INDEPENDENT SCHOOL HEALTH ASSOCIATION

Newsletter: Fall 1985

SPECIAL ISSUE

An R.N.'s Response to Legal Issues

Mary E. Anderson, R.N.,
Emma Willard School

The ISHA spring conference at Berkshire was well attended. The subject of the title "Managing a Health Service in the '80s" and legal issues generated much thinking about procedures and policies.

Keynoter Hugh Madden, Esq., well known in independent school circles in his professional capacity, opened the conference with a broad overview of the role of the health service in our schools. He cited his own experience as a school boy at Hotchkiss and the valuable service that a good school nurse gave him. "Health services is the heart of the community; if you find a good nurse," stated Mr. Madden, "you'll find a happy community."

Mr. Madden described the health services as the most sensitive area in a school. He cautioned that policies, rules and regulations, forms, confidentiality, responsibility, torte liability, professional standards and state and federal laws must always be in the mind of the health professional.

Mr. Madden recommended that every person working in the school be familiar with the contractual agreement that is signed by a parent when a child enters an independent school. The most complete statement on the enrollment contract is the best. The law always looks at the enrollment contract. This contract should specify an agreement to follow the rules and regulations of the schools; these rules and regulations must in turn be stated clearly in the literature that goes to parents and students before school starts. Parents sign this IMPORTANT CONTRACTUAL AGREEMENT.

What does this mean for the health services? It does *not* mean that the health personnel have "absolute discretion" in the care of a student. The school that has clearly stated policies on:

- birth control
- abortion
- hospitalization
- communicable diseases
- contingency plans for managing Aids and Herpes

is operating in the safest possible way.

Records. Each new student must have a complete health history on file. A shorter version for a returning student is all that is required. Mr. Madden stated that these forms are often incomplete for two reasons: 1) the parent does not remember, and 2) the parent does not want the health services to know.

At this point, Mr. Madden recommended that a school must NEVER allow athletic activity unless a medical form is completed and in hand at the school.

He explained the law regarding negligence, which he described as "absence of due care." Intentional negligence will result in a law suit should the patient decide to sue. The patient would, in all likelihood, win the suit. Intentional negligence is deliberately not fol-

(Continued on page 3)

Managing a Health Service in the '80s

Spring Conference 1985

Place
Berkshire School
Sheffield, MA

Faculty
Mary E. Anderson, R.N.
Richard Artessa
Ann Bliss, R.N., M.S.W.
Lin E. Bredenfoerder, R.N.C., S.N.P.
J.B. Farghnan
Hugh A. Madden, Esq.
David W. Panek, Ed.D.
George E. Ritter, Jr., M.D.

Conference Coordinator
Lin E. Bredenfoerder

To Operate a Health Services in the Safest Possible Way

DO	DO NOT	DO	DO NOT
Have an intimate knowledge and understanding of the contractual agreement signed by the *parent* upon a student's admission to school.		Know that an R.N. does have authority regarding health safety and welfare of a minor.	Overlook the fact that an R.N. does not have parental immunity in litigation. When *in loco parentis*, R.N. does *not* have absolute discretion regarding a minor's health.
Clearly state policies on: routine health care birth control pregnancy and abortion suicide chemical abuse hospitalization communicable diseases contingency plans for managing Aids and Herpes	Accept an incomplete health record. (Records are incomplete for two reasons—the parent does not remember; the parent does not want the school to know.)	Be very sure of your school's policy regarding confidentiality. Be sure that this policy is clearly stated in the school's policy book.	
Know that the safest way for a school health center to operate regarding drug abuse, suicide, pregnancy and abortion is to have a clear administrative stated policy ratified by the school's board of trustees.	EVER ALLOW INDIVIDUAL ATHLETIC ACTIVITY until a medical form is complete and on file in the health center.	Know the laws that are pertinent to minors in your state and country. There is no common law privilege for M.Ds. or R.Ns.	
Ensure that the local hospital will accept the school's medical history form.	EVER TREAT A STUDENT until the medical form is complete and on file in the health center.	Be aware that state laws regarding privileged communication *is* granted to M.D.s. An R.N. does have conversations that are professionally involved regarding medical issues. Make sure that your school has a policy that states the R.N. talks to the M.D. The M.D. makes the decision to inform the head administrator of the school.	Think that privileged communication is granted to R.Ns.
Have a clause that permits a second opinion on a policy on file when a second opinion is called for—e.g., telephone to parent before and after appointment, followed by a written report of findings. Include a clause on the medical form that states that "this authorization should remain in full force and effect as long as my son/daughter is at this school."		Have a policy made by the head administrator regarding areas of sensitivity, as previously stated.	
Know that a photographic copy of the record should stand as the original; this should be clearly stated on the contractual agreement.	Let students attend events off campus without a clearly stated school policy or signed permission from parent pertaining to a particular situation.	Educate the faculty in the privilege of communication.	
		Encourage a school policy that requires advisors to refer students to health services in cases of suicide, pregnancy, abortion.	
		Be aware that parents see health records at the elementary and secondary school levels. If R.N. notes are in the record, parents can have access.	Let students and parents read nurses' notes. *N.B.* Mr. Madden stated that to keep the records in separate files is cumbersome. Keeping nurses' notes in the health center files is permissable as long as they are not attached to the formal record.

Excerpt from Brown University Student Medical Form

TO ALL STUDENTS, PARENTS, PHYSICIANS: Please be candid on this form. This person will presumably be a resident of Providence for the next few years, and anything less than full disclosure could be mutually disadvantageous. This is a highly confidential document for sole use of the professional staff at University Health Services and **NO INFORMATION ON IT CAN GO TO ANYONE WITHOUT THE STUDENT'S WRITTEN CONSENT.** If there are questions, please contact the Director of Health Services.

MEDICAL CARE AUTHORIZATION: "I_____, the undersigned, hereby specifically authorize the Brown University Health Service and/or any authorized member of its staff, or duly affiliated consultant, to provide care in the installations of the Health Service, and for emergency treatment to be rendered at appropriate local medical facilities."

Signature of student, if age 18 or over, or parent/guardian if under 18 years of age _____

NOTE: Without this signed authorization, Health Service cannot treat the student in case of accident or illness.

A Counselor's Response to Legal Issues

David W. Panek, Ed.D.,
St. Paul's School

Much of what keynote speaker Mr. Hugh Madden had to say at the spring meeting of ISHA was of special interest to counselors. What follows is, of course, my interpretation of what he said; specific information should be obtained from your school attorney.

Mr. Madden's general topic was that of litigation against schools, with particular emphasis on liability and negligence. In many cases, the actions of a counselor in a particular situation depend very much on the specifics of that situation and are difficult to define in advance. This can leave us somewhat vulnerable to legal action if something goes awry. The potential problem increases if we are shown to be operating outside of our defined school role or at variance with established school policy.

From this it follows that liability protection, for both the school and the counselor, is linked to a careful spelling out of school policy. This is not always an easy task. There are areas, such as pregnancy, abortion, suicidal thoughts and some discipline questions, where a fixed policy may be seen by some as possibly closing off access to help for the student. An example would be a policy of notifying parents in cases where a student is given information about birth control. Would this discourage students from inquiring and thereby lead to a greater risk of pregnancy? This consequence must be considered against the possible cost to the school coming from, say, a reduction of the applicant pool if such a policy were not in effect. Thorough consultation with appropriate resources is a necessity in formulating policy in these kinds of areas.

Another relevant factor is the flow of information within the school. In general, the knowledge of any school staff member is imputed to the school as an institution. Put simply: if you know, the school knows. For many counselors, however, there is the special case of privileged communication. This depends on many factors, which differ from state to state. Counselors should check STATE law as it applies to privileged communication; this is not a matter of federal law. Essentially, this returns again to the need for clarity on who communicates what to whom within the school, which is another policy issue. This would probably include referral practices both inside and outside the school, as well.

In any case, the school's established policy should be presented in public documents that a parent of a prospective student might reasonably be expected to read, such as the catalog and the enrollment contract. Then, by signing a properly worded enrollment contract, the parent indicates that he or she accepts the policies of the school as stated. The ideal result of this is that the parent knows what to expect from the school, and counseling personnel know the established limits of their discretion.

There may be times, even with the most carefully wrought policy statements, where the counselor finds him- or herself in one position and the school in another. When this comes to light in a legal action against the school, it behooves the counselor to have personal liability insurance.

All of this may sound rather grim. When dealing with a determined and skillful prosecutor, it probably is. On the other hand, a well-thought-out policy position can have a freeing effect on the counseling staff, in that it defines limits. The presence of clear limits tends to clarify consequences, which, in turn, tends to facilitate decision making. It also provides the security of knowing that one is operating as a member of a team whose roles are well defined and whose goal is to provide the best possible environment for the growth of the student, in a context which is understood and supported by the student's parents.

DID YOU MISS THE SPRING CONFERENCE AT BERKSHIRE? on legal aspects of sensitive medical issues such as pregnancy, abortion, chemical abuse?

BE SURE NOT TO MISS the ISHA Conferences on:
Ethics and Morality
Deerfield Academy
October 11, 1985

Medical Practice for these same issues
St. George's School
April 18, 1986

ISHA considers these three conferences as a trilogy.

