INDEPENDENT SCHOOL HEALTH ASSOCIATION

Newsletter: Spring 1986

Fall Conference 1985

Morals and Ethics of Health Care for Teenagers

Deerfield Academy
Deerfield, MA

Faculty

Dr. Barbara E. Jones
Dr. John W. Wideman
Douglas S. James
David Connell, M.D.
Dr. Mimi Murray
Bradford Hastings
Dennis Rosen, M.D.
Mary Anderson, R.N.

Keynoters

Helping Students Deal with Ethical Issues

Keynote Address by Barbara E. Jones, Ph.D.

An introduction: "On a clear day you can see forever." The fall conference held at Deerfield Academy on October 11 made me feel the reality of the above quotation. Barbara Jones, one of the keynote speakers, set the tone for some moral issues. The text of her speech follows and is included in its entirety. — Mary E. Anderson

* * *

On the whole, schools have done a good job in facing the problems kids have today: trustees have supplied policy and money; teachers have given up teaching time and worked in committees and listened to kids; parents have paid for and brought in programs and community resources; alumni have contributed leadership, funds, speakers; and administrators have orchestrated the whole in an effort to prevent or cure anorexia, bulemia, alcoholism, drug use and abuse, chemical dependency. School communities have had to deal with a new range of problems with this generation — including increased incidents of pregnancy, abortion and suicide. And while some of the problems that schools are dealing with are not as dangerous as those I've listed, they are part of the same syndrome — lying, cheating, vandalism, borrowing without permission, shoplifting, false sign-ins, bullying, punching, nasty notes. Nothing new, but the increased quantity suggests that we are dealing with something qualitatively different. And we are. The programs we have struggled to put in place are not enough. They are like bandaids applied to cancer.

If that shocks you, good. Because we have been treating symptoms, not causes, and if anyone knows that *that* won't work, it's health care professionals. Let's look at causes; let's talk about how to treat them and let's help these kids grow up to live productive, fulfilled, joyful lives.

The causes are social attitudes, philosophies that have worked their way into our assumptions and those of our kids — into our culture. We must recognize them and understand them. But that's not enough. We must act on them, reverse them, change them, correct them. Before I detail them, let me say clearly that I am discussing morality, a word that's not very popular these days.

The word "morality" makes people nervous. "Whose morals?" they ask. "What's going to be imposed on me?" Let us define the word: *mores* comes from the Latin and *ethos* from Greek meaning ability to discern right/wrong. This discernment enlightens both acts and attitudes that are beneficial to others

(continued on page 2)

Barbara Jones is a member of the Council for Religion in Independent Schools (CRIS), a nonprofit organization that helps schools to initiate, evaluate, and improve their teaching of religion and ethics, develop their worship life, institute values programs, and promote a moral and spiritual climate. CRIS is independent of any religious body and does not impose any one point of view. It stands within the Judeo-Christian traditions, and sees knowledge of religion and ethics necessary components of a liberal education.

CRIS educates through conferences and workshops for students, faculties, administrators and trustees, and through the publication of courses, position papers, and its monthly Newsletter. CRIS is 87 years old.

(continued from page 1)
and therefore good and right and values that are esthetic, personal, moral. We may disagree about the authority for and application of these values and morals, but that they are inherent in each individual is clearly a given.

Think about the Ten Commandments. What they basically say is mercy, justice, charity. All civilizations have grappled with the notion of a power greater than self and the very basic human need not to mess up human relationships. Act with mercy, justice and charity — just what we've been teaching all along — play fair, be kind, consider others' feelings.

Let's look at religion as the getting of energy, power, ability, love to act with goodness and rightness. We have confused this religious enterprise with specific religious institutions and with particularities and positions. Moral decline began in this country when religious institutions lost influence and morality became divorced from the power to act morally. Hence, we're trying to do good without an empowering source of love. Left to my own devices, I usually fail myself and others just when goodness, rightness, love is needed most.

Human beings are composed of three parts — physical, mental, emotional — united by the spirit — the psyche, the soul, the self — and expressed in our acts and attitudes, our moral life. For the last several decades, however, we've focused on feelings as if they were the whole self. We've confused emotional and moral components of the person, as if cruelty, dishonesty and deception were behavioral stages of growth rather than moral wrongs.

We have let kids get away with things that are bad for them; we have failed to give them the structure they need within which to grow; we have let them "express themselves" as if that were the best way to adulthood. Now we're reaping the whirlwind and wondering what went wrong.

There is usually a demurral at this point. "Well, I don't want to impose my opinion on the children." That's a red herring. We're not talking about personal opinions, we're talking about universal realities. We're not talking about personal opinions, we're talking about civilization, which hands down its judgments and experiences from one generation to the next. We're not talking about impositions, we're talking about education.

If we don't witness to courage and loyalty and responsibility, to decency and honor and integrity, to justice, mercy and charity — they may die out. In fact, I'm afraid they are, because we haven't spoken in far too long. Thus, dangerous social attitudes have taken root and flourished.

First, a disclaimer: I like young people, and I trust young people. Simply because I'm going to talk about some negative student attitudes does not mean that I think young people are bad. On the contrary. We must not look at the next generation as selfish little ankle biters or junkies, ruffians, or sexually depraved fleshpots. The vast majority are idealistic, compassionate, exuberant youngsters struggling to become adults. Yes, they make mistakes, but they have a record of caring for each other, serving juice and cookies, erasing blackboards, supporting hunger programs, doing community service, relieving human misery in natural disasters. They are young persons growing into maturity and wanting to learn how. Because I love them, I want to help you help them grow.

Let's start by looking at some statements kids make in their heads. The first is apt to run like this: "I'm supposed to feel good, and I don't. So why not party? Nobody's going to get hurt, and I won't get caught. Besides, what difference does it make?" That statement has many variations: "I'm supposed to be getting As and I'm not, so why not cheat? Nobody's going to get hurt, and I won't get caught. Besides, what difference does it make?" Or: "Steal, trash, litter, get drunk, get high, make love." Or: "I'm supposed to be pretty and popular (or good-looking and tough) and I'm not. So somebody's going to pay for my pain. I'll write a mean note or start a vicious rumor or beat up on ole Charlie. I won't get caught and besides — what difference does it make?" Or, the worst of all: "I'm supposed to feel good, and I don't. So why not end it all. I'm the only one it will hurt. Besides, what difference does it make?"

There are five basic value assumptions in those messages. Interestingly, they all find their roots in classical philosophy. Perhaps if we taught more philosophy, kids would see the loopholes and the failures of these ideas to give us the good life.

First, there is the simplistic absolutism that offers easy answers. It has its roots in Hegel who thought he knew everything and said so: "I have surveyed the field and I know." It is fed by our fear as we watch old ways and old values change. We react; we get rigid. We view with alarm social developments and remember a time when life was more cloistered, rules much stricter, when young people respected the conventions of society, when social taboos were clearer. Television adds to simplistic absolutism because it shows neat, pat, fast, often violent solutions — but always solutions.

This view may be the result of our national need to be right, our desire for easy answers, our distrust of complexity, our inability to live with ambiguity and mystery. Mencken says: "For every complex problem, there is a solution that is concise, clear, simple and wrong." Let's pass that on to kids. They need to see us wrestle with the difficulties of work, life, relationships, with challenges unmet and problems unresolved.

