just over 50 years ago, a small group of psychiatrists and psychologists began to work with late adolescents in colleges and universities, recognizing the need truly to foster a sound mind—as well as an informed one—in a healthy body. Today we have developed sufficient awareness to begin to recognize how it is that we can influence the psychological maturational processes toward effective, constructive, and satisfying human living. There is still a long, arduous road ahead before it can be said that we have achieved our struggle for human dignity.

This monograph by Dr. Dana L. Farnsworth represents a milestone along this road. Dr. Farnsworth's contributions in the field of college mental health are unique. He has developed at Harvard University an extensive health program which is universally recognized for its scope and quality. Out of his long and rich experience comes this monograph setting forth a philosophy of campus mental health work, together with opinions and recommendations.

Some of these opinions and recommendations will be met with skepticism and controversy. This is to be encouraged: where issues are actively discussed there is a high probability of constructive outcomes.

We, the members of the Joint Committee of the American College Health Association and the American College Personnel Association, are all too aware of the present inadequate knowledge, communication, and cooperation among professionals working in college mental health. We welcome this monograph as a contribution to our goals: the increase in knowledge and understanding of college mental health, and the increase in effective efforts to conserve and enhance the potentialities of our most precious resource, our young people.

The Joint Committee of the American College Health Association and the American College Personnel Association

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PREFACE

This monograph on student health services in the United States has been prepared for student personnel workers who desire information concerning the range, scope and guiding principles of these services. The author holds the opinion that effective cooperation between members of health services and all other student personnel workers is essential both to the welfare of individual students and to the institutions in which they work. The idea of competing services within a college or university is abhorrent. There is far more to be done in counseling students than all available counselors can accomplish. The question is not “Who is to do the job?” but rather “How can cooperation be brought to the point that every student needing and desiring help gets to the person best suited to help him?”

If a college health service is to be fully effective it should be able to serve all who come to it with the goal of restoring or protecting their health. It should be a little island of neutrality in the complicated college community. Its staff members should have no authority over students, faculty or employees except in matters purely medical. Their task and privilege is to give the best advice or opinion they can to those who seek it. The patient or the administrator may then make whatever use of this information he chooses.

To some persons the space devoted to the emotional aspects of student development may seem disproportionate to that concerning medical and surgical problems. This emphasis is purposeful since it is in the area of how students feel about themselves and the college that physicians, nurses, and counselors have much in common as they attempt to encourage constructive resolution of students' constantly recurring quandaries.

It is hoped that this portrayal of a point of view regarding the role of health services will stimulate discussion leading to improvement of communication and cooperation among all college staff members primarily concerned with student welfare.

Dana L. Farnsworth
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For the skilled help of Mary Claire Adams, Helen S. Chasin and Ruth R. Simonds in preparation of the manuscript, I am very grateful.

Dana L. Farnsworth
Chapter 1

Development of College Health Programs and their Present Status in Higher Education

During the first two hundred years of higher education in the United States little official attention was paid by colleges to the health of their students. The management of illness was considered to be a personal matter. The medical and nursing care students received varied greatly according to individual financial status and the local medical resources available. Since the impecunious outnumbered the well-to-do, the result was that many students were at the mercy of the humanitarian and charitable instincts of faculty wives and upon the number of spare beds in professors' homes. The contributions that physicians could make to student welfare before the concepts of micro-organisms, public health and sanitation, and psychological causation of disease were not great — probably not much more than any informed and responsible laymen could make.

In about 1825 the idea that physical exercise could be something of a panacea became popular in several colleges, probably as an import from Germany and the Scandinavian countries. Harvard, Yale, Williams, Dartmouth and Amherst introduced extensive programs of calisthenics and gymnastics. (Brubacher & Rudy, 1958).

During this early period there were indications that some faculty members were aware that students had emotional problems that might be resolved if only the facts about them were known. For example, Professor Edward Hitchcock of Amherst College said, in a lecture to students in April, 1830:

There can be no doubt, that we are to impute the alarming prevalence of nervous complaints, in a great measure to the ignorance that has so extensively prevailed among students, in the early stages of their education, as to their causes, remedies and means of prevention. This has been a part of education, which it has been the custom to neglect, and thus to leave the health of the young, the very foundation of all their hopes, to take care of itself. We have yet scarcely got rid of the belief, not long since so prevalent, that nervous ailments are the creatures of imagination, and that it is ever unsafe to study into their nature, lest we should catch the mysterious contagion from the mere description. Just as if knowledge, which on every other subject is the pole star of human conduct, should in this case, prove a mere ignis fatuus to bewilder and blind, while ignorance would be security and bliss. But though such absurdities are vanishing, still the means are not yet put into the hands of the student for guarding himself against the insidious approaches of ill health. (Hitchcock, 1831).

Not long after Amherst College began its health program in 1861, other Eastern colleges established infirmaries and developed the custom of giving annual physical examinations to determine the extent of disease and abnormality in their students. As the young science of bacteriology began to throw new light on the etiology of many heretofore mysterious diseases, the various methods developed by public health officials for disease prevention and control became popular and this greatly affected college health practices. Finally the colleges became interested in the special emotional problems of students. Thus health education assumed a prominent place in college teaching, first through physical fitness programs, then public health and sanitation procedures, and lastly mental health.

Beginning about 1900 a few colleges began to take note of the plight of sick students, and provisions were made for their care. The college infirmary, designed to care for those too ill to stay in their private lodgings but not sick enough to warrant extensive care in a hospital, came into being. These institutions have continually increased in number; at present almost all colleges with residential students have infirmaries and consider them as essential as any of the other facilities.

Coincident with the development of college infirmaries, and preceding it in some instances, was the establishment of clinics or "sick call" at some regular time each day for the benefit of students who suffered from any kind of illness.

The University of California at Berkeley was among the first of the large institutions to set up a com-
prehensive health program with full-time physicians and in which treatment, prevention, and health education received appropriate emphasis. Subsequently many other institutions in all parts of the country have established such services or increased the range of those already in existence.

The American Student Health Association, now the American College Health Association, was organized in 1920. Perusal of the proceedings (1920-1964) of the first few annual meetings reveals that the problems confronting the students were about the same then as now; only the attitudes toward and means of dealing with them have changed. More emphasis was placed then than now on the importance of annual physical examination of all students, although in practice this could seldom be done because of costs and lack of personnel. Problems associated with sexual behavior were usually discussed in terms of the then prevalent concept of social hygiene. One physician said, "The sex health of an individual presents at once possibly the most important and the most complicated problem with which the colleges have to deal." Another one stated that, "One of the outstanding failures of higher education so far is that of preparing students for the most important responsibilities of life, namely, marriage, parenthood and homemaking."

Dr. Milton G. Harrington of Dartmouth College, in discussing the mental health of college students at the 1925 annual meeting said that, "If a college or university wishes to improve the mental health of its students, there are obviously two things it should do. One is to instruct its students in the principles of mental hygiene and the other is to provide them with an environment in which these principles may be applied. The first is of little use without the second." Apparently controversy over the contributions of Sigmund Freud was as acute then as now; Dr. Harrington, a member of the opposition, said that "since astrology came before astronomy and alchemy ushered in chemistry, then perhaps the mystic medicine of Freud and Jung may serve to usher in a real science of psychopathology."

Although many observers of student life seemed to think that getting enough sleep, fresh air, exercise, and eating properly was about all there was to mental hygiene, Dr. Frankwood Williams, also in 1925, took sharp issue with this oversimplified view. He stressed the need of understanding the background of the student and his interpersonal relations, thus putting to use the currently popular psychodynamic point of view. He stressed the desirability of working with advisers as well as students in attempts to devise methods of preventing crippling emotional conflict. He referred to one psychiatrist in a college health service whose time was so much taken up by the problems of the faculty that he had little time left for the students.

To those who advocated inactivity because not enough was known about emotional disorders he replied, "We must not ignore the problems simply because the solutions... are not at hand. We must go ahead working to put the thing on as good a basis as we possibly can, knowing frequently that we have got to use tools which are not desirable and are not what we would like to have them but they are the best we can get."

Another physician, who shall be nameless, said that he didn't see how an experienced person who had an interview for an hour with an adolescent could fail to tell whether the person was neurotic or a healthy happy normal person. He didn't see how a mistake could be made. Others were not so certain.

The most recent comprehensive survey of college health facilities was that conducted by Moore and Summerskill in 1953. Since it seems probable that there have been no major changes since that time (other than gradual expansion to meet increased enrollments), their results will be summarized briefly.

At that time there were 1,887 colleges in the country; 1,545 were interested enough to answer inquiries about the survey, 1,057 directors of health services were interviewed, and 768 health services were found that had a clinical program consisting of more than routine first aid. Of this group of 768 colleges more than half attempt to care only for minor illnesses or injuries, and of the remaining 311 that care for major medical illnesses, only 65 have facilities for surgery.

The quality of health care that a student may receive when he goes to college thus varies almost infinitely. Only about 20 per cent of our colleges have a fully developed health program; however, this percentage includes most of the larger universities. This suggests that inspection of a college by a prospective student or his parents should include some investigation of the quality of the health service.

Moore and Summerskill found that the percentage of colleges with comprehensive clinical programs does not vary much from one region of the country to another, nor with respect to the location of the institution (i.e., rural area or small or large city). It was their impression that the institutions that set the highest standards of medical care for students were those with the highest academic standards. Medical histories, x-ray studies of the chest, and eye examinations were required at approximately half the colleges surveyed. Dental examinations and psychologic adjustment tests were required in about a third. About 400 colleges required smallpox vaccinations for entering students, but more than 700 did not. Only about one college in 10 required that students be immunized for tetanus and typhoid. About half the health services assumed some responsibility for standards of sanitation in campus lodging,
dining rooms, washrooms and similar places. Physicians directed 42 per cent of the college health services, and of this number half were employed full-time. Nurses directed one out of four health services. About 200 colleges had a full-time physician, about 500 had a part-time physician, and more than 400 had no staff physician at all. Health service staffs were more likely to include full-time nurses than full-time doctors. If a college had a health service, the chances were 9 out of 10 that students entering that college would be required to have a physical examination. Whether such an examination was conducted by the student’s own physician or by the college depended on the individual college; there was a 50-50 split on this procedure. Health-education courses were offered at 80 per cent of colleges with a health service and were required at half these colleges. Academic credit was granted for this work in nearly every institution. The college health service was nearly always responsible for the medical care of athletes.