Reminder: CEU's available for conference participants.

(Continued from page 1)
lowing professional procedures. He then posed a series of pertinent questions: 1) Do you have a duty to your student? 2) Do you have the duty of exercising ordinary care? 3) Did you breach that duty? 4) Was there an injury as a result?

What is the standard of professional care in the eyes of the law? To act in manner as a reasonable person would—a person who is an R.N. is expected to act in a professional manner commensurate with education and experience. Nursing negligence is best described as a failure to provide such professional care.

Mr. Madden recommended that the health services of a school communicate everything to parents regarding their child's welfare. He recognized that in some areas communication with parents does not and will not take place. A referral to the contractual agreement, literature and school policies sent to the parents must state that certain information will not be relayed to parents with enough time for a parent to respond with an objection, if that is what a parent feels.

Mr. Madden concluded his excellent presentation by referring to Brown University's statement on its student health form. Brown has given its permission to publish the statement in this newsletter. *(Facing page)*

Mr. Madden emphasized that school policy on drug abuse, suicide, pregnancy and abortion must be clear and firm and ratified by the board of trustees. He reminded the audience that the R.N. is an employee of the school subject to its contractual agreement with parents and that the M.D. is an independent contractor with the school.

M.D. Position—September 1986

Full-time,
Resident School Physician

Choate Rosemary Hall
P.O. Box 788
Wallingford, CT. 06492
(203) 269-7722

Contact David B. Connell, M.D., for details

Insurance Considerations

James P. Faughnan, Jr.
Executive Vice President,
Austin & Co., Inc.

If we agree that our society contains immoral and greedy people and that our schools represent our society, then we must assume that some immoral and greedy people are going to want a piece of you and your school's hide someday.

Mr. Faughnan described his job as an insurance agent and the goal of his presentation to identify and assume some of the independent school's risks in the form of an insurance contract. The school likewise has the responsibility to avoid unnecessary risks. To this extent both the individual school and the insurance agent are risk managers.

A most susceptible and vulnerable area for litigation, the health field has seen physicians' feelings of paternal or maternal care of patients harden to defensive positions in many cases.

What is just compensation? Mr. Faughnan cited several examples of what common sense might deem excessive settlements. Having reviewed the risks and insurance coverage of 50 to 70 N.Y.S.A.I.S. member schools, Mr. Faughnan emphasized that in the many serious claims he has seen, not one has been a pure medical malpractice claim. Most claims involve injury; the malpractice aspect is usually not a part of the complaint.

The insurance provided to schools usually includes incidental medical malpractice which states:
Incidental Medical Malpractice Injury means injury arising out of the rendering of or failure to render, during the policy period, the following services:

- medical, surgical, dental, x-ray, or nursing services or treatment or the furnishing of food or beverages in connection therewith, or
- the furnishing or dispensing of drugs or medical, dental or surgical supplies or appliances.

This coverage does not apply to:

- any insured engaged in the business or occupation of providing any of the services described above;
- injury caused by any idemnitee if such indemnitee is engaged in the business or occupation of providing any of the services described above.

Mr. Faughnan noted that his company's agreements within the policy also broaden coverage to include employees and will protect them. However, he recommended that R.N.s have their own policy if there is any doubt.

Some practical concerns to consider are:

- Personal injury: libel, slander, etc., has also been interpreted to cover most psychological damage.
- "Athletic participation endorsement"—one of the most dangerous endorsements to a basic or umbrella policy.
- New exclusions for sexual or physical abuse.
- Teachers' liability should cover "all teachers," not names.
- All employees would be named insureds; this category should also include volunteers.
- Physicians should cover the school, if possible.
- An R.N.'s policy covers regardless of school policy, but some people have interpreted no cover under school policy for R.N., therapist, etc.
- All trampolines (including mini-tramps) are excluded coverage. In 1977, the American Academy of Pediatrics recommended that trampolines be barred from use in schools' physical education programs.
- Gymnastics presents the worst kind of insurance problems.
- In discussing dollar limits for school policies, the highest Mr. Faughnan has seen (in NY state) was $20 million. Most are the $10 — $15 million range. Five million dollars or under is inadequate.

Role of the Nurse in Independent School Health Services

Workshop by Ann Bliss, R.N., M.S.W.

The focus of the workshop was to promote the nurse's self-image as a professional practitioner—not merely one of the staff.

Professional Recognition:
Title—In contrast to the status of the "staff nurse" held by the majority of participants in the October 1982 workshop, current designations include:
Coordinator of Health Services
Chair of Health Education and Health Services
Dean, Infirmary Dispensary
Director, Infirmary Health Services
School Nurse Teacher
Nurse Teacher, Health Services
Chief Nurse, Health Center
Concurrent with a change in the title of the nurse has been a widespread change in the designation of the "Infirmary" to either a Health Center or Health Services. One school has a Health Lodge.

Nurses were urged to secure faculty status in order to

- Legitimize themselves to students, faculty, parents and administration
- Have more input into the welfare of students
- Represent health issues on committees concerning student life

Salary—$15,000 to 18,000 for the academic year *plus* 25–30% benefit package which should include:

- Retirement (TIAA-CREF where applicable)
- Paid vacation (4–6 weeks during the academic year like faculty)
- Health care benefits plus sick leave and disability
- Professional memberships (ANA, Nurse specialty groups, etc.) to $150
- Continuing education (1 hour per week or 1 week per year) to include paid release time to $300–$500
- Malpractice insurance

The nurse should be prepared to document both the volume and the quality of services performed as the basis for the salary/benefit package. (20 pts./day x $12 = $240/week x 36 weeks = $43,200 minus 50% overhead = salary)

Income Generation—The sources of income generated by the health services are:

- Flat fee earmarked in the tuition for health services
- Fees for services billed to parents
- Insurance reimbursement to the institution

Professional Accountability—Nurse/physician collaboration is the foundation of the school nurse's practice and provides the necessary legal sanctions which may be enhanced by:

- Standing orders
- Protocols or algorithms
- Chart audit and peer review
- Job description

Budgetary Authority or at least input should be sought by the nurse

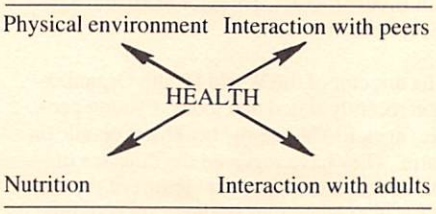
New Trends in Health Services

Workshop by George E. Ritter, M.D.
Reported by Dagny St. John, Vermont Academy

Dr. George E. Ritter amended the title of his presentation "The Role of the Physician in the Health Service" to include "New Trends." He opened his talk with the statement regarding togetherness and how its modern interpretation is encouraging the spread of communicable diseases. He referred to the early history of the school physician and the lack of follow-up care which is in sharp contrast to the '80s.

Today health care is one of the total components of well being, and health care for our adolescent population can no longer be band-aiding.

The goals of a good health program should be: (1) prevention, (2) identification, and (3) management. Dr. Ritter displayed a slide at this point as follows:



He pointed out that all four titles on the slide must be associated with prevention. A safe physical environment with a balanced, nutritious diet will encourage good relationships with peers and adults.

Within the health service group, he recommended communication and cooperation. Athletic and educational departments should be interrelated with the health services at all levels. There is no room for territorial dissention.

Dr. Ritter presented two different models for independent school health care. *INTERPRETIVE medical services* which comprises (a) programs for special needs, (b) an understandable health policy and (c) athletic medicine. In this instance the family chooses the physician; the child/family/physician relationship has continuity. This is not possible in a boarding school situation.

DIRECT medical services comprises:

School
↓
Physician → Direct Care
↓
Student

The physician needs to be a professional health advisor to students, staff, faculty, parents, administrators and health-related personnel. The physician needs to be part of the school.

School health has been "sleepy for far too long," remarked Dr. Ritter, and our schools should have an integrated health course and program. The physician needs to be an educator and catalyst whose purpose is to support the health service staff, counselors, R.N.s and athletic trainers by reviewing policies.

Dr. Ritter recommended that independent schools need to catalog more changes, e.g., birth control and pregnancy policies and malpractice policies, as they relate to the R.N. and MD.

All physicians should present evidence of liability coverage before being retained by a school. All school physicians should advise administration of a school on health matters. Dr. Ritter stated very firmly that the school physicians's role was to support the nursing staff.

The following bibliography was recommended by Dr. Ritter:

American Academy of Pediatrics Committee on School Health: *School Health—A Guide for Health Professionals*, 1981.

Duke, P.M.: *The Role of the Pediatrician in the Adolescent's School.* PCNA 27:1, 163, 1980.

Nader, P.R.: *The School Health Service, Making Primary Care Effective.* PCNA 21:1, 57, 1974.

Nader et al: *The School Health Service: A New Model.* PEDS 49:6, 805, 1972.

Senn, M.J.: *The Role, Prerequisites, and Training of the School Physician.* PCNA 12:4, 1039, 1965.

Silver et al: *The School Nurse Practitioner: Providing Improved Health Care to Children.* PEDS 58:4, 580, 1976.

Wright, G.F., and Vanderpool, N.: *Schools and the Pediatrician.* PCNA 28:3, 643, 1981.