We owe it to youngsters to teach them that life is more complex — and interesting — than any quick fixes allow because the simple, absolute attitudes won't, in the long run, work for them. For instance, look at their view of friendship: They think friendship means warm, fuzzy feelings, and they have a poster that says "Friends never tell on friends." (At the national level, that attitude is called obstruction of justice.) Thus, some students feel that cheating is often right and that "narking" is seldom right. ("Narking" is a word derived from "narcotics officer," a law enforcement official who turns in drug dealers to benefit the larger society. "Narking," in student slang, is a pejorative term for anyone who manifests group loyalty by turning in a fellow student who has acted improperly. Adults usually call such an act corporate responsibility!)
Using the model of "Friends don't let friends drive drunk," a slogan that young people accept, I've seen students as young as ten and as old as 18 learn that friends don't let friends drive drunk, or get drunk, or lie or cheat or steal, or do anything childish, inappropriate, self-destructive; that friends, real friends, ask friends to be the best they can be. One boy said in a closing conference summary, "Friends, real friends, are willing to give up friendship for the sake of the friend." Thus, students can learn that friends help friends grow up, face the consequences; that friends look for honor and integrity in each other and demand responsibility to the group, and that friends, if necessary, will tell on friends because they care about their growth and development as well as the good of the larger whole. Kids see idiocy when they are challenged by it. Another student said at a conference, "Why do we make a hero of the guy who does the most drugs? That's dumb." And the rest applauded him.

We need to be more explicit with young people. We need to spend time on friendship, using all the teaching devices, to help them learn the nature of friendship, the toughness of love, the difference between liking and loving. We need to help them grow up, accept responsibility for each other, be the best they can be. We need to turn the emphasis from personal to group — to class, team; from relationships to service. And little kids, from second grade up, are desperate for popularity. They feel their life is ended if they're not popular. We are not

(continued on page 14)

Regarding Confidentiality

Keynote address by Dr. John W. Wideman, University of Massachusetts (Amherst) School of Education
Reported by Joe Keenan, Counselor, Millbrook School

Dr. John W. Wideman, of the University of Massachusetts (Amherst) School of Education, gave the second keynote address. His subject was confidentiality. Beginning with a reference to Adler, Dr. Wideman invited us to recall our earliest memories of confidentiality — the "I won't tell if you won't tell" experience — commenting that it may be useful for us to remember the context of such pacts. He then delineated between the subjective experiences of guilt and of shame, basing his remarks on Helen Lynd's work *On Shame and the Search for Identity*.

Guilt is a "public" experience in the sense that there is a punishment to be meted out by society, by means of which one can suffer the consequences of one's actions, assuage one's guilt and "get on with business." Shame, on the other hand, is more a private experience, where we "fail to measure up to our own standards. It's a sudden exposure of oneself to oneself as less than one hopes one will be." Since shame is "self-conviction" and thus does not operate by the usual laws, one may not be as fair with oneself as society would be. Consequently, "the temptation in shame is to hide," to move toward isolation. Also, one may develop a lack of trust in one's own self, in one's own judgment and integrity.

Dr. Wideman emphasized that it is "not the meaning of others that causes shame; rather, it is our own reaction to our mistakes." He believes that "shame is more likely in our present permissive society."

Sh-Sh-h-h

Whereas the parental or societal response to guilt is punishment, the purpose of which is "to redirect my agency," with shame the purpose of the response should be "to heal a wound." However, since it is such a private feeling, "How does one talk about shame?" Most likely one will do so only in a very "safe" setting. Thus, a primary goal of counseling should be to "create a context safe enough for an exploration of shame, a sanctuary, a place free from the usual consequences, evaluation, disapproval, to reflect on the full range of thoughts and feelings. If this happens, it can become clearer. Thus, confidentiality takes on a new meaning, that being to protect one from the public exposure of shame." At the same time, according to Lynd, "facing one's shame leads to one's truest sense of identity."

Another dimension of confidentiality discussed by Dr. Wideman involves the way that confidential information is handled. As he said, "Together with the client we decide how we will share, frame or disseminate information." The "management of information" is particularly important in family therapy, as well. Within a family, information can become a form of power, where facts or feelings, known or withheld, can have the power to hurt or manipulate others. Often, according to Dr. Wideman, it is information deprivation that is at the root of a family's problems. In family therapy, there can be no secrets, and in a family where information has been mismanaged, family therapy can be a series of "learning experiences in the coordinated management of power" within the family.

Listening to Dr. Wideman discuss confidentiality from these perspectives, one was reminded again of how crucial this issue is to successful counseling.

Workshops

Is Sport Abusive?

Workshop by Dr. Mimi Murray
Reported by David Anderson, Athletic Trainer, Choate Rosemary Hall

Dr. Murray began her talk with a discussion on several physical and emotional "abuses" of sport. The physical side of the presentation dealt mainly with injuries and the fact that many athletes try to play while injured. She pointed out three major causes of injuries in adolescent sports: 1) quick and significant bone growth which often causes soft tissue injury. The soft tissue doesn't grow as fast as the bones in most cases, which results in injuries to the soft tissue. Examples of these injuries include sprains, strains, tendonitis, myositis, etc; 2) fatigue, which makes an athlete much more susceptible to injury. On this point, Dr. Murray quoted Vince Lombardi, who said, "Fatigue makes cowards of us all." Coaches should guard against hard practices the day after hard games; 3) weight loss, which is particularly evident in wrestlers and football players. Wrestlers often feel that they must continue to lose weight throughout the season. Dr. Murray gave as a good indicator of athlete over-fatigue, whether from weight loss or other reasons, a resting pulse rate 5–10 beats more than normal. Any athlete in this situation should lower their training level.

In discussing some of the emotional aspects of sport, Dr. Murray focused on why people *don't* participate in sports and why young people stop participating. A study which investigated reasons for nonparticipation in sports showed that 75 percent of respondents don't play because they feel they are not good enough. Almost 100 percent said it was more important for everyone to play, as opposed to only certain players playing, even though the team record would be poorer. Another study cited reasons why youngsters left sports: sports weren't challenging enough because of too much control by the coach; there was too much intense competition too soon; sports weren't fun; students had no sense of self-esteem; and parents' and coaches' attitudes toward losing diminished the pleasure.

Dr. Murray briefly discussed sexism and racism in American sports. Her talk concluded with comments on the abuses that are prevalent in little league sports and what could be done to help correct this situation.

The workshop ended with a half-hour movie on the abuses common to childrens' sports.

The Health Center . . . A Sanctuary?

Workshop by Bradford Hastings, Dean of Students, and Dennis Rosen, M.D., School Physician, Deerfield Academy

What is the relationship between the health center and the disciplinary process? Presented at the workshop were three alternative policies and three case studies.

Health center policy on chemical overdose
It is difficult to set a uniform policy for the treatment of a student who has taken an overdose of either drugs or alcohol. Each student and each case must be treated individually. The one fact that should be stressed to the faculty and students is that there is help available at the health center.

A student with a serious overdose initially will be admitted to the health center for treatment and there will be consideration of community hospital referral.

It is important to note that a student who is "dead drunk" needs constant observation while he "sleeps it off." A student could well be *protecting a friend's life* from aspiration or respiratory arrest by seeking help in such a situation. If a faculty member finds a student in this condition, it is his or her duty to bring the student to the health center and then make an appropriate report to the deans. It is also that faculty member's duty to assist the nurse in any way necessary. The evening and night nurse are usually alone and may need someone to sit with the student until other help is available or arrangements can be made to transfer the student to the hospital.

The health center's purpose is to treat the student and the condition; it does not act as an arm of the disciplinary office. A student should not fear asking for assistance either for himself or a friend. In these isolated and random cases, the student will be referred to and reminded of the strong support system of confidential help available through the counseling staff/core group faculty.

A student who is brought to the health center with a mild overdose will be admitted and cared for at the health center and, if a boarder, will be reported to the dormitory head as ill. However, the nursing staff will not tolerate repeated episodes of mild overdose. These students will be *required* to obtain counseling.

The medical staff cannot be expected to maintain strict confidence in a case where the situation becomes life threatening. The headmaster and/or a designated school authority will be informed. The school authority will notify the student's parents and seek the core group faculty's review of that student's status with the help of the student's faculty advisor.

Health center policy regarding admission for excessive use of alcohol and other drugs, or extreme reaction to drug taking
The confidential nature of the care provided by the health center permits, under certain circumstances, admissions for these problems without notifying the administration. Admission occurs under confidential circumstances when: the student comes of his own accord; the student is brought by another student; the student is brought under the supervision of a member of the security staff without having had contact with a faculty member.