A third of the health services operated on less than $5 per student per year, a third operated on $5 to $10 per student per year, and the rest operated on more than $10 per student per year. The average amount spent on student health throughout the country was approximately 20 per cent of what it would cost to maintain a reasonably satisfactory health service (Moore & Summerskill, 1953).

At the present time (1965), the yearly health fees in institutions supporting comprehensive health services range from $50 to $100 per student, including insurance for the cost of major illnesses or injuries over a 12-month period.

Present Status in Higher Education

In 1947, the President’s Commission on Higher Education listed 11 goals of higher education, of which four included undertakings in which health services play a prominent part. These four were:

1. “To understand the common phenomena in one’s physical environment, to apply habits of scientific thought to both personal and civic problems, and to appreciate the implications of scientific discoveries for human welfare.”

2. “To improve and maintain his own health and to cooperate actively and intelligently in solving community health problems.”

3. “To attain a satisfactory emotional and social adjustment.”

4. “To acquire the knowledge and attitudes basic to a satisfying family life.”

In preparation for the Fourth National Conference for Health in Colleges in 1954, 200 college presidents were asked for their opinions concerning the major health problems of their students. Emotional problems and accidents led the list of their concerns, with poor food and living habits following closely. Infectious mononucleosis, respiratory infections, and gastro-intestinal disturbances were also prominently mentioned.

One college president at this conference (Proceedings, 1955) stated that, while educational institutions were not health centers, it was the duty of the college or university to provide an environment that is conducive to intellectual pursuits. If physical and emotional handicaps are permitted to intrude and develop, and if the students, employees and faculty are not protected from preventable health hazards, the college is not discharging its educational responsibility.

In the first two or three decades in which organized college health programs were in operation the chief emphasis was on public health measures, such as the control of communicable diseases and the supervision of sanitation. Gradually the orientation shifted to the problems of the individual student. As concern over the high incidence of tuberculosis began to decrease (as a result of increasingly effective control of the disease), more attention was paid to the important field of mental health. This emphasis brought the health service into close cooperation with other student personnel workers — particularly those involved in various kinds of counseling. Their work often tended to overlap.

The first college mental health services were developed by psychiatrists with broadly based training in psychiatry but who did not have a psychoanalytic orientation. Gradually the principles of psychoanalysis began to influence the practice of psychiatry. A certain amount of controversy attended the inception of the movement, but in general “psychoanalytically oriented psychotherapy” or “dynamic psychiatry” has become well accepted and is now the most widely used approach in college mental health services.

The acceptance by educational institutions of at least partial responsibility for the health of students is illustrated by the fact that almost every major institution with a high academic standing maintains a health service. Quality varies a great deal, as do the range and extent of services. Some of the larger institutions (and a few of the smaller ones) take care of faculty and employees on an emergency or first-aid basis, but only a few give comprehensive care to students, faculty, and employees. Nevertheless, all subscribe to the basic principle of the necessity for provision of some health care.

Relations with Medical Societies

The attitude of the American Medical Association toward college health services has been one of cautious

1 Psychodynamics is the systematized knowledge and theory of human behavior and its motivation. It includes all knowledge about biological and social forces which influence behavior in psychological ways. Interpersonal attitudes, repressed desires and emotional conflicts form the main focus of interest of dynamic psychiatry.
conservatism and gradually increasing tolerance. By their nature, such services involve group practice, prepaid plans for medical care, insurance, free choice of physician, and physicians employed by an institution—all issues on which official policies have been rather controversial.

In 1959 the House of Delegates of the AMA adopted the recommendations of the Commission on student health services which were as follows:

Continued and intensified effort on a national level is urged to cope with the changing problems in this field. The Committee recommends also that close liaison with these plans be maintained by local medical societies to the end that suitable health programs and student health education may be developed and perfected in keeping with local practice and policies.

It is suggested further that the American Medical Association intensify its activity in this field in order to keep the medical profession informed of developments.

The proper relationship between the medical profession and student health services should be one comprising study and participation; encouragement and understanding, and consultation and advice.

A further statement of policy was, at the same time, adopted by the House of Delegates:

The American Medical Association recognizes the constructive efforts being made by educational institutions to provide medical service to students, with the observation that conditions controlling such services vary greatly, some necessitating closed panel services with limited freedom of choice of physician. It is recommended that all student health services offer the greatest possible freedom of choice of physician consistent with local conditions.

It is suggested that the Department of Health Education continue the studies initiated by the Commission on Medical Care Plans in the field of student health services and offer all possible assistance, through the library and research facilities of the American Medical Association, to constituent and component societies in maintaining proper liaison with educational institutions offering student health services.

All this suggests that college health services will usually encounter no insuperable obstacles to their further development so long as their proponents maintain good communication with physicians and health agencies in their own communities.

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MOORE, N. S., & SUMMERSKILL, J. Health Services in American Colleges and Universities. Ithaca, N. Y.: Cornell University, 1953.


PROCEEDINGS, FOURTH NATIONAL CONFERENCE ON HEALTH IN COLLEGES, American College Health Association, 1955.
Chapter 2

Administration of Health Services

During the last few decades health services have come to be recognized as necessary features of major institutions of higher learning — as fundamental to effective operation as libraries, laboratories, or athletic programs. It therefore follows that every institution committed to maintaining high standards and to encouraging students' optimum academic and matureational achievements should see to it that its own health service is as good as available resources will permit.

Support of the president, the board of trustees, and other high administrative officials is vital to the success of any college health service. It is wiser to have no health service than one which is undersupported and thus frustrates and disappoints both its staff members and the students who expect good care from it. Members of the administration should know what the health needs and problems are, should be interested in ameliorating (and, if possible, solving) them, and should be willing to develop available resources for the support of an effective health program.

Central factors to be considered in establishing and in maintaining a college health program include:

A. The size of the group that will be served,
   (a) number of residential students
   (b) number of foreign students
   (c) number of commuters
   (d) number of faculty members and employees, if they are to be given service.


C. Extent and quality of medical resources already available in the community.

D. Attitudes of medical practitioners in the community, including the policies of the local medical society.

E. Amount and reliability of a regular source of financial support.

F. Extent of services desired,
   (a) first aid during the day
   (b) (a) plus emergency service at night
   (c) (a) and (b) with infirmary care
   (d) a comprehensive insurance program
   (e) similar care for students, employees, and faculty
   (f) strong emphasis on preventive medicine
      1. through an environmental health and safety program
      2. via collaboration with counseling agencies
   (g) a complete and comprehensive health program designed to meet all medical needs of the college personnel, comprising all of the above items.

Certain general principles are applicable to all institutions in planning or improving health services:

1. Medical service should be readily available at all times.
2. If a choice must be made, the health center should be near the center of daytime activities rather than the residential center.
3. Health fees should be included in tuition (or a part of required activity fees), but with specific costs itemized.
4. Special fees should be kept to a minimum.
5. Insurance programs should cover students throughout the year.
6. The entire health program should be planned in such a way as to accomplish as much health education and preventive medicine as possible.
7. Students and others concerned with the quality of service should be consulted frequently, and their complaints should be received in a friendly manner.

A college health program should be made sufficiently useful so that, instead of being a drain on the institution's resources, it will constitute a positive attraction to prospective students. The amount and cost of medical care generally needed by young adults is predictable within fairly narrow limits. If an arrangement can be devised that will permit such care to be provided on the college's property and under its auspices, each student can be assured that his health needs will be met adequately and with a minimal waste of time. There is no obligation for the college to pay for this care; that is the responsibility of the student or his parents. The college merely uses its organizational structure to make such care possible.

Under these circumstances the health center and its program should be considered in the same light as the library, student activities building, the athletic plant, and museums. A recent national survey of college health programs has shown that there is a significant correlation between the quality of health programs and the academic standing of colleges. (Moore & Summerskill, 1953). An attractive and efficient health center should be one of the symbols of excellence to those who contemplate attending a particular institution.

Health service directors share in the consensus that the appropriate position of a health service in the administrative structure of a college or university is that of a separate department or division, more or less par-
allel with the organization headed by the dean of students, with the director reporting directly to the president or, in the very large university, to the vice-president in charge of student affairs. President Malott of Cornell University expressed this point of view clearly in a recent panel discussion before the American College Health Association: "I want the director of the health service to report to the president directly, through no intermediary, simply because I think the responsibility that these services have is important. I also think there is no way to departmentalize the health services effectively. I want a university health service with a director who is responsible for all of it." (The Health Program in an Institution of Higher Learning, p. 394).

This type of organization has proven to be the most advantageous for the maintenance of really excellent health services. A good director will place very few burdens on a president other than the expectation of his support for the program; he can be of enormous help to the president by supplying him with information (with due consideration for privacy and confidentiality) that will contribute to the process of making proper decisions.

Some health service directors report to deans of students. This arrangement works well if the dean fully appreciates the functions of a health service and gives the director freedom to practice the best medicine of which he is capable.

Including health services and a variety of the student personnel services in a comprehensive department with a single head who reports to the president or his deputy may appear logical at first glance, but its practical result would be a health service less competent than an independent one. Among the reasons for health services' remaining administratively independent of other personnel services are:

1. Physicians are the most highly trained of any personnel workers and consequently must have salaries higher than those of others. This often raises problems of morale when all are in a single division. Physicians must have at least five and usually six or more years of training before they assume positions in college health services. Psychiatrists must have at least seven years of training.