The Changing Role of the Nurse in the Independent School/Workshop

Conducted by Ann Bliss, reported by Jenette Cooper, Berkshire School

Mrs. Bliss began by determining the background of those in attendance (23 persons in the first session; 9 persons in the second) to establish the fact that the role of the nurse in independent schools is wide and varied.

The status of a nurse in the school community is reflected not only by salary but also title and the relationship with persons in the community. It is essential that a full time R.N. have faculty status. Faculty status must include consideration of salary, pension, fringe benefits, paid vacation, sick leaves and holidays and membership in professional organizations and continuing education. Faculty status increases professional interaction with teaching faculty.

As a controller of the health center, it is imperative that you assume budgetary responsibility for your department. Be aware of health fee (whether part of tuition or separate assessment). Keep track of any income Health Service generates whether procedure-related or prescription. Identify budget needs and set up an operating base. Not only is this necessary budgetary management, but it also helps to establish a sense of real value.

The Student Health Service is central to the welfare of the child in the independent school. The role of the nurse must be on the level of all faculty and professional staff.

Bibliography

Peer Counseling, Vincent D. Andrea, Peter Solovey. Science and Behavior Books, Palo Alto 1983

The New Health Professor, Ann Bliss, Eva Cohen (ed), Aspen System Corp 1977

Modern Synopsis of Comprehensive Textbook of Psychiatry IV, Harold Kaplan, M.D., Benjamin Sadock, M.D. 1985, Williams & Wilkins, Baltimore

Common Acute Illnesses Anthony Kovmaratt, Richard Winickoff, Little Brown & Co. Boston 1977

Signs and Symptoms, Cyril MacBryde, Robert Blacklow, J. B. Lippincott 1970

Problem Oriented Primary Care, John Runyan, Harper Row, Philadelphia 1982

ISHA now presents certificates of attendance for participation in full-day conferences.

Making Paper Work for You

Mary E. Anderson, R.N.
Director of Health Services, Emma Willard School

Paper worked well for us in this workshop. In fact, through our discussion of paper, we raised many of the nitty-gritty issues that plague health personnel. To open our workshop we first discussed the entrance medical form that a student is asked to submit upon admission to an independent school. Our discussion included the following points:

Legal statement. We examined a sampling of forms and found that the forms that were simple were the best. The legal statement must include permission to treat in an emergency and permission to release health records when necessary. The form *must* be signed by parent or guardian before any treatment can be administered.

Insurance. A space for this information is very important especially when a student needs to be treated in a hospital.

Mandatory immunizations. Record with dates.
Specific questions regarding injuries to joints.
Childhood disease history.
Medications—to include specific birth control information for females.

Our discussion about the health record elicited a despairing concern of "How to get parents to return the form completed." We all felt that this was the most difficult task the health personnel face every year.

RECOMMENDATIONS:

- Get administrative support—e.g., a note to parents from the principal to the effect that after a grace period a student may not attend classes if the health record is absent or incomplete.
- No athletic participation until health record is on file and complete.
- Request only information that is useful and pertinent for your health services.

We moved from health records to a consideration of communications: with parents—by telephone followed by letter; faculty; residence staff; administration; students; food service. In these areas, most schools have developed a system for almost "trouble-free communication."

P.E. excuses and absences or tardiness to class require a brief note.

A standard questionnaire to a physician off-campus guarantees a response to the questions that health personnel need answered, before conveying information to a parent.

A discussion of procedures and policies in print ensued. Reinforced by Mr. Madden's statements in the morning, ideas for policies were many. (Marilyn Spencer from the Loomis Chaffee School has agreed to join the ISHA Council to help develop an ISHA handbook that presents guidelines for non-health personnel when dealing with the important issues of pregnancy, abortion, suicide and drug abuse.)

The difficulty of persuading adults on campus to share information with health personnel provoked a lively discussion. To this concern, I will quote a statement I made regarding confidentiality in health matters from an NAIS workshop:

"Experience has shown me that a policy that helps school personnel recognize that the confidence of a minor in need of medical help often cannot be honored, and that the recognized medical practice of a clinical conference to establish a diagnosis and find a regimen for an effective cure is not necessarily a breach of confidentiality."

One of the major difficulties at all schools is transport of students to and from M.D. appointments and to hospitals for x-rays. Emma Willard School's dean of students Judy Bridges provided our health service with an excellent plan for emergencies that occur during the academic day. Each administrative office takes on the responsibility of finding a chaperone immediately should the need arise: Monday/Business Office; Tuesday/Principal's Office; Wednesday/Development Office; Thursday/Admissions Office; Friday/Dean of Student's Office. IT WORKS!

Paper works as a means for disseminating information to students. Health Notes and Food Flash Cards for the dining room table are now available through ISHA publications.

All in all, what appeared to be a pedestrian subject turned into a productive workshop. Paper works well.

From Infirmity to Health

Lin Bredenfoerder, Director of Health Service, Berkshire School

The director of the World Health Organization recently stated that today's young people, ages 10–24, are the healthiest people on earth. They have survived the illnesses of childhood and are not yet victims of the diseases of old age. Our students are certainly beneficiaries of the progress which has been made in medicine. Along with that progress in medicine must go progress in the way in which we provide health care.

Huge infirmaries are no longer necessary and nurses should assume more responsibility for patient care, teaching and counseling. There are several reasons why infirmaries are no longer necessary.

First, they are out of date. Large infirmaries were built when epidemics of childhood diseases were common, such as polio. As long as our students are fully immunized against polio, we need no longer admit them to the infirmary when they have a cold as a precaution against polio. Similarly there was a dramatic reduction in the number of cases of measles, mumps, and Rubella after the live virus vaccine came into use.

Strep throat is another illness which accounted for many infirmary admissions. Tests are now available which you can do in your office in minutes to tell if a student has strep. You no longer need to wait 4 days to get the results back from the state lab. Quarantine regulations no longer require that a student be admitted for the duration of the illness. If treatment is continued for 10 days, students need only be quarantined for the first 24 hours.

The overall illness rate for adolescents has declined steadily since the turn of the century. The only number which hasn't dropped is accidents, which is the #1 cause of death in the 15–24 age group.

The infirmaries which were built in the '30s, 40s and 50s are now empty much of the time. That costs money. Our business manager tells me that it cost $50,000 to create a new Health Service office with 6 inpatient beds and to convert the old infirmary into a 30-bed dormitory. There has been no increase in fuel or electricity consumption since we have been in the building, and the new dormitory brings in more than $200,000 in tuition annually. You may not be able to make as dramatic a change, but you should be able to turn unused beds to your advantage by trading those beds for other space which you need.

Infirmaries are no longer necessary because the delivery of health care has changed. Today the emphasis is on becoming healthy and staying that way. If not an infirmary, what? The alternative is the Health Service. In the health service the nurse need no longer be the "band-aid lady." She should expand her role in prevention, health care, patient teach-

ing, counseling and nursing diagnosis. The nursing staff can be used more effectively. For example, if there are no inpatients the nurse on duty can be "on call," but not necessarily in the health service office.

Students would still be admitted for quarantine: strep, chicken pox and other contagious diseases. They would also be admitted for observation, for example, after a head injury or fracture and at the discretion of the nurse and/or physician on duty.

Once you've decided to make the change to a health service, how do you go about it? This process should involve the nurses and the school physician. If it doesn't, it won't work. First look at your situation. Are there ways that it could be improved by change? Don't be afraid to at least consider "off the wall" ideas. Look at your building. Is there space which isn't being used efficiently? Inpatient rooms, examination areas, office, storage, kitchen, housing. There may be areas where you can give up space and other areas where you need space.

There have been advances in medical care. How many of them are you using? Do you obtain a history and do an examination when students come to your office? What type of laboratory tests do you perform in your office? Once the diagnosis has been reached how do you figure out what to do about the problem? How do you keep track of what you have done?

We do histories on all students who come to us. The history includes current complaint and past medical history. We have taught new staff members our examination skills. For example we use an otoscope for examining ears and a stethascope to listen for heart and lung sounds. We created a lab equipped to do throat cultures, urine cultures, urine dip tests, specific gravity, stools for occult blood, mono tests and pregnancy tests.

Next we wrote a series of protocols for problems which we see routinely in our office. Protocols should be written by the people who are going to use them. If you want to "cheat," there is a book on the market which you can use as the base for the protocols and then add your own personal touches where needed.

Finally we completely changed our record keeping system. The type of nursing notes which we learned to write in nursing school weren't adequate. All of us—doctors and nurses—needed to be using the same format. We decided to use Dr. Weed's SOAP approach to charting. This clearly documents Subjective information—what the patient tells you; Objective information—what you observe with your 5 senses; Assessment—what you think the problem is and; Plan—what you're going to do about it. If you've never used SOAP notes, be aware that they will be troublesome at first, but you will find that they're far superior to the old ways of charting, especially when more than one person may see a student who comes to the office.

When students are too ill to go to class but do not need to be admitted overnight there are two options. First we can keep them in one of the SHS beds for a period of observation. Or we can send them back to their own rooms. This is called a room stay and deserves an explanation. When we first considered revamping our infirmary, a consultant suggested that we eliminate all inpatient beds and send any students who were ill back to their own rooms. We felt that this was too radical a step and not one with which we were comfortable. There are some illnesses which need quarantine, some situations which need nursing care and some which need some plain old TLC.