In all circumstances of confidential admission, health center policy requires at least two follow-up interviews with a member of the counseling staff/core group faculty. Parental contact may be made by the counselor if deemed critical in terms of the process of counseling. Failure to keep these two appointments will be considered a breach of the confidentiality and will result in the matter being turned over to the dean of students office for possible disciplinary action.

Exceptions to the confidentiality admission policy include:

- the student who upon admission becomes "unmanageable" (that is, disruptive behavior suggests a threat to self or others);
- severity of the medical problem necessitates community hospital admission, for which parents' consent must be obtained;

Only in these instances is the health center *obliged* to report specific facts to the dean of students office, which will design the necessary support program and orchestrate a review of the student's status.

Health center policy regarding admission for excessive use of alcohol and other drugs

- It is the responsibility of health center staff to notify the dean of students in all cases of chemical use and overdose.
- The health center policy dictates that medical care only, both immediate and subsequent, is provided.
- The dean of students is responsible for designing therapeutic counseling and/or a disciplinary response suitable to the individual's situation.
- In case of self-referrals to the health center, it will be the dean of students' prerogative to consider alternatives to a disciplinary response and to decide whether parents should be contacted.

Case Study #1
The party was beginning to break up at 11:30 p.m. The 30 juniors and seniors knew thay had to get back down to campus by the midnight curfew. For most of the boys and girls, the party had been fun and a good change of pace. No doubt, the highlight of the weekend had been the keg of beer hidden up on the hill.

As Pat and her boyfriend, Lee, started down the hill, they noticed that Linda was drunk. As one of the organizers of the party, Linda had been "pumped up" all week about the affair. She was "psyched" about the party and was one of the first students to start drinking the beer at 7 p.m. Pat and Lee were aware that Linda never left the keg; she was always offering beer to people and being the life of the party while simultaneously drinking more than her share.

Pat and Lee tried to help Linda down the hill but she had trouble navigating the dense woods. Repeatedly, she mumbled that she thought she was going to get sick and stopped walking. She often fell; her vision and balance were significantly impaired. When Pat looked at her watch, she realized it was 11:55 p.m. and she said to Lee: "I can't afford to be late again tonight. Mr. Smith will kill me if I violate curfew once more."

"Maybe we should just split," Lee suggested.

"But what about Linda?"

"I guess that's her problem," Lee said reluctantly. "We've got to get back."

Pat didn't want to leave Linda although she felt it was impossible to get Linda back to the dorm without both of them getting busted. And if that happened, maybe everyone in the party would ultimately get caught.

A. Would a school policy of "sanctuary" facilitate Pat's making a decision? If yes, would that be the right decision for Linda?
B. If the health center is "connected" to the disciplinary process, what can Pat (and Lee) do to help Linda?

While supply lasts, additional copies of this newsletter available at $1/copy. (To defray postage cost, please add 50¢/total order.) Remit check with your request to:

Cari J. McCartan, ISHA Secretary
Emma Willard School
Troy, NY 12180

C. Is a policy of "sanctuary" helpful to students or does it make decision making more difficult? Can students trust such a policy?
D. What type of relationship exists between the health center staff and the faculty in a school that has a policy of "sanctuary"?

Case Study #2/#3

Howard was in his third year at the academy. He had not worked up to his potential and his reputation was well known. Faculty and students knew that Howard used marijuana and he would even openly defend his predilection. It seemed to be what Howard did best in the high pressure, competitive atmosphere of his school.

Last year, (2) the school physician/(3) Howard's advisor decided to find a way to help Howard. He/She had heard about Howard's marijuana smoking and had seen Howard for other minor problems. (2) The doctor (3) The advisor was determined to "salvage" Howard. When Howard saw him/her one Monday morning complaining of a headache and exhaustion, he/she seized the opportunity to confront Howard about his problem.

After being assured of confidentiality, Howard spoke candidly about his marijuana use. He argued that "it was no big deal" and that "making it to graduation was not going to be a hassle." He admitted to smoking on a regular basis. Howard acknowledged that his brother was his "source" and that he was getting marijuana regularly from him via the mail. He refused to connect his mediocre record to his smoking pot.

After an hour's discussion, Howard left. Before his departure, (2) the doctor (3) the advisor asked Howard to return at the end of the week to continue to talk. Howard said "That's cool" and he reminded him/her of their agreement to keep things confidential. After the session with Howard, (2) the doctor (3) the advisor was puzzled: Howard had revealed much more than anticipated.

A. If the school has a policy of "sanctuary" at the health center, what are the doctor's obligations? What are the advisor's obligations?
B. Could confidentiality be justifiably broken by the doctor (or the advisor) regardless of the school's policy vis à vis the health center's relationship to the disciplinary process?
C. How far can the doctor proceed with the dialogue without contacting anyone else? The advisor?
D. In Case Study #2, how would you, as Howard's faculty advisor, react when you learned that the school doctor had had conversations with Howard about regular marijuana use?
E. How should Howard's parents be dealt with, if at all?

The Realities of Drug and Alcohol Testing: Confrontation Drug Testing

Workshop by Douglas S. James, Sixth Form Boys' Dean, and David B. Connell, M.D., School Physician, Choate Rosemary Hall

Since January 1985, Choate Rosemary Hall has administered drug and alcohol tests to students. This workshop was designed to describe the equipment, our experiences and the problem — and to discuss how testing has affected confrontation.

About four years ago, Doug James considered and discussed the use of breatholyzers in helping confront students suspected of drinking. In 1985, the use of cocaine by Choate Rosemary Hall students became national news. An editorial in the school newspaper (October 1985) demonstrates the change in attitude on campus following the affair. In the editorial, Senior Mary Leydorf addressed one of the students directly implicated:

"You really took us for a ride, Derek. You shifted all the blame for your mistakes on the 'rich kids' and 'that snobby school.' On national TV you allowed *60 Minutes* to show the rust on your car in a desperate attempt to save your innocence and lessen your sentence. Did you want to threaten the reputation and existence of your school?

"Undeniably, it is perhaps your school more than anyone else's. No single person in Choate Rosemary Hall's history has done so much to change the school; and one event has never had that much of an impact. You may not have had it in mind when you maligned us on national TV, but for the most part the fruits of your failure have been beneficial. You exposed our flaws and gave us something to aim for — change. The attitude on the campus has changed more than anything. Drugs have been drained of their glamour — of course, as long as people want escape, Choate will never be a drug-free campus. You haven't made people dislike drugs, but you have forced us to recognize that school is not the place to do drugs or to drink. People who do use illicit substances talk about "partying" over vacation. The administration has introduced many new rules, one of which forbids a student from using drugs at school and at home. Recently, a senior on a no-use contract was tested and expelled."

Following the publicity surrounding the use of cocaine at Choate Rosemary Hall, the school decided to use testing instruments. There are two basic types of equipment for drug testing: a breatholyzer device for testing alcohol in the breath (at Choate Rosemary Hall we use a device called "Alcotest") and an immunoassy portable machine for testing the urine for alcohol, marijuana, cocaine and PCP (we use Emit-ST equipment).

The Alcotest requires the student being tested to blow through a tube containing a chemical into a plastic balloon that inflates when sufficient air has been blown through. A positive test is indicated by a change of color of the crystals from yellow to green. The duration of the color change is an approximate guide to the quantity of alcohol consumed. This inexpensive, portable test equipment is used when necessary by the school form deans. It has been particularly helpful when a student has been discovered in suspicious circumstances and denies the use of alcohol. It has been an important element in the subsequent confrontation and elucidation of the truth.