2. The records of health services must be kept separate from other records. The strict confidentiality required is necessary because of law, custom, and demands of patients.

3. Many of the duties of a health director or his representatives require making contact with administrative officials, faculty members, or responsible persons in the community without the knowledge of anyone else.

4. The interposition of a lay person between the health division and the president usually dilutes the interest of the latter in the work of the health services. This could be said for any department, but as yet health services are in a very vulnerable position in many institutions and require high-level support for their development.

5. The usefulness of a health service director and in some instances his ability to make impartial judgments may be impaired if his position is dependent upon keeping the favor of the head of his division. With an "understanding" dean or vice president who appreciates the necessity for independence of physicians, any system will work. With some of them physicians are greatly handicapped.

6. It is very difficult to persuade capable physicians to accept appointments in departments or divisions of health services that are equated with other personnel functions.

A student health service director who reports to the dean of a medical school (in those universities that have medical schools) may be in the unfortunate position of having no one who can or will give him the support necessary to develop a first-class service. The medical school dean already has too many competing department heads to contend with and the president assumes that the medical school is supporting the health service properly. The result may be a narrowly based service, even though what there is may be of excellent quality. Sometimes, however, the medical school administration may give more support to the student health service than the general university administration.

The fact that a university does not have a medical school is not a handicap in the development of a good health program. As has already been stated, even when an institution has a medical school it is preferable that the health services be operated independently as a separate unit. What is needed for the development of a first-class program in any particular institution is the presence of sufficiently modern and adequate medical facilities in the surrounding community to permit a health director to adapt them to the special needs of members of the college community. Without such facilities, and with no opportunities for teaching, it is of course more difficult to attract and keep highly competent physicians on the staff. Under these circumstances an attractive career for college physicians may be made possible, especially for those who enjoy teaching in subjects related to the health professions, by giving them teaching and counseling opportunities that will take advantage of their special interests and abilities.

Financing College Health Programs

Financing a health program is a serious problem, especially for smaller colleges, unless everyone connected with the institution (and particularly the administration, students, and their parents) appreciates the sig-
Health Service Buildings

There has been an encouraging trend in the last decade toward improving college health facilities in all parts of the United States, perhaps more so than in any other period in the past. New and quite adequate health centers have recently been constructed at Connecticut College for Women; Mount Holyoke, Wells, and Goucher Colleges; at the Universities of Colorado, Delaware, Illinois, Massachusetts, and Nebraska; and at Cornell, Harvard, Michigan State, Northwestern, Purdue, Rutgers and Tulane Universities. For the most part, those buildings have been planned to facilitate administration of preventive medicine, health education, and medical service, and they are centrally located so as to be easily accessible to the students. The American College Health Association maintains plans of all recent buildings; these are available upon request to college authorities planning new buildings, presumably to enable them to utilize new and desirable features in their construction and to avoid previous mistakes.

For most of the colleges in the United States and Canada the demands on their physical facilities are practically overwhelming. In the general competition for funds the health services do not fare well unless there is a general consensus among students, parents, faculty members, and administration that the health service building encourages the development of good health programs, and that such programs facilitate good education and do not divert resources from the central (i.e., strictly academic) functions of institutions of higher learning.

Before making plans for health service buildings several basic decisions should be made concerning the functions to be performed within it. These include decisions as to who will be treated in the new building — whether students only, or employees and faculty members in addition — and how many offices, beds, and special departments are to be provided. The determination of these items requires much planning with those college officials who determine policy regarding the size of the institution, or who are in a position to predict growth trends of the institution. Any architectural plan should take into account the need for a widely fluctuating census, for supervision by as few nurses as possible (particularly when the census is light), and for the student patients to be able to do as much of their school work as their physical and mental conditions will permit. In short, the ideal is not that of a hospital, nor that of a dormitory room, but something in between. It is desirable to have as few wards as possible but instead to have single or double rooms. This arrangement enables the staff to carry out a wide variety of isolation procedures.

Recently the Educational Facilities Laboratories gave a grant to three colleges — Colorado College, Knox...
College, and Wittenberg College — to make a study of the health service needs of small colleges and to come up with appropriate recommendations for the type of building that would meet as many of these needs as possible. After considerable study and visits to several institutions the Commission came up with a prototype college health center which was in essence a round building, the outer portions of which could contain patients' rooms, entrance lobbies, special rooms for consultations and examinations. The inner core, to which ambulatory patients were to have access, was reserved for the nurses' station, reception area, and a study area. Other services not requiring outside light, such as the x-ray service and the food preparation unit, were assigned to interior spaces. (A College Health Center, 1963).

Medical Excuse Systems

During the early decades following the establishment of college health services the custom arose of asking physicians in those services to give medical excuses to students who missed classes or examinations because of illness or any type of physical disability. This appeared to be a fair way of resolving many issues, especially when attendance at all classes was required, but eventually abuses of such a system began to develop. Students began asking for such excuses retroactively; sometimes they exaggerated mild disorders. In many health services, physicians' time was taken up to an alarming degree in making judicial decisions (Was the illness sufficiently serious to warrant an excuse?) or in acting in a disciplinary capacity when requests were found to be dishonest, rather than in treating patients. The mere possession of a special slip of paper signed by a physician suggested to some students that they were completely excused from the work itself rather than from the necessity of doing it at a particular time. In brief, the excuse system degenerated in some instances into a device to encourage dishonesty, hypochondriasis, or both.

In recent years many schools have substituted a much less rigid and time-consuming plan for dealing with commitments unfulfilled because of illness. This consists of letting all students and faculty members know that no medical excuses of any kind will be issued for missed engagements. Instead, a student who becomes ill goes to the health service for treatment as usual, and if he misses a class or examination he gives a verbal explanation to his instructor. If there seems to be any doubt or unusual aspects about the explanation, the instructor may consult with the health service, telling the student that he is doing so, thus resolving the uncertainties. Such a system rarely encourages exaggeration of illnesses and of course discourages misrepresentations, since at least two persons must be deceived. Furthermore, it more nearly resembles the situation prevailing in later life.

Students ill enough to be retained in the infirmary are obviously unable to go to class, and the health service records clearly show this. Examinations may be sent to the student in the infirmary if his illness does not involve his capacity to work efficiently. A special situation arises in physical training exercises. A practical solution is to require a minimum number of exercises for credit in the course, permitting a student to miss a class and make it up later if he so desires, as, for instance, when he has a cold or some minor disability that might be increased by physical exertion.

One medium-sized college with an enrollment of about 3,700 recently eliminated all vestiges of a medical excuse system and found that the total number of calls for the year was reduced from 27,137 in 1962–63 to 20,258 in 1963–64, a reduction of practically 25 per cent. (McCoy). This released a large amount of medical time for other purposes and, at the same time, did not increase the load of anyone else in the college to any perceptible extent. There was general satisfaction over the move.

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Although medical records are the property of the physician, or of the college in the case of institutional health services, their privacy must be guaranteed. This means that they should be seen only by those who are entitled by the nature of their jobs to do so — physicians, staff nurses, and clerical help. These persons, however, must be very carefully indoctrinated about the nature of the records and the importance (from all standpoints, including the legal) of preserving their privacy. Undergraduates should not be permitted to work on records nor, in most instances, even graduate students. Sometimes graduate students working on research projects wish to make a survey of the medical records; it is not good practice for them to be allowed to do so. The same issue arises when students’ wives have jobs that involve access to records. Ordinarily such an arrangement is all right provided that their understanding and integrity prevent their discussing any material they come across. Maintenance of confidentiality is, of course, a more sensitive problem with psychiatric cases than with any others and is absolutely mandatory for psychiatric records.¹

If a physician reveals confidential material without the permission of the patient he may be subject to a suit for damages. Medical facts may be given to parents, however, and in fact must be if the best interests of the patient are at stake, particularly when the student is under 21. Even in the matter of providing information from the medical record to the Workmen’s Compensation Board, the employee involved is asked to sign a release. Since this is generally in the employee’s interest, he is willing to comply.

A physician has an ethical, moral, and legal obligation to keep the confidence of a patient. If he violates it he may be liable for legal action and lose his license to practice. When, however, medical examinations are performed for a third party — for example, a federal agency or an insurance company — there is a responsibility to divulge accurately and completely all information obtained. The physician who holds back any information under these circumstances may be held liable for negligence.

If there is a legally valid order to produce records — i.e., a subpoena — the physician is, of course, excused from liability. Under other circumstances he is liable for legal action or even loss of license to practice. In other words, all records are privileged, and written consent is necessary for their divulgence. Considerable pressure is sometimes exerted by members of personnel and counseling services for medical records to be made available to officials of the institution or to those engaged in counseling. This is not good practice even with permission of the patient, because sometimes this permission can be obtained under duress.

Another question is: should medical personnel see counselors’ records? There is no reason to assume that they have any more right to see the counselors’ records than vice versa, but it is reasonable to suppose that if a physician, particularly a psychiatrist, could benefit by talking with a counselor it would not be difficult to get permission from the patient. In any case, permission from the patient is necessary if material learned in confidence is to be discussed.

Anything which a student divulges in confidence should be respected, with the possible exception of such situations as suicidal preoccupations, homicidal thoughts, commission of a felony, or similar cases.

Sometimes this becomes a very delicate matter because a faculty member, not fully realizing that the student considers the interview confidential, finds himself in possession of information which makes him very uncomfortable. He may feel that he should report it to the dean or someone else in authority. However, the necessity for preserving confidentiality requires that under ordinary circumstances he work directly with the student until he has received permission to take whatever action he deems necessary, or has communicated to the student the embarrassing position he is in by having possession of this information.