We did decide to pursue the idea of sending students with certain problems back to their rooms after they had been evaluated. An example: a student complains of GI symptoms. The examination is negative. After several hours of observation he is no longer vomiting or complaining of stomach pain and is able to retain clear liquids. He is not in any shape to attend the remaining classes or sports so we send him to his room. He is restricted to his own room, the bathroom on his corridor or the faculty apartments in his dorm. No visitors are allowed in the room. Violation of room stay is a steep offense. Room stay lasts until 7 a.m. the next day. A note is sent to the person on duty in the dorm listing who is on room stay each day. The nurse on duty checks on the students who are on room stay at some point during the day. Students who have GI upsets are given diet instructions and Clear-Soft solid foods to eat for the next 24 hours. Students who are not on restricted diets receive meals from the dining room.

There are several advantages to having students in their rooms. I find it very helpful to see what students' rooms look like. When I visit a student who is coming in daily with one complaint after another, and it's the 4th week of school and he hasn't put up any pictures or put out any personal belongings in his room, I have a major piece of information to consider in his care. I know that even though he denies being unhappy here he certainly doesn't look as if he plans to stay.

We also have found that no matter how many beds we have it won't be enough if we have an epidemic. We have a plan in place for sending students to their rooms. We have not found our incidence of illnesses to be any different since we went to a roomstay policy for selected illnesses.

Traditionally school nurses took care of inpatients, often cooking meals, changing beds and admitting any student who arrived at the door saying he was ill. Students who were injured were bandaged up and removed from participation until they could prove to their coach that they could play again. That return often depended on how much the coach needed his player. When there are inpatients, the nursing role should still involve patient care. It should also make use of improved skills of observation and use the protocols to provide care and education. Care of outpatients involves interviewing, diagnostic skills, patient teaching, anticipatory guidance and counseling.

As we reorganized the health services, we added a full-time certified athletic trainer who is responsible for prevention and evaluation of injuries, referral to the school physicians and rehabilitation. He is also involved

(Continued on page 8)

Letter on Insurance

Richard A. Artessa, Peerless Insurance Company

Dear Mary and all Members of the ISHA Council:

First of all, thank you for your invitation to participate in your spring conference and act as your broker of record for the ISHA Student Health Insurance Plan.

The final enrollment figures are as follows:

Schools enrolled by written authorization		Schools enrolled verbally by phone	
Cambridge	- 115	Berkshire	- 105
Dana Hall	- 65	Emma Willard	- 30
Darrow	- 150	Miss Hall	- 200
MacDuffie	- 255		355
Millbrook	- 55		
	640		

Net Total = 975

These are the only schools that notified me directly. Incidentally, we did receive one formal "no" response, that being Choate Rosemary Hall.

As I have already indicated, I am disappointed by the response but understand many of the schools' time problems. However, I firmly believe that the groundwork had to be done and that interest is still very much there for an insurance program. I would be very much interested and honored to be able to re-present a program, this time in the fall. If I can be of any further assistance please let me know.

(Continued from page 7)

in the health education of our students and coaches.

The student health service office is open from 6:45 a.m.–7:35 a.m. for walk-in visitors. It is open for appointments and emergencies from 7:35 a.m.–2:05 p.m. The training room is open from 2:00 p.m.–5:00 p.m. One of the 2 RN's is on call from 5:00 p.m.–6:45 a.m. There is also a full-time counselor who is part of the health service staff. She works with a psychiatrist for back up much as we work with the school pediatricians.

This brings us to the role of the physician. Before the change to a health service our physician was on campus only for the home varsity football games each fall. His office was 10 miles away where he would see students when necessary. One of the changes in our reorganization was to have the physician on campus more. He sees students for 2 hours twice a week at their request or on referral from a nurse or the trainer. His presence on campus gives us an opportunity to discuss cases and see students together.

He is no longer on campus to cover athletic events. Varsity football games and all other athletic contests are covered by EMT's. This is legal in Massachusetts. Before you make this move, check with your lawyer regarding what is required. Bob Duchardt, the athletic trainer, Mary and I are all EMT's. We have found that the EMT training is excellent preparation for care of students in case of an emergency. The training which EMT's receive goes beyond that given in first aid classes and gives us the knowledge we need to deal with a situation BEFORE it gets to the emergency room. I highly recommend it for your own peace of mind even if you aren't going to provide coverage for athletic events.

Routine Treatments for Shin Splints

L.W. Flagg, Jr, RPT, ATC
Therapist and Trainer
Phillips Exeter Academy

Shin splints is a catch-all phrase for lower leg pain. There are many causes of leg pain and examination at Health Services is recommended. A variety of exams, including x-rays, may be used. Treatment may vary depending on the findings.

However, for the common irritation the following has proven the most beneficial.

1. Start aspirin (not Tylenol)—two tablets with each meal and at bedtime to help reduce inflammation. Continue for one week.
2. Take hot whirpool 10–15 minutes daily; best time is just before your sport.
3. After your whirlpool, be sure to stretch legs well.
4. Foam rubber pads inside the heels of your sport shoes are helpful.
   Special SORBOTHANE pads may be obtained from podiatrists, orthopedists and some sport stores and training rooms.
5. Taping lower legs has been found to make the condition worse in many instances and should be avoided. Tape may restrict tendon function.
6. Ice applied AFTER sports is helpful in reducing irritation.
7. Report back to Health Services in one week.
8. If legs are too painful for running, a daily swim is advised in place of regular sports.

Once you've evaluated what you have and have decided what you want to do, you'll probably want to ask for suggestions from faculty, administration, and students. Take your ideas to the headmaster, business manager, and/or treasurer. Once you have decided what changes you are going to make, you need to do some PR work to inform the trustees and the parents. We used a letter at the beginning of the school year which told people what we were trying to do and introduced them to our new health form.

Emphasis on illness is no longer valid and it does students a disservice. Students need to know what is wrong with them. They need to know what they should and should not do to become healthy, and what they ought to do to remain healthy. Today's health service center goes a long way in meeting this important need.

Health Education in the Curriculum

By Nancy Cushman, M.S., Ed.S.
Counselor, Emma Willard School

The curriculum instituted at Emma Willard School in September of 1984 introduced a one-semester health and interpersonal relations course in the health, physical education and recreation division required of all tenth graders and open to freshmen. Prior to this, the Health Services provided health education through school assemblies, voluntary evening programs, printed material posted in the dorms and occasional 40-minute classes in conjunction with physical education. This approach was not reaching the majority of our students. Underlying it, too, was the message that health education was less important than traditional learning. This approach has not been abandoned; it has been augmented by the new requirement. Much continues to be done informally by the nursing staff while treating students.

As many of our students have had short health courses in junior high school and some health-related topics are covered in our biology classes, we wanted to create a syllabus that would complement prior learning. The emphasis of the course was to be on both physical and mental health stressing the close relationship between the two. A woman from the physical education division with health education background and I, as the school counselor, were appointed to design the new course. Our first task was to overcome student resentment that another required course had been added to their academic career and student perception that knowledge in this area was not "academic." The onus was on us to create a course that was relevant to students and which freed them to talk about personal issues.

We decided to choose a credit no credit grading system rather than letter grades to encourage risk taking. The Random House college-level text, *Life and Health* by Levy, Dignan and Shirreffs was selected as a primary text. Unlike high school texts, it does include information on human sexuality, yet the reading level is appropriate for our students. The "activities" included in each section are excellent motivators for student discussion. *Changing Bodies, Changing Lives,* edited by Ruth Bell (Random House) will be used next year as a complementary text.

The use of speakers, films and hands-on materials has helped to overcome student prejudice against health in the curriculum. Speakers were invited to address the topics of suicide, rape and death. Next year we plan also to invite a therapist to speak about depression and a female physician to explain holistic health concepts. Each speaker is asked to talk about her profession, thus introducing in a small way career education. Films or filmstrips augmented reading in the areas of stress, birth, sexually transmitted diseases, vaginal examinations and aging. Samples of various birth control methods were purchased from Planned Parenthood and each student was asked to prepare a "commercial" on one method.

Readings on diet, nutrition and weight management were combined with discussions of anorexia and bulimia. Chapters on emotional health, stress and suicide were paired with teaching basic listening and responding skills to provide tools for coping with these problems; use of these skills is encouraged in class discussion throughout the year.

We spent less time on cancer, cardiovascular and infectious diseases and reproduction, as much of this material is covered in biology. Schoolwide participation in the Freedom from Chemical Dependency program meant less class time on drugs, alcohol and smoking. The largest amount of time was spent on human sexuality encompassing contraception, sex roles, values clarification, marriage and alternative lifestyles. The students seemed least interested in consumer health and self-care, topics we believe are vital to the course. We hope to invite speakers or plan a field trip to an area health maintenance organization in future years.

The list of topics is endless; those chosen seemed most relevant to our school population. Student reaction predictably has been mixed, but more positive than negative. The girls openly admit to saving homework for this course until last yet believe they have learned valuable information. Our highest marks came in the affective realm. As one student concluded, "She [the teacher] was open and acted like another peer, instead of a teacher. The class was like a rap learning session, not as much like a class/teacher situation. This way was better."