After the breatholyzer had been used a few times, one of the students who had a positive test, claimed he had drunk a third of a bottle of Nyquil, a cough mixture which contains a variety of ingredients for head colds and coughs, and, in addition, has a significant alcohol base. The school physician was asked whether he thought the Nyquil could have caused the positive test result. He said he thought this was very unlikely, but couldn't be absolutely certain; so the vice principal for students elected to test the effect of Nyquil on himself. He consumed half a bottle of Nyquil. The subsequent test was indeed negative; however, he was very woozy that evening and found correcting papers nearly impossible. Certainly, this member of the faculty went more than the extra mile in the implementation of his job.

The Emit-ST equipment is used to perform an immunoassay test on urine. The immunoassay uses antibodies that react specifically with a substance tested for. Antibodies are formed by the body's immune system as a defense to prevent future attacks by a specific disease. Because of the specificity of antibodies, the test, according to the manufacturer has a 95% accuracy rate. The remaining 5% are false negatives, arising because the quantity of the drug remaining in the body is too small to be detectable by this equipment or because a mistake in the testing technique has occurred. The length of time that these substances remain in the body and are detectable by this equipment is as follows:

PCP — three days
cocaine — two–seven days, depending on the individual
cananbinoid — one–two days for low and moderate users, two–four days for heavy users and up to ten days for very heavy users
Alcohol — 12 hours

(continued on page 6)

(continued from page 5)

A positive test means that the drug or its metabolites have been detected in the urine and that this substance must have been ingested at some time. It cannot give any information about the quantity or other circumstances.

To date, 23 students have been tested, six girls and 17 boys. Five students had positive tests (four for marijuana and one for cocaine). Some of the students were tested more than once because they were on a "No-Use Contract."

Following are some of the frequently asked questions as found in the handbook provided by the manufacturer of the Emit-ST machine.

How long after taking a drug can it be detected in the urine?
Drugs vary considerably in how quickly they pass through the body. This variation depends both on the drug itself and on the individual. Sometimes drugs can be found in the urine days or even weeks after they have been taken. Depending on the dose taken, most drugs can be detected in the urine for up to three days after they have been taken. Marijuana, methaqualone and phenobarbital, however, may be detected for as long as two to three weeks. Other drugs, such as amphetamines and secobarbital, pass through the body so quickly that a negative result may be obtained from someone who has used the drug recently.

Are there any foods or medications that can cause false positive test results?
Medications with very similar chemical structures may sometimes produce positive results in certain tests. These medications, and the levels at which they will interfere, are listed in the product literature accompanying the tests.

Is it necessary to confirm a positive result?
It is good scientific practice to confirm a positive result from *any* test method in cases where a person's rights, privileges, treatment or employment is at stake. Even with a reliable method such as EMIT, there is always a slight chance that specimen handlers and test operators may not have followed the recommended procedures precisely. Therefore, confirmation is important.

In lay terms, how does an EMIT test work?
An EMIT test works as follows: A) An EMIT test contains antibodies that attach themselves to drug or drug metabolites (which are products resulting from the breakdown of drug by the body) in a person's urine sample. B) EMIT test instruments measure the sample's light absorbance response, which is related to the amount of drug it contains. The more drug present in the person's urine, the greater the response produced. If there is no drug present in the sample, the response is minimal. A negative result means that either there is no drug present in the sample or the level is so low that it is undetectable by the test. A positive result means that the drug is present in the urine sample at a detectable level. It does not mean that the individual is intoxicated, since there is no definition of intoxication for any substance except alcohol.

How long after smoking marijuana can drug be detected in the urine?
Studies have shown that marijuana use in typical low and moderate users (1–4 joints per week) can be detected for 3–5 days after discontinued smoking. Heavy drug users (one joint or more per day) are detectable for at least 7–10 days. One 4-joint-per-day user was consistently positive for 15 days after discontinuing smoking. The simpler, less sensitive test, the EMIT ST Cannabinoid Assay, detects drug in the urine of low and moderate users for 1–2 days after discontinuing smoking and in heavy users for 2–4 days after smoking. Very heavy users may remain positive for at least 10 days after discontinuing smoking.

If a person gives a negative result one day and a positive the next, does it mean that he has smoked marijuana again?
Not necessarily. Marijuana is stored in the body, and its breakdown products are released in an erratic pattern over a period of days or weeks. This means that a person could give a negative result several days after discontinuing smoking, followed the next day by a positive result. Depending on the person's prior frequency of marijuana use, it may take days or even weeks before test results become consistently negative.

How can a test for marijuana work when there are so many different types of marijuana?
Although there are many different types of marijuana, all contain the same active ingredient, delta-9-tetrahydrocannabinol (THC). Because all types of marijuana are converted to the same breakdown products, they are all detectable by our tests.

Over the past several years Choate Rosemary Hall has adopted the following overall approach to major school rules, chemical use, counseling responses, rehabilitation, testing, and the involvement of parents. Essentially, our school has moved dramatically away from a "second-chance" philosophy as to use or possession of all drugs, while retaining the *option* of immediate dismissal regarding alcohol. In principle, we desire to be a drug-free community, and therefore have chosen to make "intoxication" of any kind our absolute business. Toward that end we have made testing, as indicated, one of our several resources, in part because it does seem to generate a substantial deterrent value. In addition, we are currently attempting numerous other responses: to sustain an educational facet within our approach (through our own behavior and ethics course offerings, a school-wide task force on drugs and alcohol, and outside presentations by such groups as Phoenix House of New York City); to offer peer counseling support as often as possible; to monitor more carefully the weekend, off-campus plans of all students; to intervene in extreme cases based on information collected in confidence by our own assessment team (with the possible option of off-campus rehabilitation); and to encourage dialogue and communication between as many students and adults as possible concerning the use and abuse of drugs and alcohol.

In pursuit of this last goal in particular, as stated in our Student Handbook, we make a distinction between counseling and discipline situations. That distinction is defined as follows: "Whenever a faculty member discovers a student apparently in violation of school rules, or when our attention has been directed to a problem by security or by the police, we are facing a disciplinary situation. Whenever we approach a student out of concern which arises from information offered to us by students or faculty of a more general nature about past behavior, we are acting as counselors. Parents will be notified as soon as possible in either instance."

The operative school rules, as well as direct reference to the possibility of testing or a unilateral disciplinary or judicial response on the part of the dean's office, are also clearly articulated. Our Major School Rules (beyond the Honor Code) grow from the following statement: "The use of controlled substances is detrimental to the well-being of the individual and the community and incompatible with the purposes and objectives of the school. Rules regarding possession, sale or use of these substances are essential to maintaining a healthy academic and social environment. Therefore, the following are forbidden and are grounds for major discipline. You should also be aware that there are circumstances when the breach of these rules could result in immediate dismissal.

"1. Possession, sale or use of controlled drugs, or abuse of any other chemicals and possession or use of drug paraphernalia result in immediate dismissal. Since Choate Rosemary Hall aspires to be a drug-free community, if circumstances suggest that you have violated the school rule on drugs, you will be tested. If the result is positive, you will be dismissed whether you used the drug on or off campus.

"2. We do not condone the use of alcohol. Further, Connecticut law prohibits the purchase and use of alcohol by those under the age of 21. The school complies with this law. If there is sufficient reason to believe that you have been using alcohol, a breathalyzer test may be administered."

Any positive test in a disciplinary situation, for either drugs or alcohol, obviously requires a major disciplinary response. When, on the other hand, a "violation" is established within the counseling context, a No-Use contractual relationship will usually follow. This differs, at least with regard to chemicals other than alcohol, from the general Statement of Understanding that all students sign each school year only in that random, regular urinalysis also attaches. The No-Use Contract is clear and concise, and makes a particular effort to enlist the knowledge and support of the parents.