A particularly complicated situation is that of pregnancy in an unmarried student. The person in

¹ For an elaboration of these points see sections on confidentiality (pp. 72-78) and legal aspects of university health service practice (pp. 208-235) in Farnsworth, D. L., Ed., College Health Administration. New York: Appleton-Century-Crofts, 1964.
whom the student confides quite obviously wants to do the proper thing, but this would not necessarily involve reporting to the college authorities. Under these circumstances, it might be desirable to strongly urge the girl to get in touch with her parents. If she refuses, a little time might be given for her to think it over, but ordinarily the person with such information, if he is a responsible college official, should tell the girl that he will have to inform her parents or next of kin of the situation.

Requests from state and local authorities for records should not be granted unless the records are subpoenaed. Requests from security agencies such as the FBI, ONI, etc., are also delicate matters. In general, it seems desirable to refuse to give screening information of any kind, and only to give details about any illness or its treatment to the physician concerned after the applicant has been accepted by the organization; of course, the usual written permission is then necessary.

In communication with deans and other members of the faculty the usual rules of confidentiality should always be upheld. Under ordinary circumstances, the student who has a problem may ask the dean or faculty member to get in touch with the physician; that is usually all that is necessary. Similarly, if the physician feels it desirable to talk with a member of the administration or faculty about the student, he gets permission from him to do so.

In some colleges the dean may fully support the efforts of the medical staff to maintain confidentiality but insist that a list of all students who see the psychiatrist be given to him in order that he may know, in any unusual situation, whether the person or persons involved are under appropriate supervision. This constitutes a clear violation of confidence and should not be done. Such lists may be seen by someone other than the dean and possibly cause embarrassment and annoyance to the student concerned. Whatever communication of this nature between the dean and the psychiatrist is necessary should be conducted on a verbal basis.

When the dean sends a student to the physician with a question of illness, it should be made quite clear to the student that this is not a completely confidential interview and that the physician will have to make a report to the dean. It is usually wise to inform the student of the content of the report.

There is no reason for a physician, dean or counselor (or any member of the faculty) not to talk about a student in any way they wish so long as the information under discussion has not been obtained under conditions of confidence. Even under these circumstances, however, discretion should be followed.

When a student who is a minor seeks medical help and an important operation or other procedure is necessary it is always desirable, and usually necessary, to get written permission from the parents. Sometimes parents object to their child's being referred to a psychiatrist. It is the custom of most psychiatric units of college health services not to notify parents unless there is a very serious matter such as a psychosis or suicidal or homicidal preoccupation, or some condition which is likely to be brought into public knowledge. The reasons for this, among others, are that students simply will not consult psychiatrists if they know that their parents will be told, and also that psychiatric treatment is not generally considered a major proposition — many of the cases seen by psychiatrists are more educational than medical. When it is necessary to notify the parents, the patient should always be told of it and the reason clearly explained, if his condition permits.

An effective procedure used in several institutions is that of a weekly or bi-monthly meeting of psychiatrists and other physicians, deans, psychologists, counselors, sociologists, or others who have the responsibility for students, to discuss whatever problems are most acute in the institution at the moment. Sometimes individual cases are discussed, but if so no material obtained in confidence is used without gaining permission from the student concerned. At the meetings various plans, movements, inter-group pressures, or disturbing events or situations of any kind, including matters of public relations, are discussed and measures taken to alleviate any disturbing factors. As an added precaution for the benefit of students, or as a mark of respect for their privacy, the contents of the meeting themselves should remain confidential and not be discussed outside these meetings. One of the best results of such meetings is that the various members of the faculty and administration who have responsibility for students get to know each other quite well, and thus develop an intricate informal network of communication by which students who need help may receive it quickly and from the persons best equipped to give it.

Relations between physicians, psychiatrists, and counselors should be characterized by cooperation, not competition. There is far more to be done for a student than all the professionals put together can do, and hence the question is not so much who should do the work but who can do it best and how can it be accomplished most effectively. In general, those problems that can be dealt with by academic advisers should be handled by them. Those that are more complex or specialized and which require the services of professional counselors should be referred to them. Chaplains may be referred cases of a religious nature. Financial aid officers may have to look after some of the problems. Those whom diagnosis reveals to require psychotherapy may be referred to psychiatrists, psychologists, or social workers. Those who have serious illnesses in
which psychoses may be a factor, or for which hospitalization is needed, should always be referred to the psychiatrist.

**Communications**

If a health service is to be effective it must have good communication with a variety of other offices within the college or university. Some of the main principles of confidentiality have already been discussed. Blaine (1964) has recently listed several quandaries in which divided loyalties are involved, and he gives suggestions as to how these may be reconciled.

The American College Health Association has been concerned for some time about ethics and professional relationships, and a special committee is working on these problems. In most instances, information about the presence of an illness, the time of onset and duration, its severity and prognosis, can be relayed to proper officials without permission of the patient. Likewise, recommendations regarding physical education and athletics, changing residence, or medical leaves of absence do not require such permission.

All laws concerning public health regulations in a community must be observed, of course. It is desirable for one person to be involved in communications with the press, thus creating as few complications as possible. In general, close collaboration between the health service director and the head of the public relations division helps a great deal to minimize confusion.

Health records and x-rays are the property of the health service. Control of their privacy, however, is an inherent right of the patient.

Obviously, every college physician is committed to adherence to the code of ethics of the American Medical Association. The use of healthy, normal students as research subjects has been a topic of considerable inquiry, and the most elaborate of the regulations thus far devised are those now in force at Harvard University. (Farnsworth, 1964).

Occasionally, a patient or his parents may demand that the college destroy a health record that contains something that might be detrimental or embarrassing to the patient. This is a poor policy and compliance should be refused, although even greater care than usual must be taken thereafter to make sure that the record never becomes available to anyone without proper permission.

Sometimes a physician, and particularly a psychiatrist, may be attached to the dean’s office or to the counseling bureau, and he may then be asked to submit his records for inspection. He may make recommendations to his superiors, but his official records should never be made available to a lay person.

**References**


Chapter 4

Medical and Surgical Services

The medical service is the core of any college health program regardless of the size of the institution. Surgical consultations constitute the most urgently needed supplement to it, especially from the standpoint of good relations with students and their parents. Neglect or misdiagnosis of a surgical emergency is usually clearly apparent and the results quickly disastrous. Psychiatric consultations are frequently needed, but their absence is, as a rule, neither so immediately apparent nor tragic in consequence.

The amount and availability of surgical consultation depends upon the size of the institution. In the large colleges and universities one or more surgeons hold daily office hours, usually in both morning and afternoon. In the medium-sized and small institutions, a surgeon is usually on call for emergencies or he may go to the health center at a regular time each day to see those nonemergency cases calling for surgical attention. Emergency service should always be available in all institutions.

Because of their technical nature and admitted necessity this monograph will not go into detail concerning medical and surgical services. Extensive information about them is available elsewhere (Farnsworth, 1964).

Common Threats to Student Health

The most common disorders with which students come to a college health service are respiratory infections; of these the common cold is by far the most frequent. Although there is no definitive treatment for colds, it is possible to alleviate some of the more annoying symptoms. However, colds must not be treated lightly because quite often they usher in more serious diseases — not only those which may be life-threatening but also communicable diseases which are not so serious. It is therefore desirable for students who have colds to be encouraged to go to the medical clinic for observation in the event of any unusual symptoms. Sometimes this causes students to be somewhat annoyed because they do not get treatment or relief from their symptoms.

Acute tonsillitis and pharyngitis are ubiquitous, constituting a large percentage of the respiratory system diseases. A recent study at the University of Wisconsin showed that these infections accounted for 25 per cent of all respiratory disease admissions to the infirmary (Evans & Dick, 1964).

Emotional conflicts and skin disorders are high on the list of reasons for students’ visits to a general medical clinic.

Another one of the common ailments that particularly affects college students is infectious mononucleosis. This disease is prevalent in practically all colleges, and it may well be that its higher “incidence” in colleges is an index of the good medical care of this population. It is quite probable that many young persons who are not in college go through periods of low-grade illness but do not go to a physician, and hence the disease is not recognized.

Dalrymple (March, 1964; April, 1964) has recently reviewed the literature on this disease in detail as part of a comprehensive study of it. His basic hypothesis was that students are disabled almost as much by their pessimistic expectations of the disease as by the objective symptoms. Of all cases reported, numbering many thousands, only 47 have been fatal. In some of these the diagnosis was questionable; of the remainder, neurological complications, rupture of the spleen (frequently enlarged and softened during the course of the disease), and superimposed infections figured prominently. Modern methods of treatment, by corticosteroids and antibiotics, have still further decreased the risk of mortality of the disease.

Dalrymple made a controlled study of 131 patients who undoubtedly had the disease, as shown by careful laboratory tests. He kept one group of 36 patients (chosen alternately) at bed rest until they were afebrile and blood examinations had become nearly normal. Another group of 47 were unrestricted in their activities while in the infirmary and were discharged as soon as their subjective symptoms permitted. A third group of 48 patients remained active and did not require admission.
Of the entire group, 90 per cent had recovered completely within six weeks; even their fatigue had disappeared. Those allowed activity as desired during illness and convalescence improved more rapidly than those kept at strict bed rest during the acute stage of the disease. Dalrymple thus concluded that strict bed rest is justified only in unusually severe cases or in the presence of severe complications.

This study is of importance to all student personnel workers because it suggests that they should not encourage invalidism by suggesting to students who have the disease that they will have a long illness with depression and fatigue occurring for several months thereafter, but rather should indicate that infectious mononucleosis is usually a mild nuisance and they should keep on with their activities unless instructed not to do so by their physicians.

Infectious hepatitis is not very common among students but it is exceedingly important that each case be recognized and the patient isolated at once in order to prevent spread to other students. Infectious hepatitis is always a serious disease, but the mortality is low if it is appropriately treated by bed rest, suitable diets, etc.

German measles is very common, occurring in epidemics every two or three years; its greatest danger is to women students in their first three months of pregnancy. In fact, theoretically it would be desirable for single girls to try to get the disease if possible so that they would not be involved with this hazard later on.