The Question of Gender

Charlotte Gifford, Vermont Academy

"Eve—Apropos de Rein"
It is not fair to visit all
The blame on Eve, for Adam's fall;
The most Eve did was to display
Contributory negligé.

Oliver Hereford

It was a joy to be present at this year's NAIS conference. There was a real sense of excitement, so many things going on, so many lectures to hear. What was perhaps most thrilling was that all of the above could be said of one particularly important area: gender issues. Such a large number of related sessions on the topic were going on that it wasn't possible to attend them all. Admittedly frustrating, but clearly indicative of great progress!

A salient feature of the conference was the terminology used; these were not only "women's" or "feminist" issues (although they certainly have an effect on females!). The label "gender issues" more clearly shows to my mind that the well-being of both sexes is at stake. Throughout the various sessions I attended, I was encouraged by what I perceived as an offshoot of this change in nomenclature. Given the quite different positions and roles of men and women in our society and schools, many speakers pointed out the need to blend characteristics and styles of each so that both may benefit.

I was still aware of those at the sessions who were skeptical, perhaps wondering what this "gender issue" business had to do with them, their schools and their classes.[1] But I left with a positive feeling of direction, having seen a lot of progress, as well as some areas needing change and some good thoughts on ways to implement it.

[1] "Amos, amas/I love a lass,/as a cedar tall and slender;/Sweet cowslip's grace/Is her nominative case/And she's of the feminine gender." (John O'Keefe)

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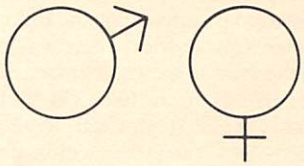


Pelvic Inflammatory Disease (PID)

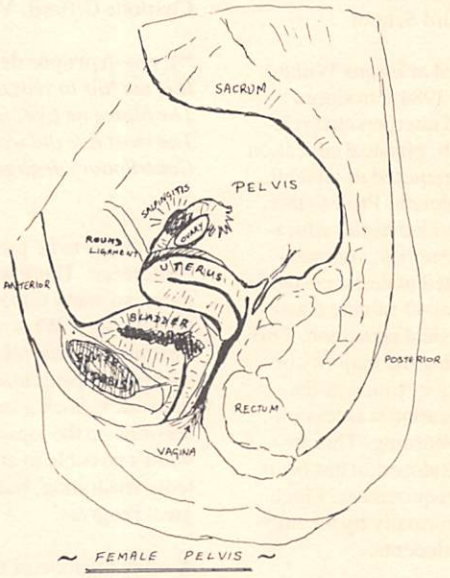
David B. Connell, M.D.
Medical Director
Choate Rosemary Hall

A 17-year-old was admitted to the school infirmary complaining of right upper quadrant abdominal pain. This started the previous week. She had a normal white count and differential, but her sedimentation rate was noted to be 41. There was no explanation for the pain. She was admitted then to the local district hospital. She was suspected of having cholecystitis. Testing, which included an ultrasound and a scan, showed no abnormality of her gallbladder or kidneys; however, her sedimentation rate was noted to be 68. She was discharged with no cause for her pain having been found—it was postulated as being due to a "viral infection." Though she became afebrile, her abdominal pain continued to come and go, and so the school physician arranged for her admission to a nearby university medical center.

Her periods were normal. She had no gynecological symptoms, though she was noted to have had sexual intercourse three months before admission. However, a cervical culture grew hemophilus vaginalis, 4+. The diagnosis was finally made by means of a laparoscopic examination. This showed dense adhesions surrounding the Fallopian tubes, uterus and ovaries. There was also filmy adhesions on the undersurface of the ribcage, diaphragm and liver. On this basis, a diagnosis of Fitz-Hugh-Curtis Syndrome was made. This is an inflammation of the liver capsule and is a complication of pelvic inflammatory disease. Despite intensive courses of intravenous antibiotics and another hospital admission, it took three months for the complications of the PID to resolve.

This difficult illness, both for the patient to endure and for the medical staff to diagnose, focused our attention sharply on PID and the complications thereof.

Pelvic inflammatory disease is an infection primarily of the Fallopian tubes; it may also involve the ovaries, uterus, cervix and other intraabdominal structures. PID increasingly is being encountered among adolescent women. Because intercourse is occurring at a younger age, we are seeing more sexually transmitted diseases (STDs) in students of high school age. In America, Chlamydia trachomatis is the most common STD. PID is caused by Neisseria Gonorrhoeae, Chlamydia trachomatis, genital Mycoplasma and other bacteria including anaerobes. IUDs are associated with a higher incidence of PID. Adequate contraceptives can diminish the likelihood of contracting STDs and PID.



~ FEMALE PELVIS ~

However, the younger adolescent quite frequently has intercourse without adequate contraceptive counseling. This is one of the reasons for PID being prevalent between the ages of 15 and 20 years. In one series of acute salpingitis cases, in those females under the age of 20 years, 60 percent of the patients had positive Chlamydia cultures.

Symptoms
PID symptoms include lower abdominal pain, intramenstrual spotting, low back of leg pain, fatigue, weakness, mallaise and intermittent fever.

Diagnosis
As well as the history of the present illness, information should be obtained about sexual activity, menstruation and contraceptive use.

Work Up
The work up should include a pelvic examination to look for signs of inflammation and to gather the following specimens:

A. Wet preparation of cervical secretions
B. An endocervical smear for gram stain or fluorescent antibody testing
C. An endocervical swab for culture for Gonococci and Chlamydia (culturing for Chlamydia is not easy; you should discuss with your local laboratory what procedures are necessary)

Bimanual examination for masses and cervical uterine tenderness must also be done. Lastly, check urine for GC, Trichomonas and other bacteria.

Examination of sexual partners may be advisable.

Treatment
Which antibiotics are used depends upon the causative bacteria; consult the experts.

Conclusion
Pelvic inflammatory disease is becoming an increasingly important complication of STDs in the adolescent population. Chlamydia is the most common STD in the U.S. Infertility is a most possible consequence of PID.

Further information can be obtained on page 502 of the lastest edition of *Our Bodies Ourselves* by The Boston Womens' Health Book Collective and "Pelvic Inflammatory Disease" by Smith and Eschenbach, "Clinical Pediatrics," Vol. 19, No. 12, December 1980. Syva and Abbott Laboratories also have information available.

The Choate Rosemary Hall Medical Services have started a GYN clinic for students at school. We would be interested in talking with other schools to compare experiences and learn from each other. If you are interested, please write to the ISHA Newsletter Editor.

Soaps

Dr. Mark W. Wolfe, Resident in Internal Medicine and Dr. Edward L. Parry, Staff Dermatologist, Kessler USAF Medical Center

Soap—a compound of fatty acid with an alkalie, used for cleansing purposes.

Ever since the Phoenicians first invented soap 2300 years ago, man has benefited from the pleasure of using soaps to produce a feeling of freshness by removing grit, grime and grease. With our emphasis on personal hygiene and pressure from Madison Avenue, soaps have become an increasingly important commodity. The average American uses 28 pounds of soap and detergents yearly. However, soaps are more than just a luxury. In addition to making us feel fresher, soaps also have been instrumental in decreasing the rate of skin infections.

Soap is produced through a chemical reaction which combines selected fats and strong alkalis (lye is one such strong alkali). This is usually accomplished by boiling the fat and alkali in large vats. The quality and texture of the soap is controlled by the careful blending of animal and vegetable fat mixtures. Milling is the process whereby the dry boiled soap is ground and cut into bars. Perfumes and coloring are added to the soap prior to milling.

The ability of soap to cleanse us is dependent on the basic ability of soap to break up and remove the oil and grease that binds the dirt to our skin. The alkalis in soap actually draw the dirt from the surface of our skin and suspend it in water. While removal of the dirt is what we are trying to accomplish, the oil and grease binding it to the skin are also removed. If the natural oil of our skin is removed more quickly than it can be replaced, our skin will become dry, flaky, red and irritated. The drying action of soaps is worse during winter, and in areas of low relative humidity. Soaps also work more efficiently in soft water. Residual soap, perfume and/or the antibacterial chemicals added to certain soaps can further irritate dry skin.

The decision as to which soap to purchase is often difficult. In addition to numerous claims about soap's ability to get us going, keep us clean and fresh and make us more appealing, there exists a vast array of shapes, fragrances, compositions, milling techniques and specialty features. Basically, there are six types of soaps:

1. *Milled soap*. The most common product with perfume or coloring added before a single milling, after which the soap is compressed, cut into bars, stamped and packaged.

2. *Multi-milled (French) soap*. These have decreased alkalinity secondary to repeated milling and careful control of the chemical reaction. The moisture content is lower, and high quality perfumes are used.

3. *Floating soap*. These have a higher moisture content and float secondary to trapped air within the bar. They tend to shrink rapidly during use.

4. *Super-fatted soaps*. These are designed to produce a characteristic "feel" and improved mildness by depositing a thin film of oil on the skin surface.

5. *Transparent soap*. These contain 10% or more glycerine and thus produce an emollient feel after use. Secondary to their tendency to lose water, these soaps must be wrapped in a plastic wrapper.