What does our experience of the last twelve months suggest? Certainly, that enforcement — rather than words or anxiety or a batch of "new" rules — is the essential ingredient in addressing the issue, or problem, of chemical abuse. Nothing can replace the need for direct and thorough confrontation. Other issues or controversies, such as jurisdiction or the invasion of privacy, particularly when perceived as part of some unjust witch-hunt or overreaction, may not really be overriding concerns at all. The vast majority of our students seem to respect and support our current approach wholeheartedly. Above all, the topic or concern here is integrity — of both the body and mind. The biggest, real problem, or obstacle to the truth is denial. Fundamentally, it would seem that our collective adult spirit cries out for a precise, professional approach, one that creates a clear climate of consequence as well as a comprehensive set of alternatives to use or abuse. No longer can we tolerate the assumption of many of our young people either that we know exactly what's going on "out there" or that somehow we tactily approve of experimentation with drugs. No longer do we wish to hear a student ask (as one did just last spring): "I think I know where you stand now. Where did you stand three years ago?" It's not really a jungle out there. But without clear rules and a precise but humane procedural approach, it will be. All of us — both within and outside of our schools — deserve better than that.

Adapting a Navy motto to our school, "We aim for the individual student to be drug free, the class to be drug free and the whole school community to be drug free." To this end, our use of drug testing equipment has enabled us, in confrontations, to cut through the fog of denial and lying. This is enabling Choate Rosemary Hall to strengthen community moral values of justice, mercy and understanding.

At the end of the workshop, a school counselor asked, "If a school is serious about drug and alcohol abuse, should it institute testing?" Our answer is a resounding, "YES."

Sources for drug testing equipment

Alcotest Breatholyzer
National Draeger Inc.
101 Technology Drive
Pittsburgh, PA 15230
(412) 787-8383
$14.50/box of 10 tests

Emit-ST Urine Drug Testing
Syva Company
P.O. Box 10058
Palo Alto, CA 94303
(415) 493-2200
Orders — (800) 227-9948
$5697 (machine and starter chemicals)
(Though the cost of the Emit-ST equipment appears initially high, it must be realized that the cost of an individual test at the local laboratory would be in the range of $28 *per substance*.

Panel discussion: An Institution's Response to the Issues of Pregnancy and Abortion in the Independent School Setting

Panelists: Judy Bridges, Dean of Students, Emma Willard School; Dagny St. John, Counselor, Burr and Burton Seminary; Robin Wallace, M.D., School Physician, St. George's School. Moderator: Mary Anderson, R.N.

From the notes of Peggy Brown, Dean of Students, Albany Academy for Girls
The questions posed to the panel were:

- Given that federal and state laws permit prescription of birth control pills to minors, what is your response to the establishment of gyn services and the prescribing and dispensing of birth control methods on your campus?
- What is your response when a student approaches you with information that she or her friend has a late period?
- Most students are unable to share this kind of problem with their parents. Can you highlight the potential risks that will be taken by the school administration, physician, nurse and counselor when the parents are not informed?
- If pregnancy is established, how far do you think the institution should or can go in helping a student to resolve her dilemma?

Judy Bridges, Dean of Students at Emma Willard School, answered as follows. Before establishing a gyn clinic on campus, check state and county laws with regard to minors and birth control. Acknowledge in the school's written policies that teenagers indulge in sexual activity. The school does not necessarily condone sexual activity by establishing a gyn clinic. Students should be strongly urged, but not forced, to tell their parents. This area of student activity should not generate a disciplined response. The parents of students should be informed of the school policy with an adequate amount of time to respond in the negative if they do not want their daughter to avail herself of the service offered.

Judy emphasized that for such a clinic to work well in a boarding school, the dean's office and health center must have a good working relationship and that limits of communication be well understood by health center and school administration. The administration must have faith in the health center procedures established for any sensitive area, and especially for the sensitive area of sexuality.

The introduction of a gyn clinic is best done with small groups of students by the health center staff. At Emma Willard a student must have two appointments before a supply of birth control pills or a device is dispensed. In addition to blood pressure, weight and urine testing, the first appointment includes careful birth control counseling and discussion of the responsibility involved in a sexual relationship. The student is strongly urged to discuss the step she is about to take with her mother. The second appointment is for a vaginal examination, pap smear and a thorough physical. If a school is coed, or if the male involved in the sexual relationship is readily available, he should be included in the first appointment and be counseled to pay half the expenses involved. Judy feels this system is a good one.

Judy stated that in cases of pregnancy in which a student chooses abortion, the school should support the student through the experience. The difficulty of transportation to and from appointments was discussed. It is a problem to which there is no satisfactory answer. To ask a member of the faculty to drive a student means to break confidentiality, and an R.N. is seldom available to undertake this task.

Dagny St. John of Burr and Burton Seminary gave the counselor's response. She prefaced her comments with a brief allusion to the way abortion and sexuality was handled by three different schools. One school ignored the problem and as a counselor she

(continued on page 8)

(continued from page 7)
was in the position of helping a student with no backing by the school administration. "Experience and knowledge has shown me the risks I took," Dagny said. A health service that is expected to inform the headmaster of a pregnancy is not going to be used very often. The school that can be open about a gyn clinic and the dissemination of birth control information is the ideal. Dagny emphasized that encouraging the student to share her condition with her parents must be the first response of the counselor, R.N. and M.D. The role of the counselor is to assume confidentiality and to share the burden of fear and uncertainty with the student. The counselor should establish a relationship with the student then help her proceed to the necessary action in each individual case.

Dagny pointed out that a young person's immediate response to sharing the information with parents is shame. Experience, however, has proved that most parents respond well and if a student can be persuaded to share her plight with parents, then the procedure regarding pregnancy or abortion becomes simpler to handle. It is important for a student to be counseled to tell her parents at some point; such an exchange between parent and child cements a relationship.

Robin Wallace, school phsyician at St. George's School, responded with very practical suggestions. Make sure your student medical form asks the specific question: "Does your daughter have your permission to be examined and treated by a gynecologist?" Malpractice suits pose no real threat on this issue.

Parents react to their child's sexual assault with fear and anger at first, but they are reassured when they become aware of the support given by the school and health services. Robin emphasized that the usual professional approach in these matters is to maintain confidentiality at a patient's request.

It is important for the health team to find out about the extent of a student's sexual activity and to be very sure that birth control is being used properly.

The physician will test for pregnancy with either urine or blood, examine vaginally to confirm diagnosis and then work with the student to consider options. Robin cautioned that a minor should NEVER be told date of delivery. Doing so could result in severe depression on that date. Robin recommended a period of counseling to help the student move from one experience to the next and to assist the student in making responsible decisions regarding any further sexual relationships.

Mary Anderson pointed out that when a student can share information with parents, it is easier to help a young person through the experience of a sexual relationship and its possible consequences.

ISHA now presents certificates of attendance for participation in full-day conferences. Attach your copy of the program to the certificate.

ISHA Update

Future Plans

Spring Conference at St. George's School, Newport, RI, Friday, April 18, 1986
Topic: Teen-age Sexuality
Keynoters:
Sol Gordon, M.D. — "Promoting Self-Esteem with Specific Focus on Sexuality"
Powel Kazanjian, M.D. — "The Newer Sexually Transmitted Diseases"
Workshops:
"When Living Hurts — Teenage Suicide," Sol Gordon
"Current Issues in Sports Medicine," David Kroll, director of athletic trainers, St. Paul's School; Edwin Henrie, M.D., school surgeon and sports medicine physician, St. George's School; Frances Rotella, school trainer, St. George's School
"Teaching Moral Issues to Young Children" (kindergarten through grade 9), Nancy Jo Jander, Eaglebrook School; Carol Cowles, counselor, Eaglebrook School; John Hawlin, counselor, Tower School, Wilmington

BOOK EARLY FOR THIS POPULAR TOPICAL CONFERENCE. Keynote address and workshops limited to 150 persons. The keynote address only will accommodate up to 400 persons.

Fall Conference at Dana Hall School
Date: To be announced
Topic: Is Your School Community Healthy?