Unusual conditions that are prevalent in the general population are also found in students, but with a lesser frequency because of the younger age of the students. Malignancies of various kinds occur; most often they involve blood-forming mechanisms, teratoma of the testicle, tumors of the thyroid, or brain tumors.

Accidents of all kinds are common in any student group. The most serious injuries are those arising from automobile accidents. The use of bicycles and motorcycles in heavy traffic is a particularly dangerous custom. Injuries suffered in athletic activities are discussed in Chapter 5.

In general, the treatment obtainable in college infirmaries is for comparatively simple conditions. Whenever major operations are necessary, involving entering the cranial, thoracic, or abdominal cavities, the students should be sent to a local community hospital unless there are adequate facilities and personnel on the campus for such procedures. Similarly, in serious emergencies requiring immediate life-saving measures, the student should always be sent to the best equipped hospital available.

Under ordinary circumstances a well-equipped and generally accepted medical service will have from five to six visits per student per year. This figure tends to be larger in a small residential college in a small town than in an urban university. A tabulation made recently at Cornell University indicated that 95 per cent of the students required medical care and 43 per cent required treatment in the college infirmary or outside hospital prior to graduation.

The average length of stay in college infirmaries is usually not more than three or four days, although to many students it seems much longer.

Epidemics of various kinds are always a threat to the health of college students. Fortunately they are much less frequent than a few decades ago, mainly because (to a greater extent than formerly) college students have been immunized in childhood against some communicable diseases and have had the others before entering college. German measles still occur frequently in epidemics, but this is not a serious disease except for women who are in their first trimester of pregnancy. There is no reason why most patients cannot be allowed to remain in their rooms. Infectious mononucleosis is endemic rather than epidemic. Influenza and other respiratory infections of a viral nature constitute the greatest remaining epidemic threat. Every decade or so hundreds of students at the same time become ill with one of them, crowding infirmary facilities far beyond their limits. Many of these patients can also be treated in their rooms, and those who develop high temperatures, chest complications, or other symptoms can be sent to the infirmary. Ear ache, severe coughing, spitting blood, severe weakness, fainting spells, and other such symptoms should be taken quite seriously. It is, of course, imperative that persons who are allowed to stay in their rooms be sent plenty of appropriate food, and that they be seen by a physician or nurse at least twice daily.

No college can justify investing sufficient funds to build an infirmary large enough to care for all students who may become ill during epidemics. Instead, the number of beds should be great enough to take care of peak loads during the winter months of "ordinary" years and alternative facilities should be arranged by the college health service to see that students with epidemic disease are adequately fed, nursed, and supervised closely enough to permit the recognition of any serious complications that may occur. These auxiliary facilities may be devised in a fraternity house, one or more entries of a dormitory, part of the athletic facilities, or in any space where beds may be set up in a quiet area with good ventilation and heating, and facilities by which the usual body needs are met. Ordinarily such arrangements are not needed more than once every 8 to 10 years.

College health services are usually not equipped to meet all students' needs for medical care. Even the largest and most comprehensive of the large university health services integrate their functions with those of
hospitals in their vicinities. A common criterion for the disposition of surgical cases is the extent of the operation involved. For example, any operation that required opening the cranial, thoracic, or abdominal cavities would not ordinarily be done in a college infirmary even if it possessed a well-equipped operating room.\(^1\) Injuries of a multiple nature, particularly if internal organs are damaged, would also be treated in a hospital. Those medical conditions frequently calling for extensive emergency treatment such as bleeding ulcers, heart attacks, and severe infections should also always be transferred from college infirmaries to hospitals. A good general rule to follow is that every attempt should be made to treat students in the facilities where the help they need can best be given to them.

\(^1\) Exceptions to this rule would be appropriate when the college infirmary is in fact a community hospital, such as exists at Purdue University, Oklahoma State College or California State Polytechnic College.

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Chapter 5

Intercollegiate and Intramural Athletics

However much some of our educational philosophers may deplore the prominence of athletics in colleges and universities they continue to flourish and will probably do so throughout the foreseeable future. College physicians, and particularly psychiatrists, usually believe that the benefits of good athletic programs outweigh their disadvantages by far. Whether because of self-selection or by reason of athletic participation itself athletes appear to have less need of psychiatric help than other students (Davie, 1938). It is also quite probable that they channel restless energies into satisfying rather than destructive channels. In Professor Samuel E. Morison's (1936, p. 401) account of student life at Harvard a century ago he observes that "as athletics increased, riots and disorder faded out." From a health standpoint athletics seem highly desirable and should be widely encouraged providing that all who participate receive appropriate medical supervision and abuses are prevented, especially those which exploit students or deflect interest from the intellectual goals of the institution.

If medical supervision of athletic activities is to be truly effective the entire program should be a part of the regular health service of the college. There is no justification for the rapidly disappearing custom by which athletic departments employ team physicians who operate quite independently of the college health service. Such an arrangement divides responsibility for students who are athletes, often resulting in quite embarrassing complications.

Recently the Committee on the Medical Aspects of Sports of the American Medical Association adopted a set of principles governing supervision of athletes which has been widely approved and which constitutes the ideal toward which all colleges might well strive.

**THE BILL OF RIGHTS FOR THE COLLEGE ATHLETE**

Participation in college athletics is a privilege involving both responsibilities and rights. The athlete has the responsibility to play fair, to give his best, to keep in training, to conduct himself with credit to his sport and his school. In turn he has the right to optimal protection against injury as this may be assured through good technical instruction, proper regulation and conditions of play, and adequate health supervision. Included are:

**Good Coaching:** The importance of good coaching in protecting the health and safety of athletes cannot be minimized. Technical instruction leading to skilful performance is a significant factor in lowering the incidence and decreasing the severity of injuries. Also, good coaching includes the discouragement of tactics, outside either the rules or the spirit of the rules, which may increase the hazard and thus the incidence of injuries.

**Good Officializing:** The rules and regulations governing athletic competition are made to protect players as well as to promote enjoyment of the game. To serve these ends effectively the rules of the game must be thoroughly understood by players as well as coaches and be properly interpreted and enforced by impartial and technically qualified officials.

**Good Equipment and Facilities:** There can be no question about the protection afforded by proper equipment and right facilities. Good equipment is now available and is being improved continually; the problem lies in the false economy of using cheap, worn out, outmoded, or ill-fitting gear. Provision of proper areas for play and their careful maintenance are equally important.

**Good Medical Care...** Including:

*First...* a thorough preseason history and physical examination. Many of the sports tragedies which occur each year are due to unrecognized health problems. Medical contraindications to participation in contact sports must be respected.

*Second...* a physician present at all contests and readily available during practice sessions. It is unfair to leave to a trainer or coach decisions as to whether an athlete should return to play or be removed from the game following injury. In serious injuries the availability of a physician may make the difference in preventing disability or even death.

*Third...* Medical control of the health aspects of athletics. In medical matters, the physician's authority should be absolute and unquestioned. Today's coaches and trainers are happy to leave medical decisions to the medical profession. They also assist in interpreting this principle to students and the public.

Although athletic departments may be justified in obtaining insurance for catastrophic injuries, the opinion that health insurance programs should be developed that are identical for all students, athletes and others alike, prevails in most institutions. Special benefits for participants in intercollegiate athletics suggest that their activities are in some way inherently more important than those of other students; this should be avoided.

Training tables are time-honored institutions in the conduct of intercollegiate athletics, especially football. There is no conclusive evidence that they serve any essential purpose so far as nutrition is concerned, tradition notwithstanding. The benefits of a training table may have considerable psychological value in the de-
velopment and maintenance of morale. However, this should be considered in the light of the possibility that such isolation of athletes from their fellow students may have undesirable social consequences. Segregation of athletes in dormitories is a dubious practice from the standpoint of the personal development of such students.

References


Chapter 6

Preventive Medicine, Health Education, and Environmental Health and Safety

In a modern health service it is hardly possible to separate those aspects of the program that are preventive from those that are curative. The ideal is a blend of each with health education being the medium through which the students are given the opportunity to learn what they can do to protect their own health and safety.

One exception is the division of environmental health and safety (or occupational medicine) in which nearly all the activities are preventive in nature. Its activities will be described later in this chapter.

In many colleges, more often those of small or medium size, health education courses are given, and in many instances required. Health educators offer these courses, aided in some institutions by members of the medical service. In Moore and Summerskill's 1953 survey such courses were offered in 80 per cent of the colleges with a student health service, and in slightly more than half of these all students were required to take them.

In the large universities courses in health education are seldom compulsory for several reasons—the competition for the students' time and the lack of properly trained teachers being among the reasons given frequently for the lack of any requirement. The health services in those institutions make various efforts to teach principles of health education by a variety of indirect methods. A basic goal is to develop a favorable attitude in students toward the acquisition of knowledge and skills that will protect their health and enable them to work effectively with their health advisers. Each contact between physician or nurse and student is looked upon as a learning situation.

Immunization programs are conducted against all communicable or contagious diseases for which specific preventive measures are available. Insurance programs and prepayment plans serve as vehicles to disseminate knowledge about paying for patient care. Brochures are often distributed by many services to acquaint students with some of the factors in treatment or prevention of colds and other respiratory infections, infectious mononucleosis, infectious jaundice, skin disorders, gastrointestinal "upsets" or other disorders affecting students.

It is futile to argue which is the more important, health education or health service. Both are important and essential to any good health program.

All institutions, regardless of size, have problems in this area. Most of them do not develop any program to meet these needs until there is a catastrophe which subsequent investigation reveals might have been prevented. The prevention of even one serious injury a year will pay for a program. For example, in one institution a man came to work one morning while moderately intoxicated and his supervisor, feeling very angry toward him, reprimanded him sharply and told him to get to work, instead of sending him home as he would have done had he been properly trained. During the course of the morning he cleaned a space for laboratory animals with steam. He lost consciousness and the steam burned the lower half of his body rather severely, resulting in a payment by the institution of more than $50,000 over the next few years for medical services and workmen's compensation.