6. *Special soap*. These range from soaps with abrasive granules to soaps containing germicides.

In addition to the large assortment and different qualities that must be considered when selecting a soap, it is apparent that the consumer must be aware of the effects of soap on skin and the difference between soaps in terms of producing these effects. Over the past 40 years there has been a realization that soap, while generally helpful, can cause or worsen certain skin conditions. In the past it was common practice to implicate soaps as the cause of most all hand eczemas. Recent studies support that there is an effect on the skin by soap, but that there are differences among soaps.

As is the case with all irritants, it has been found that there is a large variance in an individual's response to soaps. By studying 18 soaps using a test called a "soap chamber test," it has been found that these soaps can be ranked according to their overall irritancy. This is measured by their ability to produce redness, scaling, and cracks in the skin. It has been found that Dove is one of the mildest soaps available, and that Zest, Camay, and Lava are among the most irritating. The remainder of the soaps fall between these two extremes.

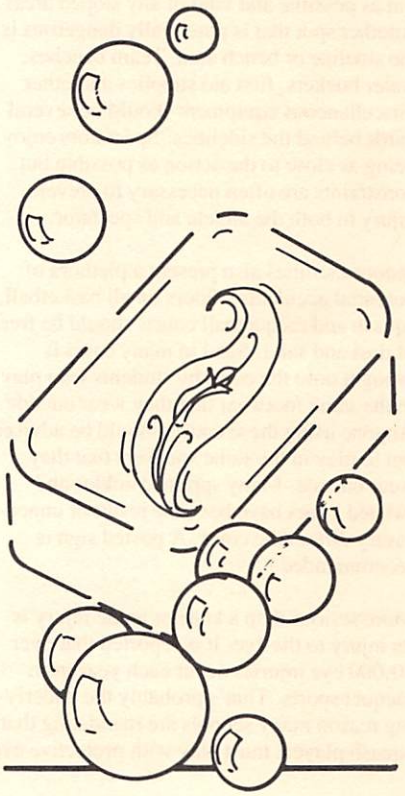
In addition to selecting soap carefully, one must also consider the type of skin to be cleansed. With infants, for example, a minimum of soap needs to be used, and tepid water by itself frequently makes the best bath. Special care must be paid to the diaper area, of course, avoiding soaps when redness exists. In the preteen years, soap can be used more liberally as the sweat and oil glands operate more efficiently. In the teens, when the oil glands are at peak function and acne is a problem, washing the face two or three times daily can be helpful. However, in the older adult and elderly, the oil gland activity of the skin diminishes steadily, and frequently soaps induce more drying than is desired. It is recommended that soap cleansing be confined to the skin folds, such as armpits, genital areas and toes. Individuals with atopic eczema, and other skin sensitivities need to use mild soaps and decrease the frequency of bathing. Application of an emollient immediately after bathing is helpful in avoiding dryness of the skin.

An emollient is any agent that helps soften the skin by trapping in water. The "best" emollient is the one that is cosmetically acceptable and used frequently. An inexpensive emollient that is used frequently may be just as effective as a more expensive or exotic preparation. A partial list of popular emollients follows:

Neutrogena	Purpose	Alpha Keri
Vasoline	Carmol	Lubriderm
Nivea	Eucerine	Clo-cream
	Petrolatum	A & D Ointment

The following is a list of soaps in decreasing order of mildness as determined by the "soap chamber test." The lower the number on the right, the milder the soap.

1. Dove	0.5	10. Lowila	3.2
2. Aveenobar	2.2	11. Jergens	3.3
3. Purpose	2.3	12. Lubriderm	3.4
4. Dial	2.4	13. Cuticura	3.9
5. Alpha Keri	2.5	14. Basis	4.0
6. Fels Naptha	2.6	15. Irish Spring	4.0
7. Neutrogena	2.8	16. Zest	6.1
8. Ivory	2.8	17. Camay	6.4
9. Oilatum	2.8	18. Lava	6.4



Safety Considerations in Athletic Programs

David Anderson,
Head Athletic Trainer
Choate Rosemary Hall

Why wasn't the goal post properly padded? Why wasn't the catcher wearing a throat protector? Why was there a hole in the middle of the soccer field? Unfortunately, it's questions such as these that many times don't get asked until an injury has occurred to an athlete or class participant. Safety in any athletic program must be a paramount concern. The worst type of accident is always the one that could have been prevented.

Ensuring that our gymnasiums, playing fields, hockey rinks and other areas of recreation and athletic competition are safe is something that cannot be overlooked. An open line of communication between the ground crew or maintenance team and the athletic department is crucial in establishing necessary environmental awareness. Each athletic season should begin with a thorough inspection of areas being utilized. This inspection should be done by a member of the athletic department and a maintenance worker who are both familiar with the particular facility.

Outdoor fields should be checked for holes, broken glass and other small debris that could lead to an injury. Every effort should also be made to ensure that the fields are as flat as possible and void of any sloped areas. Another spot that is potentially dangerous is the sideline or bench area. Team benches, water buckets, first aid supplies and other miscellaneous equipment should be several yards behind the sidelines. Spectators enjoy being as close to the action as possible but constraints are often necessary to prevent injury to both the athlete and spectator.

Indoor facilities also present a plethora of potential accidents. Floors on all basketball, squash and racquetball courts should be free of dust and sand. Sand in many cases is brought onto the court by students who play in the same footwear that they wear outside. Anyone using these courts should be advised not to play in the same sneakers that they wear outside. Many sprained ankles and twisted knees have been the result of unnecessary dirt on the court. A posted sign is recommended.

More serious than a knee or ankle injury is an injury to the eye. It is reported that over 10,000 eye injuries occur each year from racquet sports. That's probably the underlying reason many schools are mandating that squash players must play with protective eye wear. Players with vision problems may want to play with eye glasses; however, this should not be allowed if they have glass lenses. Safety prescription glasses can be made which are shatterproof and scratch resistant.

A periodic check for loose boards, nails and other abnormalities should be done at least twice a year. Other danger areas are the walls at the end of a basketball court. Players often crash into them after a driving lay-up. These walls should be protected by padding which is at least an 1–1 1/2" thick. Portable basketball stands must likewise be protected. A good rule of thumb is any immovable or hard object which is in close proximity to the action must be padded. A good example of this is the metal standards in volleyball. Players can very easily collide with one of these standards and if not padded a serious injury could result.

No discussion on safety would be complete without mentioning certain precautions which are necessary in maintaining safe and reliable equipment. All equipment should be checked at least twice a year. A good time to do this is at the beginning and end of each new season. Special attention must be paid to all head gear. Football helmets must have a NOCSAE seal of approval before being used. After the season it's advisable to send all helmets out to be reconditioned. Often a helmet may have a small crack which is difficult to detect by eye. Once the helmet is tested, however, the crack will show up. Hockey, lacrosse and baseball helmets must also be checked with an equal amount of care.

A complete and thorough record should be kept which outlines the date the equipment was bought, the dates of any reconditioning and the dates of annual checks. If the equipment lists are broken up into specific sports, it will make any paper work much easier. This record keeping facilitates long range budget planning but more importantly helps to maintain safe equipment.

Finally, any athletic department must ensure that all indoor facilities are locked when not in use. Swimming pools and hockey rinks present the most serious problems when used improperly or by unauthorized personnel. Any time a facility is open there should be at least one staff person present to handle any problem or accident. No one should ever be allowed to swim unless a certified lifeguard is on duty.

It's encouraging that so many of our students are involved in some type of exercise or athletic competition, but let us never forget that safety is an area where we can't afford to compromise.

Safety in the Science Lab

Lynda M. Blankenship
Emma Willard School

Nowhere *more* than the science laboratory does the adage "an ounce of prevention is worth a pound of cure" hold true. Self-reliance is gained in the doing of science experiments but an unexpected accident or an adventurous extension of experimental procedures often presents students with situations where ingenuity and common sense are found lacking. Instructors must anticipate and educate in these matters.

All laboratory classes should begin with the fundamental "safety precautions speech" usually delivered before students have had time to acquaint themselves with the peculiarities of the laboratory furnishings much less the exotica the teacher is rambling on about in tonal pitch of a misplaced flight attendant.

Teacher attitude forms student attitude. Our first commitment is to improve our attitude and our transmission of the basic safety information.

General awareness of the location and use of such equipment as eye wash stations, fire blankets, sand buckets, safety showers, gas cylinders, chemical storage areas and circuit breakers should be part of the students' inventory of his/her lab equipment. Old standby awareness such as "hot glass looks like cold glass" and "always read the label *before* using a reagent" must be repeated often.

A safety-conscious instructor:

- properly stores and handles flammable materials
- advisedly deals with chemicals corrosive to the skin and eyes
- habitually avoids closed glass containers for rapid reactions
- promptly inventories chemicals
- carefully disposes of chemicals whose shelf-life has expired
- regularly replaces damaged or faded reagent labels
- skillfully and appropriately uses first aid equipment.

Although these guidelines reduce many immediate problems to distant probabilities, lab-to-lab warnings and instructions must be included as need arises.

Safety is a continuous concern and thus certain features should be followed at all times:

- No working in any lab without an instructor present.
- No food or beverages in the laboratory and/or science facilities.