About Sol Gordon
Sol Gordon — writer, lecturer and educator — is director of The Institute for Family Research and Education. Dr. Gordon received his Ph.D. from the University of London in 1953. He has served as professor of child and family studies at Syracuse University, where his popular class on human sexuality had an enrollment of over 400 students each semester.

Located in Syracuse, NY, the Institute for Family Research and Education was founded in 1970 and is dedicated to strengthening the American family by encouraging honest communication between parent and child. The Institute has developed two key projects. The first involves family life education programs for parents. It trains key leaders in community agencies, schools and religious groups to educate parents to assume their role as primary sex educators of their own children. The second consists of programs to reduce pregnancies among teenagers. The principal philosophy of the Institute is that ignorance, not knowledge, stimulates inappropriate sexual behavior.

Dr. Gordon has spoken on the subjects of sexuality education and promoting self-esteem throughout the U.S. and abroad. He was recognized for his creative work in the field of sex education when he received the annual American Association of Sex Educators, Counselors and Therapists (AASECT) Award in 1982. In March of 1985 Dr. Gordon was the recipient of the Raymond B. Bragg Award for Scholarly Contributions and Personal Commitment to Humanism by the American Humanist Association.

Dr. Gordon's work has been featured in such magazines as *Good Housekeeping*, *Woman's Day*, *Family Circle* and *Teen*. His writings include both popular and scholarly works and he has served as a consultant for several films, filmstrips and audio cassettes.

Some publications:*
Psychology for You (Sadlier/Oxford, 1978). A high school text. Revised 1983.
Facts About Sex for Today's Youth (Ed-U Press, 1983). New edition.
Did the Sun Shine Before You Were Born? With Judith Gordon (Ed-U Press, 1977). A sex education primer for children aged 3-7.
Girls are Girls and Boys are Boys — so what's the difference? (Ed-U Press, 1979). A nonsexist liberating sex education book for children aged 6-10.
The Teenage Survival Book (The New York Times Book Co., third edition, 1981). A graphic tour-de-force designed to communicate essential life-knowledge and enhance self-acceptance among youth. Cited as one of the best young-adult books in 1976 by the American Library Association.
The New You (Ed-U Press, 1980). A "help-each-other" book of poetry, essays and slogans on life.
A Better Safe Than Sorry Book — For Sexual Assault Prevention. With Judith Gordon. (Ed-U Press, 1985).
When Living Hurts (Union of American Hebrew Congregations, 1985). A suicide prevention book for teenagers.

*A complete list of Dr. Gordon's books is available from Ed-U Press, P.O. Box 583, Fayetteville, NY 13066.

Dyslexia — You Can Help

Rosemary F. Bowler

Nurses and counselors can play a critical role in students' educational achievement. Be alert to students presenting any of these behaviors and conditions:

- short attention span and difficulty in attending
- restlessness and/or irritability
- poor coordination
- unusual frustration
- above-average frequency of migraine, allergic reactions or diseases of the immune system (e.g., celiac disease, ulcerative colitis, myasthenia gravis)
- familial history of left-handedness, delayed speech and/or stuttering.

These students may be dyslexic. Did you know that 30 percent of our population is handicapped by severe reading problems, according to a recent report of the U.S. government? And, says Jeanne Chall of Harvard University, between a third and a half of these poor readers have dyslexia.

For years, reading experts and special educators tended to dismiss dyslexia as an umbrella term of little value in deciding on educational plans for students encountering problems in learning to read. Fortunately, that attitude is undergoing a major turnaround. The October 1985 issue of *NEA Today* (the newspaper of the nation's largest teachers' union) devoted a two-page spread to dyslexia, its causes, its symptoms and the new hopes for treating it effectively.

The medical profession, in particular the World Federation of Neurology, has used dyslexia as a diagnosis for some time, defining it as "a disorder manifested by difficulty in learning to read despite conventional instruction, adequate intelligence and sociocultural opportunity."

The seminal work of Geschwind and his associates at Harvard Medical School and Beth Israel Hospital has sparked a new wave of medical and psychological research into dyslexia as an organic condition. Most brain researchers now consider dyslexia to be caused by anomalies in the development of the cerebral hemispheres, which in turn, it is hypothesized, may result from left-hemisphere development delay caused by testosterone.

School health professionals who observe any of the signals mentioned above should consider the possibility of dyslexia and refer the student for evaluation, particularly if academic performance is poor. While dyslexia cannot be "cured," the good news is that, with proper educational planning and treatment, the dyslexic — often bright and blessed with special talents — can succeed as a student and, more important, as a human being.

For many years a public school teacher and administrator, Rosemary F. Bowler, Ph.D., is currently a consultant on dyslexia and is retained by The Orton Dyslexia Society to edit its publications. The society's Annals of Dyslexia *is a scholarly journal whose contributors consist of the foremost researchers — medical, psychological and educational — in the field. For competent testing in your area, The Orton Society recommends that you contact them for information: The Orton Society, 725 York Road, Baltimore, MD 21204.*

ISHA PUBLICATIONS

****NEW****

Faculty Guidelines for Crisis Situations and Sample Medical Forms $8

Working booklet. Contents: recommended guidelines for safe policy making. 23 pages.

****NEW****

Audio Cassette Tape $4

Fall '85 Keynote Addresses: Barbara E. Jones, "Ethical Issues" and John W. Wideman, "Confidentiality."

Health Notes $16

12 different "letters" (printed 8½ x 14). Intended audience: our adolescents. Topic: Wide range of health-related concerns.

These publications are available by mail; all prices include postage.

They will also be on display and for sale during the ISHA spring conference, April 18.

Please remit payment with your request to:

C. McCartan
ISHA Secretary
Emma Willard School
Troy, NY 12180

AIDS Policy for Schools

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

The disease known as AIDS — Acquired Immune Deficiency Syndrome — is currently on the rise in the United States. Sooner or later the independent school will be faced with the dilemma of how to respond when a student has been diagnosed with this condition. Should a student with this disease be admitted? Should a student who is diagnosed after admission be retained? (The incubation period is thought to be five years.)

The ISHA council respectfully submits the following suggestions to help with policy making in the area of health care.

- We urge all schools to have a policy accepted by the board of trustees and in place before the question arises of whether or not to admit or retain a student with AIDS.
- The education of faculty, staff and students should be an ongoing process so that all are well informed of current developments in the management and control of the disease. (ISHA strongly feels that the schools are responsible for providing medical facts both to inform and to correct misinformation.)

The school that decides not to accept or retain a student with AIDS need proceed no further with a policy. The school that decides to accept and/or retain a student with AIDS must take into account the following health-related issues when making policy.

- Is the physician willing to treat an AIDS patient?
- Are the R.N.s willing to care for a patient with AIDS?
- Are the health facilities adequate? Are isolation facilities available and staffed when needed?
- Are local facilities such as hospitals available and willing to care for a patient with AIDS?
- Is the counseling team able to deal with the effect of the AIDS sufferer on student peers and faculty?
- When a student is diagnosed through school health services, what is the administrative policy with regard to confidentiality as it applies to both parents and school administration? How is this information regarding confidentiality disseminated to parents and student body?

ISHA will make every effort to assist with policy making and to keep updated information available.

The First Seven Years of ISHA

David B. Connell, M.D.
School physician at Choate Rosemary Hall
and past president of ISHA

At the end of this academic year, 1985–86, Mary Anderson will be stepping down as president of ISHA, leaving Emma Willard and retiring to England. By coincidence or synchronicity, I will be leaving Choate Rosemary Hall and returning to England to take up work in counseling and psychotherapy. This seems a propitious time to look back over ISHA's first seven years and see what has been accomplished.