The main difficulty involved in getting credit for preventing illness or injury is that when one does so he destroys the evidence of the hazard's existence. Indirect forms of evidence, such as lowered cost of workmen's compensation programs and reduction of accidents, is about all that can be expected.

In the field of safety, one of the greatest opportunities for reduction of disability exists. Every institution has slippery stairs, hand railings that either should be constructed or are not in order, precautions that should be taken during icy weather, etc. All have fire hazards, elevators which do not work satisfactorily, hoods in the laboratories that are not effective. Programs to induce employees to use proper methods of lifting to avoid strain of the lower back, to use head protection to avoid head injuries, to use hard-toed shoes to prevent foot injuries from dropping heavy objects,
and to use safety glasses to avoid eye injuries are always appropriate.

Every institution that has laboratory activity may use carbon tetrachloride improperly; it may use benzene for cleaning glassware, and thus subject people to exposure to a substance that causes anemia. A laboratory may have mercury spills on wooden floors, and thus subject students and employees to inhalation of mercury vapor which will affect the kidneys. Exposure to a variety of other toxic agents is possible.

Those who are concerned with pre-employment physical examinations may want to make sure that persons with heart disease or histories of convulsive seizures, or who have a tendency to be accident prone or to use alcohol improperly are not assigned to kinds of work that involve control of intricate machinery or working in high places.

The basic philosophy in health and safety programs is that research can be done safely if the proper safeguards are taken. Persons responsible for such programs should offer their services to those in charge of research, but should not put themselves into the position of censoring such work. When faculty members have confidence in their department of environmental health and safety they are usually glad to enlist its aid in seeing that research is done safely.

Another important task of the environmental health and safety program is the safeguarding of food supplies. Sanitary inspection should apply to the preparation of food, facilities, vending machines, peddlers, snack bars — even to the visual cleanliness of such facilities. Swimming pools also have to be inspected regularly. Sometimes attention must be paid to small stores, restaurants, etc., in the community, although here, of course, the work must be done in conjunction with the local public health authorities.

In many places off-campus housing comes under the aegis of this program. Joint committees of the American College Health Association, the Association of College and University Housing Officers, and the Campus Safety Association of the National Safety Council have developed a set of standards (1962) for the guidance of those college officials who must make decisions regarding the suitability or safety of student lodgings away from the campus. In this comprehensive document special attention is given to basic construction, exit routes and interior communication, space requirements, toilet facilities, water requirements, heating and ventilation, lighting, electrical facilities, food services, pest control, cleanliness and fire protection.

If accidents are recorded in the health service it is the duty of the persons who carry on this program to analyze the data and try to work out methods of decreasing the number of accidents.

Maintaining safety in sports is another important activity. Football helmets, dental appliances to prevent injury to teeth, contact lenses for those engaged in contact sports whose vision needs correcting, and safety glasses and crash helmets for skiers are very important.

Lighting, ventilation, and noise levels in various buildings of a college or university are of interest to those responsible for environmental health.

Radioactive substances always require constant and competent supervision. Film badge programs, the location and storage of radioactive sources of energy, isotopes, etc., and programs to ensure the safe operation of large machines such as Van de Graaff generators, etc., come in this category. Here again, there is no reason why these materials cannot be handled safely if appropriate safeguards are known and put into practice. In the larger institutions a separate environmental health and safety division located within the health service organization is desirable. In the smaller institutions, where there are very few persons in the health service program anyway, operations may have to be supervised by a committee made up of knowledgeable persons from various divisions, with the director of the health service being a member of this committee, and, in some instances, its executive officer. In some schools the safety program is developed entirely separately from the health program because of various traditional sensitivities, and under these circumstances there is frequently a duplication of effort or a rivalry that is becoming to faculty members, as well as inefficient. Furthermore, such duplication of effort adds to the expense of the total health program.

Reference

Dental Care

Young people of college age need more dental care than other segments of the population for two reasons. First, they are at an age when dental cavity formation is more rapid than at any other time during life. National surveys show that a very high peak in the need for fillings occurs in the age group 15 to 19; the age group 20 to 24 is second. On the average these needs are hardly ever fully met by the students’ family dentists. Indications are that about two-thirds of the students will need some dental attention at the time of entrance to college, regardless of socio-economic status.

The second reason for maintaining dental service in the college health center lies in the fact that most college students are away from home just at the time when they must learn to make their own plans for health care. Good dental care requires carefully thought out relations with professional personnel and systematic planning for periodic recall. The college student needs help on this, and will benefit from having a “substitute family dentist.” Far from being inattentive to their dental needs, most college students show a good level of intelligent interest in their dental problems and are therefore good prospects for dental health education.

Most colleges with dental services concentrate on case findings, diagnosis, emergency service, consultation, dental health education, preventive measures, and dental prophylaxis. Some colleges go beyond this and offer routine restorative dental care, either on a first-come, first-served basis or to certain special groups (such as low income and foreign students). Currently no college considers itself obligated to undertake the entire load of routine restorative dentistry for its student population; thus the private practitioner of dentistry plays an important role. The dental health service should bear in mind that the student will in most instances establish a relationship “on his own” with the family dentist, or will seek out a new practitioner. The dental service should concentrate on recognition of defects and explanation of their nature to the student, without committing the student to a specific plan of treatment which may embarrass the private practitioner who later receives the case.

Emergency dental treatment is a very important phase of college dental service. Many acute situations arise which necessitate immediate care when the private practitioner is not available. Toothaches from deep cavities and the problems concerned with erupting or impacted wisdom teeth are the most common, but a considerable variety of problems occur. The student naturally turns to the college health center under such circumstances and, when a dentist is on duty, quick relief is usually possible. Certain phases of restorative after-care are also logically rendered by the college dental service. Root canal treatment (endodontics) is the chief of these. It can seldom be postponed until a college vacation, and it is difficult for the family dentist to handle it at such a time because of the need for several treatments with proper time intervals between. Root canal treatment can well be performed in the college health center without compromising the plans the family dentist may have for later restoration of the crowns of the teeth.

Dental health education on an individual basis is an important part of a college dental service. Students want advice about their frequently rapid rate of cavity formation, their wisdom teeth, their orthodontic problems, and perhaps even such simple items as tooth brushing. They want to know the facts behind any recommendations, too. The dental hygienist plays a very important role in health education, as does the dentist himself. Simple pamphlets prepared for distribution will often help to answer the more common questions.

Most of the measures designed to prevent dental disease or injury require that students be instructed in self-care, but in one important respect the college has an operational responsibility, i.e., the provision of athletic mouth protectors to college students engaged in body contact sports. Many kinds of protectors are now available and their design has improved so that they are increasingly well accepted by college athletes. The National Alliance Football Rules Committee has recently made a regulation that all football players within that alliance must wear mouth guards. The provision of custom-made guards (the best type) requires the par-
ticipation of the dentist in taking impressions of the players' mouths.

Routine dental care is not as easy to insure as medical care, since the need for the former is reasonably predictable and almost universal. No college has prepaid dental care in full, and the problem actually has more to do with budgeting than with insurance. Insurance does apply, however, in the field of accidental injury and certain oral surgical operations. In a recent poll of colleges within the American College Health Association over half had some accident insurance for injury to the teeth or for oral surgery. In most instances upper limits for this insurance were from $100 to $300.

Some reassurance is frequently necessary concerning the use of dental x-ray films. X-rays are particularly valuable in the care of young people of college age because they detect early cavities forming between the teeth and damage (periodontal) to the sockets of the teeth and impacted wisdom teeth. Two bite-wing films usually provide enough pertinent information for a given patient. It was estimated a few years ago that it would take 500 such films to equal one roentgen of exposure to ionizing radiation; the National Research Council had at that time specified an upper limit of 10 roentgens during the first 30 years of life. Subsequent improvements in dental x-ray technique (fast films, filtration, etc.) have further reduced this risk to negligible proportions. Bite-wing x-ray surveys of entire college populations, particularly the entering students, are thus both valuable and safe.

All these activities demand a dental service under the supervision of a competent dentist (aided by other dentists when necessary), by one or more dental hygienists, and by suitable auxiliary personnel. Larger institutions will wish to maintain such clinics as part of their own health center facilities; smaller colleges can provide quarters for part-time dental personnel or can maintain active relations with a nearby dental practitioner in his own office. College dental clinics are not yet as prevalent as the need for them warrants; those in operation have constantly growing demands for service with evidence of their usefulness.
Chapter 8

Psychiatric Services

Those who work in the field of student health are by now well aware of the statistics indicating that, by conservative estimate, at least 10 per cent of college students experience sufficient emotional conflict to warrant professional treatment and that, during their period of residence in the college community, 18-25 per cent of students will seek consultation with a psychiatrist if this service is available. (Two-thirds of these come on their own initiative, one-third by referral.)

The question is no longer whether psychiatric services should be provided but which ones are appropriate, considering the nature of student populations, particular institutions, and certain factors fundamental to the educational process.

It is generally agreed that an institution's environment should be, insofar as possible, therapeutic, i.e., should stimulate and encourage intellectual endeavors and should not create undue stresses for students that obstruct their capacities to learn and to pursue academic interests. Nevertheless, even if a completely therapeutic milieu could be created, students would bring difficulties with them — unresolved childhood conflicts and the not inconsiderable problems of late adolescence. Moreover, no area of life is devoid of stress, and in fact it has been found that, if managed correctly, stress provides a constructive challenge and its mastery is a source of great satisfaction. The tasks of adolescence, and of education, are part of the human maturational process; the success with which they are met depends upon a variety of personal and social factors. In other words, it is the responsibility of a college and its psychiatric service to be as effective as possible — which means knowing what can be profitably undertaken and what cannot.