(Continued on page 13)

ISHA at NAIS

Cari J. McCartan, ISHA Executive Secretary

For the first time ISHA was formally represented at the NAIS annual convention in March of this year. ISHA President Mary E. Anderson and ISHA Consultant Ann Bliss were workshop presenters. We hope in a future article to highlight Ann Bliss's excellent presentation on counseling models. It provoked a great deal of controversy and inquiry from workshop participants.

This article, however, considers Mary's talk entitled, "Health Services in the Independent School: Caring Properly for our Teenagers." Mrs. Anderson underscored the vital role filled by a school's health services. "Health services are at the hub of the domestic life of today's students," she emphasized.

She overviewed the transition from the old notion of infirmary to the health center of the '80s. "The old style infirmary," she stated, "with its rows of beds is obsolete. The old school nurse—so good at the bedside—is dead."

She suggested a direct connection between this upheaval and that in our society at large. Today's students reflect a changing society whose hallmarks include the breakdown of family life, the lessening influence of religion, sexual and chemical revolutions and a shrinking global village living under the threat of self-annihilation.

Almost unknown in our school population 10 to 15 years ago are some major threats to adolescent health today: venereal disease, pregnancy, abortion, drug abuse, suicide and depression. Tragic statistics are all too easy to obtain. For example, in 1983 a million teenagers became pregnant; of the 600,000 who gave birth, 2 out of 3 were not married. A 1985 research study charts 96 pregnancies per 1,000 among 15–19 year-old American women (compare this to Netherlands 14/1,000, Canada 44, England 45). In the last 25 years the number of teenage suicides has tripled to 5,000 per year. For every completed suicide, there are 50 to 100 attempts.

Society's infatuation with health and appearance is another factor affecting adolescent health care. "We are exhorted to jog, exercise, weigh, eat certain foods, avoid others, choose between pharmaceutical products all claiming extraordinary results," stated Mrs. Anderson. Today's adolescent, reared by the media, tries to follow *all* the rules, as contradictory or illusory as they might be. "They need reassurances," added Mrs. Anderson, "that it is normal to have acne, to be a little overweight, to have hair that does not bounce and teeth that are slightly crooked. The adolescent response to this insidious and continuous hidden stress is manifold: to deny themselves food; to feel guilty when, after denial, they 'pig out'; to diet and exercise to the point of exhaustion and in extreme cases to develop anorexia or bulimia—both diseases almost epidemic these days; to experiment with bizarre hair styles and make-up; to dress behind sloppy unattractive clothing; to become hopeless; to get stoned; to feel depressed; to feel suicidal."

Mrs. Anderson also considered parents' and students' expectations of the school health center. Parents want the best medical attention for their child; they sometimes will interfere with an established regime of treatment; others do not want to be involved at all. Students share parental expectations with one exception: they want strict confidentiality, especially on those matters pertaining to sex, drugs or emotional needs.

Today's school health team needs, "R.N.'s with experience in adolescent medicine and counseling; a school counselor who is a psychiatrist, psychologist or psychiatric social worker; a physician; an athletic trainer. Above all, each member of the team must have an interst in and understanding of this generation of adolescents.

"The director of this team must be able to coordinate those persons on campus who are involved in the life of the student. The director must know when, where and to whom students can be referred when campus resources are exhausted."

Some guidelines for school health personnel:

1. Professional standards of nursing skills and ethics must be maintained at all times.
2. Decisions and diagnostic screening must be based on professional knowledge of (a) federal, state and county laws, (b) school rules and (c) R.N. professional limitations by law. The health professional with a solid understanding of these matters will help protect the school and other members of the health team from lawsuits.
3. The health person must establish and put in writing practical procedures to be used in the case of such emergencies as suicide, overdose of chemicals, severe accident or sickness.
4. The health team needs to develop a policy with regard to confidentiality. Experience has shown that school personnel must recognize that the confidence of a minor in need of medical help often cannot be blindly honored. *The recognized medical practice of a clinical conference to establish a diagnosis and find a regimen for an effective cure is not necessarily a breach of confidentiality.*
5. The health professional must be able to teach students those life habits that are not taught in the classroom.
6. The health professional must be able to communicate with outside agencies when appropriate.
7. The health professional must be involved in the life of the school and be apolitical and nonjudgmental. He or she must maintain the traditional role of helper and counselor and at all times remember that the majority of patients on the campus are adolescents with specific needs.

Mrs. Anderson also listed outside resources that can provide a range of services to the independent school student. (This resource list is available from the ISHA office.)

For next year, ISHA may consider reserving an exhibitor's booth as a means of extending ISHA's professional services and membership. This year's convention was attended by over 7,000 independent school personnel.

(Continued from page 12)

- No unauthorized experiments in the laboratory.
- Safety glasses and aprons must be worn. Note many states require by law the wearing of "safety glasses." (Cumbersome, unattractive goggles are not mandatory; rather, hardened lens instead of regular lens glass are available in regular eyeglass frames.)

Last, a word about cautions. Students respond to special warnings directives, *i.e.*, "We can't use a regular neon sign transformer to energize our spectral tubes. This procedure is extremely hazardous as low frequency high voltage is produced." Safety must not be empty directives. Explaining possible results from a certain action is good science class protocol. Interrupting students during lab work to caution them is poor timing. It is difficult to get everyone's attention and indicates to students a lack of planning in initial lab instructions.

Local fire departments and state agencies are only too happy to provide safety information to instructors. Chemical manufacturers are labeling their products with detailed information pertaining to the safe use of the chemical. We, as on-the-scene agents, are the frontline of a long and concerned line of health and safety personnel.

The Health Survey—An Interim Report

Sprague W. Hazard, M.D.

In late April 1985 a Health Survey form was mailed to 115 independent schools who are either institutional members of ISHA or have staff who are individual members of our organization. The purpose of the survey is to learn the extent to which the respondent schools have developed their health program and, subsequently, to share some of the data with the membership as a learning opportunity. Over half of the schools contacted returned a completed form by the end of the school year.

The response to date has been excellent, not only in quantity, but in the amount of information provided about health services and the setting in which they function.

Innovative programs such as the *Crisis Booklet* prepared by one of the larger boarding schools represents an important model for other schools to consider. The book outlines procedures to be followed when health-related crises occur on the school campus. Among the issues planned for are chemical overdose, pregnancy, sexual assault, child abuse, suicide attempt or threat and psychological turmoil.

Another excellent program relates to the development of an information sheet for prospective visiting athletic teams and accompanying staff. This advisory indicates the services and personnel available for the injured or otherwise disabled visiting athletes. In addition, the range of services, including transport, in the adjacent community and their location are noted. Such information should be of great reassurance to the coaches, trainers and other responsible adults of the visiting team.

Several respondents indicated plans for changes and upgrading in their health programs, based on information gained at one or more of the ISHA Conferences. There was very little information in the survey forms on student health insurance. It is clear from this limited reply that there is a need to clarify responsibility of schools with regard to student health insurance.

This commentary represents a preview and a sampling. A second appeal will be made this fall to those schools that have not returned the health survey form. Following an anticipated increase in returns, a more detailed summary will be prepared for publication in a future issue of the *ISHA Newsletter*. For those who have sent back information regarding their health programs, there is the greatest appreciation for the important contribution you are making to students, their health and their education.

ISHA Update

ISHA Membership: For the 1985 calendar year, ISHA members number 135; of that number, 57 represent school memberships. A total of 113 different schools participate. You will be interested to know that an ISHA California connection has been established with 9 schools.

Future Plans:

Fall Conference at Deerfield Academy, October 11, 1985
Topic: Morals and Ethics of Health Care for Teenagers
Keynoters: Dr. Barbara Jones, Director of the Council for Religion in Independent Schools—"Helping Students Deal with Ethical Issues" and Dr. Jack Wideman, Professor of Education, U.Mass—"Confidentiality"
Workshops: Health Center as Sanctuary
Moral Issues in the Areas of Athletics and Training
Pregnancy, Abortion, Venereal Disease—Moral Questions
Ethics and Morality of Drug Testing

Spring Conference at St. George's School, Newport, RI, April 18, 1986
Topic: Teenage Sexuality

Student Health Insurance: This has *not* been launched through lack of participation. We are sorry but will try again this fall for commitments from those schools that expressed interest initially. Insurance Agent Richard Artessa's letter to ISHA is included in this newsletter.

ISHA Council: We have re-recruited two members. Nancy Jo Jander of Eaglebrook School will represent schools for students up to the 9th grade. Marilyn Spencer of Loomis Chaffee School has agreed to help the Council write an ISHA handbook of guidelines to use in such sensitive areas of student care as suicide, drug abuse, pregnancy, abortion, birth control and that most controversial of all areas in the independent school—confidentiality.

Membership Fees

The ISHA Council has agreed that the current system of membership fees is confusing and cumbersome. It has been agreed that: 1.) There be a single category for school membership with a flat rate of $100, 2.) The individual membership be $25 and subscription only. This second type of membership will no longer include reduced conference rates. The revised membership fees take effect with the 1986 calendar year.

Student Medical Form: As a result of the Berkshire conference, a need was expressed by members to consider an ISHA student medical form. The Council is planning to look into this.