ISHA was born in May 1978, with a meeting at Choate Rosemary Hall called "The Ten School Medical Seminary." The meeting was attended by nine counselors, five nurses, four physicians, two psychologists and one psychiatrist. So successful was this first seminar that a second meeting was held at Loomis Chaffee School in April 1979. By then, the name of the organization had become "Independent School Health Society" and 20 independent schools were represented. They were Emma Willard, Dana Hall, Ethel Walker, Miss Porter's, Avon Old Farms, Deerfield Academy, Stoneleigh Burnham, Choate Rosemary Hall, Hebron Academy, Lawrence Academy, Loomis Chaffee, Middlesex, Northfield-Mt. Hermon, Phillips Academy, Suffield Academy, Taft, Wilbraham and Monson, Eaglebrook, Milton Academy and Berkshire School. Support structures were discussed. After the second meeting, it was commented: "Though many schools have religious courses through which students can compare religious doctrines and historical events, very few offer experiential religious opportunities. Despite attempts to provide religious programs for students, many of these schools agreed that the atmosphere of the institutions mitigates against experiential student involvement. Each school's schedule so rigidly adheres to a system of bells that it inadvertently prevents students from coming to grips with their private, individual selves. The universal prep school motto seems to be (in essence), 'Keep them busy.' Though this extreme has merit, obviously it has some disadvantages as well. It seems to promote the value of the American dream, 'The more you hustle, the better or more successful you are.' The consensus is that the institutions themselves need to look long and hard at the values they are encouraging in their students at the expense of ignoring much of the 'inner self.'" How much progress have schools made over this issue? Certainly, in the last year or two some schools have begun to devote considerable energy to the promotion of moral and ethical values within their own communities.

Since those early beginnings, ISHA has continued to grow, particularly under the guidance of Mary Anderson. During her two-year tenure as president, she has strengthened existing programs and added new ones.

- ISHA has become a busy referral source. Phone calls and letters to the president and executive secretary have come from not only New England but from as far south as Pennsylvania and into the Midwest.
- Through the observed needs of students, Mary has taken considerable initiative around the subjects of dieting, nutrition and general physical and mental health appropriate for adolescents.
- The newsletter has grown in size and in quality. Recent issues have dealt with subjects ranging from AIDS to the creation of a "Crisis Booklet" and good medical forms to fair and just salaries for nurses.
- Mary has achieved changes in the structure of the ISHA Council to reflect representation from all the various constituencies involved with and having an interest in student health.
- The financial stability of ISHA has been strengthened. Membership categories have been revised to include both school and subscription members. Currently, membership represents 125 schools. Geographically, ISHA now serves not only the original cluster of New England states and New York but also members in California, Colorado, Delaware, Illinois, Maryland, Michigan, Montana, New Jersey, Ohio, Pennsylvania, Virginia and Washington, DC.

Mary and I can leave the shores of the United States feeling that we have helped the Independent School Health Association grow and prosper.

An Addendum

Mary E. Anderson:

As retiring president of ISHA, I would like to acknowledge the founding and faithful members of ISHA. In response to an observed need, ISHA past presidents Alexandra Kubler-Merrill, Sprague W. Hazard and David B. Connell had the insight to realize that the modern problems of their adolescent students were probably not unique to their institutions. They recognized that an exchange of information regarding treatment of physical and mental conditions was necessary and would be invaluable to the independent school communities, and acting on this insight ISHA was born. David's article reflects the past seven years; I would like to stress that without the first five years of hard work, the last two would not have been possible. I am proud to have such a firm foundation on which to work.

Richard A. Artessa, Peerless Insurance Company
140 Everett Road
Albany, NY

Letter on Insurance

Dear Mary:

I am writing to update you and the council as to the progress made concerning ISHA's Student Health Insurance Plan. To date we have four schools officially enrolled for an approximate enrollment of 500 students. There have been informal inquiries made by at least six other schools.

I would like to remind ISHA member schools and their business managers that although this insurance plan is endorsed by ISHA and enjoys a group-based rate, all policies are issued on an individual school basis. The deadline for enrollment was January 1, 1986. However, we would consider any school after that deadline if it was very interested in committal to the plan.

Thank you for the opportunity to work with ISHA in providing this most valuable service. We have been able to create a most comprehensive insurance package and affordable price and to launch the project from the drawing board. I am assuming that, if we are successful in servicing the charter members in this plan and if the insurance marketplace continues its trend to tighten insurance plans and prices, our enrollment will increase in subsequent years. I see that as a positive outgrowth for each school and ISHA.

Head Injuries: Evaluation and Management of Concussions

by Dave Anderson
Head Athletic Trainer
Choate Rosemary Hall

A concussion is a "clinical syndrome characterized by immediate and transient impairment of neural function, such as alteration of consciousness, disturbance of vision, equilibrium, etc., due to mechanical forces." Athletes are particularly prone to concussion in the course of practices or games and it is wise to know the symptoms and treatment of choice should a student be injured.

Concussions are usually classified according to the duration of unconsciousness.

- A *first-degree* concussion results in a short or momentary state of confusion and dizziness and sometimes a mild tinnitus. There is normally a quick recovery, usually within a couple of minutes, and little or no headache and no dizziness, memory loss, unsteadiness, nausea or visual impairment. It is best to keep this athlete out of the game for several minutes to insure that there aren't further complications. If no unusual signs or symptoms are present, the athlete may resume participation.
- A *second-degree* concussion results in unconsciousness that may last as long as two to three minutes. Upon regaining consciousness, there will be momentary confusion, retrograde amnesia, moderate tinnitus and dizziness, and unsteadiness for five to ten minutes. Although the sufferer may appear totally functional after a few minutes, he or she should be watched closely for recurring symptoms and should not be allowed back in a game. It is wise to put the student in the infirmary for at least 24 hours — or at the doctor's discretion. No further athletic activities should be permitted for three to five days, after which time athletics may be resumed if no headache, nausea or dizziness occur.
- When an athlete suffers a *third-degree*, or severe, concussion, he or she will remain unconscious for a longer period. Symptoms include mental confusion, lasting five minutes or more, prolonged memory loss, severe ringing in the ears, dizziness and unsteadiness. A student suspected of suffering a severe concussion should be taken to a hospital or doctor's office for further evaluation.

Before allowing an athlete who has suffered a concusion of *any* severity to practice or re-enter a game, an examiner should administer a series of simple tests. These tests are also useful in determining the severity of the concussion.

1. Does the athlete have headaches, dizzy spells or nausea?
2. Can the athlete answer simple questions such as "What is the score?," "Where are you playing?," "What happened before you were hit?"
3. The eyes should be checked, bearing in mind that some people have anisocoria (unequal pupils) normally.
4. Check for nystagmus by asking the athlete to follow a finger with his or her eyes while keeping the head still. The examiner's finger should be approximately 12 inches away and should move in all directions.
5. Can the athlete pass the "100 minus test"? Ask him or her to subtract 8 from 100, then 8 from the resulting number and so on — as fast as possible.
9. Use the "Romberg Test" as an indicator of steadiness. Have the athlete extend his or her arms to 90° of forward flexion, and close his/her eyes. Watch for any swaying or loss of balance. Have the athlete extend the arms to 90° of shoulder abduction and, again with the eyes closed, touch the nose with the right and left index fingers.

Having administered these tests, the examiner will have a much better idea of the extent of the concussion. If the examiner finds that an athlete suspected of having a first-degree concussion is unable to perform one or more of these tests satisfactorily, the student should not be allowed to continue play. Athletes sustaining two or more second-degree concussions in a season should be kept out of practice and play for the remainder of the term. Athletes who suffer two or three third-degree concussions in a career should be kept out of contact sports permanently.

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.

Acute Respiratory Infections in a School Population

Vina Patel, M.D.

The recognition, control and management of acute respiratory infection presents the most common and at times formidable problem for the school physician and nurse. The diagnosis of upper respiratory infections is confusing at times. The clinical syndrome for viral and bacterial infection can give rise to similar symptoms; hence, one needs to look for clues that point to specific etiology on clinical grounds and through the use of laboratory tests.

URIs all have common symptoms and signs. They usually start with varying degrees of nasal congestion, postnasal discharge, sore throat, cough, pharyngeal and tonsillar reddening, fever, exudate and swollen glands.