Late adolescence is often characterized by emotional turbulence. Contrasts and fluctuations in behavior and attitudes abound. Students grapple with problems of self-esteem, indecision, conformity, rebellion, relations with authority figures — that is, with all issues relating to their own identities. The majority of students who seek help from college psychiatrists do so because they undergo anxiety or depression of sufficient severity to impair their ability to work. Another disturbance which has been found to be common among students at Harvard is apathy; an excellent study of this phenomenon has been done by Walters (1961). Suicide, the most severe (and irreversible) manifestation of emotional disturbance, is believed to occur more frequently among college populations than in the nation as a whole, but the evidence to support this belief is not conclusive.

The experience with emotional disorders in the health service of Harvard University during the past 10 years is probably similar to that of other colleges, except that the resources for managing them may be more complete than in most health services. Each year from eight to nine per cent of all students enrolled seek psychiatric help. An unknown number, but certainly three per cent or more, obtain help from private psychiatrists, usually in the form of intensive psychotherapy. Each year 15 to 25 students (from a total enrollment of 14,000) withdraw to enter mental hospitals because of psychoses. One to three suicides occur yearly and there are five to eight attempts for every one completed. Of those undergraduates who leave because of psychosis about 70 per cent return and, of these, about 60 per cent are graduated.

There is no fundamental difference between the emotional disorders experienced by college students and those of other young people of the same age. Members of both groups suffer from disturbed interpersonal relations and respond via anxiety, psychosomatic symptoms, depression, apathy, suicidal attempts, hypomanic behavior, character disorders, and, if the circumstances are overwhelming, schizophrenic reactions. They may also learn how to cope with these interferences with their development and become more resilient and stable individuals as they do so. Fortunately, most of them do learn how to surmount difficulties, including the problem of resolving emotional conflicts. The task of psychiatric as well as other counseling services is to see that as many of them as possible do so.

If only the weak or otherwise inferior students developed disabling symptoms, an insensitive person
might conclude that allowing such students to drop out of college constitutes a good screening device for eliminating the unfit. But such is not the case. Emotional problems affect the brilliant and the average as frequently as the less well endowed. Moreover, the highly intelligent are not for that reason more prone to develop emotional or mental disorders. The key consideration is not the individual's potential intellectual capacity, but the nature and quality of his social, cultural, and interpersonal experiences prior to college entrance.

A college psychiatric service could, from the standpoint of content, appropriately concern itself with any of the myriad aspects of an educational institution's total function, i.e., with anything involving academic activity or interpersonal relations. And, at least theoretically, it does. But the goals of such a service cannot be divorced from realistic appraisals of what actually can be accomplished and therefore must depend upon many limiting factors: size of the student population, size of the staff, time available, skills available, finances, efficacy of various forms of treatment, etc. In other words, a system of priorities must be set up. The general aims of a college psychiatric service include:

1. Changing attitudes of students, faculty and employers toward emotional problems from aversion, fear, or denial to understanding, tolerance, and cooperation in their management.

2. Improving relations between students and college staff for the purpose of increasing educational effectiveness.

3. Freeing the intellectual capacity of students to do creative and satisfying work.

4. Identifying and countering anti-intellectual forces which impede or prevent learning.

5. Creating a complex network of communication among all people in the institution to facilitate early discovery of signs of disabling conflict. This must be done without creating the impression that there is a spy system, even one established for benevolent purposes.

6. Participation in the coordination and integration of all counseling services in the institution to see that all available resources are available to anyone needing them. (Farnsworth, 1962).

The psychiatric service is prepared to give top priority to those students who are in acute psychiatric difficulty — students who find their emotional status intolerable and incompatible with carrying on school activities or students whose behavior is socially disrupting and necessitates treatment for their own protection and for the good of the community. Of course, such extreme cases demand a small portion of the psychiatric service's efforts; this will be discussed further below. In College Health Administration Farnsworth describes the criteria utilized at the Harvard University Health Services:

"We have found no fully satisfactory method of deciding who should get psychiatric help when the demands on the service are greater than staff members can meet, as is usually the case. Instead we have developed working rules, often compromises, that result in a reasonably fair distribution of services. They are as follows:

1. Anyone for whom the college is responsible is given care — diagnosis, recommendations for further treatment or referral, or consultation in crisis situations in which no one person is designated as a patient.

2. Short-term supportive psychotherapy is offered to members of the university. Students receive priority; we attempt to give them appropriate support in critical situations so that they can cope with them and continue to work without interruption.

3. Long-term or intensive psychotherapy is not promised to anyone; if a student needs such care, if no outside resources are available, and if the college psychiatrist has time for it in his schedule, the student may be treated intensively.

We do not believe that a student should be retained in college because treatment is available to him there but not elsewhere. If he is too ill to meet academic standards, he should be given a leave of absence to permit him to get treatment or to find other solutions to his problems; following this he may reapply for admission." (Farnsworth, 1964).

The psychiatric service provides a wide variety of services, both direct and indirect, some chiefly educative and some chiefly psychiatric, to the college community. A health service should have at least one psychiatrist for every 2,000 students. As mentioned before, choices must be made: only a service in a very large university (which implies that it is well supported and more than adequately staffed) can hope to undertake all of the following activities. And even under such circumstances there must be frequent delegation of responsibility and sharing of effort with other counseling professions.

1. Diagnostic interviews. At the least, a college psychiatric service should provide diagnostic interviews for all students who come for help, whether they are self-referred or sent by a member of the faculty or administration.

2. Referral. If it is indicated, the psychiatrist should be prepared to refer the student elsewhere for help: to a private psychiatrist in the community, to a clinic, to one of the college counselors (religious, vocational, social work, psychological), or to any other agency established for the purpose.

3. Short-term therapy. If the psychiatrist decides that the student would benefit from a short course of therapy, and if the psychiatric service schedule permits,
brief psychotherapy can be undertaken. Experience at Harvard University indicates that many students are greatly helped by five to six visits, and in fact find this small amount of treatment sufficient to enable them to carry on effectively without requiring further aid. Farnsworth states: "... the majority of students who consult a psychiatrist cannot be classified as emotionally ill according to the existing diagnostic categories, but should be seen as showing failure at adaptation at one point or another in their emotional and intellectual maturation. Early evaluation and brief treatment serves to reconstitute the normal developmental process and direct the student from socially unacceptable means of adaptation." (Farnsworth, 1964).

4. Emergency treatment and crisis consultation. Emergency treatment is probably the most dramatic function a university psychiatrist performs, and the emergency itself may require the collaboration of many different individuals associated in various ways with the university. Of such situations, Farnsworth writes:

"There are an infinite number of ways in which a troubled person may signify that he needs help. The individual is aware of some of them; some are largely unconscious. When a student (or any other person) says he is in trouble, he usually is. When behavior does not make sense to the person engaged in it, or to his friends, help is usually desirable. We have found the following principles and practices useful in dealing with psychiatric emergencies: (1) Any student who comes to the health service and states that his predicament constitutes an emergency should be considered one. (2) A situation declared by any faculty member or officer of the administration to be an emergency must be considered one. This should usually apply as well to judgments made by house mothers or other residents in the dormitories. Such individuals should know that they have this power to declare a situation an emergency and be encouraged to use it properly. (3) Urgent requests for help by physicians and nurses in the health services as well as in the local community should be honored as emergencies. (4) Suicidal and homicidal attempts or preoccupations are always to be taken seriously and investigated promptly. (5) Obviously assaultive, combative, destructive, or grossly inappropriate behavior should be considered to be evidence of a psychiatric emergency until the causes are determined. (6) In the long run it usually takes less time and trouble to respond as soon as possible to urgent appeals for help than to attempt to minimize their significance because of a desire to postpone treatment and cope with them during the regular daily schedule." (Farnsworth, 1964).

Ordinarily, college infirmaries are not equipped, in terms of staffing and physical facilities, to treat psychoses; however, they often can be used to house temporarily a psychotic student until hospitalization can be arranged. The psychiatric patients who can benefit most from infirmary care are those suffering acute anxiety states with various degrees of perturbation and panic, because supportive nursing care and a short period of isolation from the pressures of ordinary college routine often suffice to tide these students over their crises and enable them to return to work.

"The goal in crisis consultations is to attain a clear idea of the issues involved and some leads as to how they can be resolved." (Farnsworth, 1962). Crisis consultation is a particularly valuable part of the psychiatric service's function, because many students who seem to be acutely disturbed at the time they present themselves can, with the aid of a small amount of immediately administered skilled professional help, achieve rapid resolution of their crises and can thus avoid serious interruption of their academic work.

5. Consultation. Treatment is only one aspect of the psychiatric services that a college health service should provide; there are others that are equally necessary and that have the added virtue of reaching larger numbers of people. The problems involved may not be as acute, but ultimately their solution is just as important to the effective operation of the institution. There are a variety of areas in which consultation with the psychiatric service can be of use, e.g., in evaluation of applications for admission or leaves of absence, disciplinary actions, bizarre examination books, psychological term papers, library vandalism, and antisocial behavior. In all such circumstances it is not the task of the psychiatric consultant to make a decision—that is the job of the particular teacher or administrator involved—but to give whatever information or opinion is appropriate and thus avoid an injustice to the individual involved. Consultation should be available to student advisers, to student government groups which must deal with questions of cheating or violations of social regulations, and to groups whose functioning is being disturbed by excessive emotional reactions in one or more members. (In all of these instances previous psychiatric records must never be used as a basis of screening; such a practice would constitute a gross breach of confidentiality.)

6. Representing the community. The psychiatric services are an integral part of the total academic community; as such it is part of their function to protect the interests of that social body. Any community is vulnerable to antisocial acts; the degree of disturbance engendered by them will, of course, depend upon the nature of the acts and the character of the community. Conflicts that affect only the student and his therapist are the proper concern only of those two. Conflicts that are acted out and that thus have social repercussions may properly involve any or all other citizens;
these include stealing, cheating, promiscuity, drug addiction, etc.

7. Teaching. Members of the psychiatric service can participate directly in teaching. They can conduct seminars for nurses and university police in management of psychiatric problems, particularly of homosexuality; they can also tutor undergraduate research projects, particularly in the area of psychology.