A Request for Input: In order to be effective, we need your input. If you have issues you would like ISHA to consider, please submit them. We invite you to participate in this publication with letters to the editor. Please consider writing to us of a success or failure, a criticism or question regarding ISHA conferences—in fact, anything that will generate interest and learning in our members.

Drug Abuse: Is communication the missing link?

Evan Eggers, Feature Editor, Deerfield Scroll

Editors note: All student names in the following article have been changed. The schools at which research was conducted are independent New England institutions for high-school aged students.

Drug use by teenagers has reached epidemic proportions. Responding to a recent poll sponsored by The Scroll of over 1,000 high schoool students at 15 New England schools, 60 percent of the students said they had tried marijuana, 25 percent said they had used cocaine, and 86 percent said they have used alcohol.

No one needs to be told that drug abuse is a problem — particularly prep school communities. They already know. However, what hasn't been found is a solution. In the past, schools put together policies to deal with substance abuse within the traditional framework of their disciplinary policies. But after the extent of drug use among their students was realized, schools began to experiment with new ideas like rehabilitation programs, on-campus suspension, and drug education programs.

Administrators at the schools polled indicated that most of them now have similar policies to deal with drug users.

1. Some kind of drug awareness or education program,
2. A confidential counselor available to students,
3. An off-campus rehabilitation program to which students may be referred, and
4. Disciplinary action.

The Freedom from Chemical Dependency Foundation in Natick, Mass., and Phoenix House, in New York City, have created two of the most respected drug education programs.

Dr. Paul Fischbein, from Phoenix House's public information office, described their program. "We've found that it doesn't do any good to go into a school and have an ex-addict recount his really negative experiences. We let people know what goes into the decision to use drugs, so that if they're ever offered drugs, they won't make a snap decision.

"We explain why people use drugs and what to expect from drugs. In this way, they'll understand that drug use isn't a normal thing; it's caused by pressure, ill-considered motivation, and so forth. And we try to equip them with the knowledge of drugs and their effects, and especially to dispel some of the myths about drugs. For example, most people realize today that drugs have a very steep down side, in the sense that people suffer greatly from excessive involvement. And the only way to become excessively involved is to get involved in the first place."

Freedom from Chemical Dependency's program is similar. Ms. Nancy Morley, the assistant director, explained their philosophy. "We have a four-day program. Basically, we teach all the facts, but we emphasize alcohol because it's still the most used drug. We talk about why we, as Americans, use chemicals. More often than not, drug abuse is just the tip of the iceberg, particularly in adolescents. In this society, certainly, there's an underlying *something* that's going on, when you consider we have around three million teenage alcoholics in this country. Something's wrong that we're not addressing."

Unfortunately, only about 30 percent of the students polled said that they thought a drug awareness program convinced them to avoid or give up illegal substances. While 46 percent of those who had never used a drug said that an awareness program helped them, only 22 percent of present or former drug users said they had been helped.

Meanwhile, there is no doubt that peer pressure plays a role in decisions to use or not to use drugs. Of those students who said their friends suggested that they use illegal substances "often," 89 percent have used a drug other than alcohol. Of the students responding that their friends "occasionally" suggested they use drugs, 79 percent had tried a drug other than alcohol. But of those whose friends never asked them to use drugs, 22 percent had never used a drug other than alcohol.

Many young people, however, *are* helped by drug awareness courses. They are usually the ones who are considering trying a drug, but remember the facts about it and decide against it. To check the effectiveness of their methods, Phoenix House conducted a study on students' attitudes before and after participation in the course. According to Dr. Fischbein, many students' attitudes about drug users and drugs themselves were changed.

Confidential counseling is available at all of the schools polled, either by a trained counselor, the infirmary, or by faculty members. Unfortunately, 99 percent of the students polled at schools with infirmary counseling programs indicated that they would be uncomfortable going to the infirmary for help.

Off-campus rehabilitation programs are used by a few of the schools polled for students caught using illegal substances. In these programs, the student will meet with a counselor one-on-one and/or in a group to talk about drug use. None of the students interviewed or polled had gone to a rehabilitation program unless his school had suggested it.

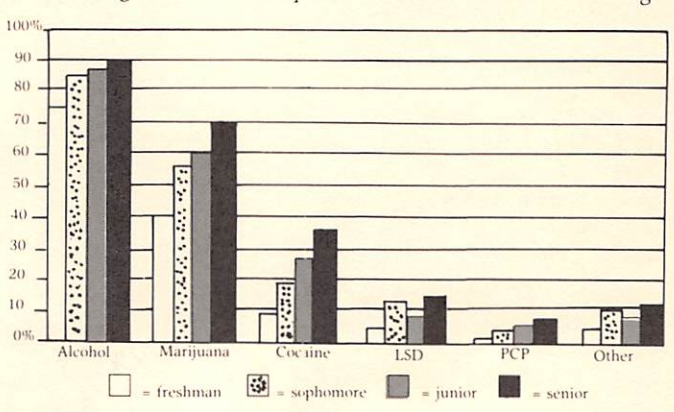
Disciplinary action is the last option available to schools, and the most visible. Half of the schools polled have a mandatory suspension for a first-time drug use offense, while the other half will give a suspension depending on the circumstances. But drug distribution will result in expulsion at all of the schools.

Of the students found using illegal substances by their school, only 19 percent gave up the substance. So schools must find additional ways to attack the problem. Although many of the reasons for abuse, such as personal problems, are out of the schools' control, there are constructive actions a school can take. Each school community needs to foster better communication between its three elements: students, faculty and administration. There is a feeling among students that their administrations don't care about them — that the administration's first priority is the school's image. Although this may have been true to a point in the past, it has changed as consciousness of the problem has grown. As long as students perceive the administration and the faculty as enemies, candid communication just won't happen.

Many comments from students showed frustration at a perceived lack of compassion in the administration. "The administration should try to help and not just to catch us." "The administration only cares about the school's image." "The administration doesn't care what happens to the students."

Continued on back cover

Percentage of students by class who have tried each drug



Continued from page 15

One Dean of Students wrote that he'd like to see proctor and student involvement in confronting the problem instead of "busting." Another Dean of Students wrote that "any student may talk to any member of the faculty without fear of disciplinary response on more fundamental issues than sports, grades, and weather." He continued on to say, "We attempt to stay out of disciplinary action . . ." A headmaster wrote that he'd like to see the entire community "listen to each other and cooperate with each other."

Clearly, administrations *do* care about students; it just doesn't seem that way to the students. And almost all of the faculty want to help as well. In responding to the question, "What should the faculty role be in dealing with substance abuse?" faculty indicated a concern for the student's well being. "Counseling, advising, trying to understand. . . ." "Make an effort to be supportive of students. . ." For every teacher who replied simply, "bust the student," there were ten who wanted to help the student. Of course, almost all the teachers indicated they support disciplinary action for repeat offenders.

Another convincing measure of the faculty's commitment to helping students is that almost 2 out of 3 faculty members indicated that they wouldn't necessarily "bust" a student found to be using drugs. Rather, they might try to help him themselves, refer him to a counselor, or do a combination of these things. Unfortunately , students never find out about such occurences, because they might never show up publicly. The only well-publicized cases are the discipline cases.

Because of the perceived "them against us" attitude, student drug users feel persecuted. But they're normal people. Thoughtful, well-spoken, and intelligent. Many *know* what they're getting into. They know how many different drugs are in marijuana, and they know how to pronounce the chemical names. "We just don't fit in with what other people accept," Jeff Maxwell told me recently. "We don't bother anyone. I don't try to push drugs on anybody else. And I've made an informed decision to use marijuana, just like anyone else would decide to use tobacco, alcohol or any other substance, legal or illegal. So why should people hassle me?"

Furthermore, many student drug users find the phrase "the substance abuse problem" laughable. First of all, Jeff, Tom, and Bill Thompson said, "it's not substance *abuse*, it's substance *use*. Second, the problem, isn't with the users, it's with the people who think that users are 'abnormal.' Who's to say non-users are 'normal?' " It's a startlingly different perspective. "Everybody at a high-pressure school like this needs help to get through. Some people love their music, others love their sports. And how many people are addicted to caffeine around here? We just happen to find relaxation in marijuana."

Many schools are now starting Peer Support groups, some with the help of Freedom from Chemical Dependency. Jeff Maxwell commented, "I've been in peer support for quite a while. It hasn't made me quit, but now I understand where other people are coming from. Another kid I know who was in peer support *did* quit, and even though he doesn't use anything now, I think he understands us."

Creating a greater sense of trust between students, faculty and administrators should be a top priority at every school. The rift that presently exists hurts everyone. Faculty must realize that drug abuse is as much their concern as the administration's, and that students *do* have reasons for using drugs. The traditional student-faculty relationship must be modernized to allow less strained interaction, where students can feel safe *trusting* the faculty. **Administrators must embark on a massive public relations campaign to make students *believe* they want to help.**

Even if better communication doesn't eliminate drug abuse (or use, depending on the perspective) on campus, at the very least it will result in more understanding between students, their teachers, and the policy makers. And what's wrong with that?

Evan Eggers is a 1985 graduate of Deerfield Acad. and an early decision acceptance at Princeton University. This article from the 2/22/85 isssue of The Deerfield Scroll is reprinted with the author's permission.

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