Administrative Structure

A psychiatric service should always be part of the college or university health service; its chief should report to the health service director while at the same time maintaining a considerable amount of autonomy. This is necessary to prevent any breaches of confidence. However, the senior psychiatrist must always work closely with the health service director, because the latter must bear the ultimate responsibility for anything that goes wrong; often he must make major decisions about disturbed students if the psychiatrist is temporarily unavailable.

Psychologists and social workers form an integral part of the psychiatric service. In most health services their work with students is functionally the same as the psychiatrists', although psychiatric supervision or consultation should always be readily available. Some services are directed by social workers or psychologists, particularly when little psychiatric consultation is available. Occasionally psychiatrists, psychologists, and social workers have joint appointments in the health services and in a counseling service or in some other academic or research unit; these arrangements usually work quite satisfactorily.

Practically any administrative system will work if the individuals keep in mind the immensity of the tasks confronting them and use their knowledge for the purpose of getting along well with their colleagues. Even the most perfect system can be wrecked if any person in it becomes unduly competitive and strives to impress his co-workers with the greater importance of his own discipline.

Relation with Other Counseling Groups

It has been pointed out, with regard to management of emotional disturbance in elementary school children, that children in conflict are usually referred on the basis of the most prominent symptoms, rather than according to the basic causes; thus if there is excessive absence the truant officer takes charge, the disciplinary officer handles cases of "misbehavior," the social worker or psychologist sees cases of openly bizarre behavior, and children with physical symptoms see the school nurse or physician (Hollister, 1963). The result is a failure to maintain a unified approach to various aspects of emotional difficulty and a fragmentation of effort and technique. The danger of such a situation occurring in a college setting also exists. Farnsworth points out: "... students who are in emotional distress and have no recourse to psychiatric help will choose modes of expression that are not generally regarded as 'psychiatric' but which constitute clear evidence of disturbance: dropping out, academic failure, plagiarism, stealing, excessive drinking, vandalism, and inappropriate sexual behavior." (Farnsworth, 1964). It is very important that college counselors recognize such symptoms as symptoms. If they do, deans, advisers, chaplains, social workers, psychologists, sociologists, anthropologists, vocational counselors, guidance counselors, etc., can greatly increase the effectiveness with which they deal with students. In fact, in some colleges a committee of these individuals may do much of the work of a psychiatric service. If they see apparently isolated manifestations of conflict as signs of more extensive or deeper conflict, they can provide the student with much of what he needs: a clarification of the real issue at stake, and an indication of a logical and appropriate method of attempting to deal with them. These staff members should meet weekly (on a confidential basis) to discuss matters of interpersonal relations and academics (and their overlapping areas) that are relevant to the effective function of the institution. The keystone of any counseling program is cooperation among those carrying it out; competition for ultimate authority is, of course, finally most damaging to the students who need help.

Preventive Psychiatry

Much of what has already been described constitutes preventive psychiatry, but it must be remembered that prevention is still in a pioneering stage and the methods are even less clear-cut than those involved in treatment.

For purposes of discussion, prevention can be divided into primary and secondary forms. Primary prevention, as it relates to colleges, constitutes all those measures taken to influence or reduce the intensity of events or situations that are likely to produce damaging emotional conflict or to increase the capacity of students to deal with pressures or events which are stressful to them.

The secondary form consists of all efforts designed to detect serious disorders early in their course, and to reduce their intensity by early and effective treatment. It includes not only early diagnosis and treatment, but also the recognition of personality traits or forms of behavior which are precursors of later clinical manifestations, as well as the measures taken to prevent their appearance.
To paraphrase Allinsmith and Goethals (1962), the idea is not to relieve students of their responsibilities or to shield them from appropriate challenges in life, but rather to protect those who are temporarily vulnerable and to reduce the effect of truly exceptional stresses so as to avoid unnecessary frustrating and basically destructive experiences.

In the colleges and universities there are almost innumerable situations in which some type of preventive activity may be indicated. Students who come from cultural backgrounds whose value systems contrast sharply with those prevalent in the colleges they attend may need help in making the necessary compromises or changes. Disciplinary methods which stimulate further rebellion or increase hostility toward society, rather than encouraging appreciation of the need for authority and respect for it, may require modification. Peer group pressures on many campuses are sufficiently anti-intellectual to cause some students to become bored with their studies and develop apathy and general ineffectiveness. Hostility or resentment toward parents may be displaced to persons or aspects of the college and impair effective study. Social customs of fraternities and sororities may harm some students as much as they help others. These and many others form the focus of cooperative activities (among psychiatrists, deans, counselors of all kinds, and student leaders) designed to maximize the kinds of stimuli which encourage learning and the love for it and to minimize those forms of stress which only reduce both the individual's capacity to cope with difficulties and his sense of competence and self-esteem.

Training Centers

Centers that provide training in student health for psychiatrists who have completed their three years of formal residency training are few in number; judging from the applications being received by them there should be more. The University of California at Berkeley, Harvard and Yale Universities, and the Massachusetts Institute of Technology are among the few training centers, and they can accommodate only a few (three to four) trainees each year. Several institutions — the University of Wisconsin is a good example — permit psychiatric residents in their third year to work with students in the college health service under supervision of a senior psychiatrist.

Ideally, the young psychiatrist in a training center becomes acquainted with the members of the administration of the institution, learns how to aid them with their problems concerning students while at the same time observing the rules of confidentiality, covers the emergency service (including crisis consultations in the manner developed by Gerald Caplan) (1959), does brief psychotherapy with several students and more extensive treatment with a few, and attends a variety of staff meetings and conferences. All this is done under close supervision by a senior psychiatrist.

Several psychiatric services that do not have a formal training program nevertheless give good experience to psychiatrists who take regular part-time or even full-time positions in them.

References


Chapter 9

The Small College

The special problems of small colleges result from their being generally short of funds and located in areas not close to comprehensive medical facilities; in addition, in many instances there is no medical director. Most of the actual care of the students is done by nurses (who, incidentally, do an excellent job). However, students and staff in small colleges have the same health needs as those in the large universities. It is desirable, therefore, to evolve a set of principles governing the operation of health centers in small colleges.

In the first place, there should be an effort to achieve excellence in this field as in all others. This means that there should be (1) good treatment of minor ailments; (2) good counseling and cooperation between all the persons in the college who are doing counseling; (3) cooperation with other medical and health personnel in the community; and (4) knowledge about existing medical facilities so that skilled referrals can be made. In other words, what is done should be done well. A small college should not attempt to do too much.

The problems of a small college differ widely, depending upon whether the college is in an urban or a rural location and whether it is made up largely of residential or commuter students. A commuter college in an urban location has less need for a health center than has a largely residential one in a rural location. In the former, the students have their own accustomed sources of medical care which they are usually reluctant to leave, particularly if they do not recognize the effective role of a college health service. In this situation it probably is desirable to have a health service organized mainly to give complete first aid and to emphasize excellent counseling, both for physical and mental health.

The college which is located in a rural area and is predominantly residential needs a relatively large number of infirmary beds and has considerably more visits per student than the urban college. A college with 1,000 students that is located in a small town or rural area probably needs about 20 beds in its infirmary; arrangements must be made for an overflow into a dormitory or fraternity house during periods of high incidence of respiratory infections or other epidemics. It should also be expected that there will be five or six visits per student per year to the health center. It is in these colleges that particular care must be taken to identify those students who have serious difficulties and to transfer them to the nearest medical centers as quickly as possible. There will not be very many of them each year, but one mishandled case can lead to unnecessary suffering or risk to the patient and result in excessive demands on the college physician, dean, and president.

The small college is particularly dependent upon the medical facilities of the community, and this makes it all the more desirable that the best possible ties be built up between the health service staff and the local physicians, hospitals, and community agencies of all kinds. Neighboring physicians will often be called upon to handle emergencies that appear during the evening hours. It is wise to have ambulance service readily available. Most important of all, however, is the development of good relations with public officials. Sanitary supervision in college dining halls and in fraternities is always a problem. There may be some question as to the authority of the college or the local health agency to intervene, but under most circumstances the officials of fraternities are very receptive to appropriate supervision if it is tactfully exercised.

Each small college should have a physician whose task it is to think in terms of the total health needs of the college. He should be concerned with developing his staff, obtaining funds, carrying out procedures during epidemics, organizing volunteers to help during emergency periods, and he should be spokesman for the college for medical affairs in the community. He should be aware of the great contributions that health education can make, and should work closely with health educators who are on the faculty.

The important thing is to make sure that prompt and effective treatment is available for all those who need it. This does not mean that only members of the college should have this privilege, but that the college physician and other members of the college staff work for improved total care for the whole community.
Mental health programs in the small colleges are less likely to enjoy the services of a psychiatrist for a significant amount of time than are the large colleges. This makes it all the more necessary that several people in each college pay special attention, through counseling, to the acute needs of students and to methods of meeting them. If only a few hours of the psychiatrist's time is available each week, there should be much consideration given to how to use that time most effectively. It certainly will not be best utilized if he does nothing but see disturbed students. On the other hand, he should see some of them to familiarize himself with the kinds of problems that occur.

In the small college, as in the large university, a central aim in the care of students is to see that their medical needs are met and that, at the same time, they are given every opportunity to keep up with their studies if they can. This means that a health service is organized primarily around the needs of the patient — that is, is patient-centered rather than procedure-centered.

A difficult problem in a small school is the conflict between the ideal of having nurses work on eight-hour shifts, and the fact that this makes nursing care extremely expensive. Many colleges are fortunate in having nurses who live on infirmary property or nearby, and who are willing to take a 24-hour shift, which means that they will have a great deal of free time but will not know exactly when it will be.

It is no longer justifiable for a small college to rationalize a poor health service by saying that it cannot afford a good one. The time has come when the small college cannot afford not to have an efficient health service.
Bibliography