Symptoms of *common cold* are febrile, nasopharyngitis, acute respiratory disease, acute catarrhal tonsillopharyngitis with or without conjunctivitis, usually present in similar fashion. These are viral in origin usually but secondary infection of bacterial origin can occur. This condition is self limiting and supportive treatment suffices.

In addition to the above symptoms, *acute tonsilitis* shows exudate and/or membrane on the throat. When symptoms are accompanied by a temperature, throat culture will reveal the presence of streptococcus of the hemolytic type, which yields a definitive diagnosis of strep throat. (A membrane can be also seen in infectious mononucleosis and diphtheria, as well as in adenoidal infections.) Strep throat should be treated to prevent such sequelae as rheumatic fever, nephritis, scarlatina, etc.

The presence of vesicles and apthous ulcers on tonsils, anterial fauces, palate, and buccal mucous membranes are for the most part of viral etiology and present the classic picture of herpes simplex or Coxsackie A virus. This can be associated with gingivitis and supportive treatment helps the sufferer.

The symptoms of fever, cough, respiratory stridor and beefy red epiglottis are usually caused by H Type B influenza, but haemolytic streptococcus, pneumococcus, staph aureus and other viral agents can be the cause of the epiglottal swelling. These infections respond well to an antibiotic such as tetracycline or ampicillin unless other resistant organisms are present.

Dr. Vina Patel, an internist and practicing physician in Troy, is from Bombay, India. For the past five years, she has been the school physician at Emma Willard School. Her speciality is chest and lung disease.

Laryngotracheitis with or without bronchitis that is with productive sputum is a fairly common infection and is spread easily because of its viral origin. The throat and epiglottis often appear normal in this instance. The H influenza and parainfluenza viruses can give rise to a similar picture.

In *asthmatics,* acute bronchiolitis or acute bronchitis is often presented as an increase in wheezing, accompanied by fatigue, loss of appetite and coughing particularly at night. It is advisable to take a throat culture and blood count. Measures should be taken to alleviate the wheezing, and antibiotics aimed at the common culprit of this condition, the H influenza virus, should be administered.

Infectious mononucleosis always poses a challenge and seroconversion does occur in 15% of patients. The glands are much larger and more extensive; these symptoms with those previously mentioned give a clue to the diagnostician. An abnormal CBC and titer will verify the diagnosis.

Microplasma infection is very common with the onset of cold weather. Symptoms of acute respiratory illness and symptoms that exceed the findings give the clue. A blood test with positive cold agglutinin and titer confirms the diagnosis. Quite often adventitious sounds are heard in the chest even with a normal X-ray.

Influenza-like illness has symptoms of extreme fatigue, muscle pain in the back and extremities accompanied by a lack of localizing signs. The cause of this adenoviral disease is para-influenzal, Cocksackie B. This disease is self limiting.

In all these infections the most difficult question is **to treat or not to treat.** Hand washing, supportive care and mental support are the mainstay of therapy irrespective of the type of illness.

Indication for antimicrobial therapy is usually determined by clinical course of the disease and the results of lab data.

Of course — don't forget to call the mother!

Ankle Rehabilitation

L. W. Flagg, Jr., R.P.T., R.T., A.T.C.,
Trainer, and
Dana Weeder, M.D.
Injury Consultant
Phillips Exeter Academy

When an ankle injury is sustained, whether mild or severe, time and treatment must be provided for the best possible healing. This slow rehabilitation period can be disconcerting for the young athlete, who may be able to walk or even run and is anxious to return to his or her sport. However, injured ligaments must be allowed to heal in a "snug" position so that scar tissue doesn't form over a *stretched* ligament leaving an unstable joint vulnerable to repeat injuries.

Following the initial post-injury period of rest, taping, cast or splinting, rehabilitation should begin. Daily physical therapy treatments, including whirlpools, massage and exercise, are aimed at regaining full range of motion. The ankle may be stiff at first and between treatments taping or high-top shoes may be helpful.

The student should be encouraged to engage in only light exercise: walking — making an effort not to limp — and light jogging as the injury continues to heal. Even though the ankle may feel fine, re-injury can mean a much longer period of recuperation, so students should be warned against playing frisbee, tag football or other strenuous informal sports. A regime of daily exercises should be instituted.

The student should be followed regularly by either the infirmary or the gym trainer and can be returned to sports once certain functional tests can be performed.

Ankle strengthening exercises — to be done morning and night.

The following exercises should be recommended for strengthening and increasing mobility of the ankle. Each should be done twice daily.

1. Sitting, flex and extend foot pressing hard in each direction for a count of three. Repeat 50 times.
2. Rotate foot in each direction 50 times.
3. Put a bath towel on floor, place bare foot on towel; with toes gather towel under foot. Repeat several times.
4. Stand against wall, two feet away, place hands on wall, walk backwards keeping heels down, stretching Achilles tendon. Repeat several times.
5. Stand on bottom step, balance yourself lightly with railing. Foot should be half on step. Lift body, count three and lower. Repeat 30–50 times.
6. Throughout day while sitting, studying, etc., "write the alphabet" with foot.

Going Out the Door

Michael Eanes, Headmaster
The Gunnery School,
Washington, CT

When infirmaries become health centers, the emphasis in services evolves from one of curing to one of prevention. Programs in nutrition, human relations and sexuality, peer counseling and drug education emanate from the health center and nurses and medical directors deserve credit for developing these outreach programs and for beginning to change the atmosphere of the health center from one of passive receptivity to one of active involvement. However, much more needs to be done in order to complete the transition from infirmary to health center.

One of the most obvious — and difficult — steps is to *go out the door.* Medical personnel, feeling the need to be always accessible in a predictable location for emergencies, are effectively prevented from intermingling with students and faculty in their daily routines. This separation interferes with the teamwork and mutual respect that would be beneficial in accomplishing the aims of the health center.

Nurses must get *out*. They should attend the drama productions, games, debates and recitals. They should stop by the trainer's room, the faculty room and go to school meetings. They should host open houses for faculty and students, or help chaperone a school trip. Good health care is the first priority, but if health care centers truly want the respect, confidence and cooperation of the students and faculty, then the staff must become participants. The goal of every nurse should be to be known by *name*, not as "the nurse."

The working day of school nurses is full. In addition to dealing with students, doctors, hospitals, parents and faculty they must also keep up with their journals and professional meetings. It will be difficult to make time to do these extras, but the benefits will be enormous. They'll have a much easier time getting an advisor to cooperate in a confidential situation with a student if they have established a relationship with that faculty member previously. Coaches will respond more positively to being handed a "pink slip" if they know the person who signed it — and if that person has shown some interest in the team.

Forging relationships is a two-way street, of course. If the head sets a tone of respect and support for the work of the health center, the faculty will follow his example. Certainly the change will take time but a little public relations from the health center will go a long way toward making the school constituency not only aware but also appreciative of that very important human resource: the school nurse. Today's professional health center staff members have a great deal to offer both as individuals and as an organization and they must confidently make their presence felt on the campus. It will certainly make things easier going on the days when nurses must use their ultimate power — the irrevocable pink slip!

Health Education References

Nancy Cushman, MS, Ed.S.,
Counselor, Emma Willard School

Interest in the article "Health Education in the Curriculum," a review of the required health course at Emma Willard which appeared in the last ISHA newsletter, has been encouraging. The following is a review of two books which have proved to be particularly valuable resources for this course and a list of other resources that specifically address women's health issues.

Both of these books use educational games and strategies to promote education that is enactive rather than reactive and student rather than teacher centered. Educational games were introduced to the business community in the mid 1960s. Since then, they have found their way into the classroom at all levels of education. It has been found that the use of these games and strategies promotes greater student involvement, motivation and interest. A few studies have indicated a significant change in level of knowledge; however, most educators have found little significant difference in cognitive learning.

There is some evidence that games can help change students' attitudes and clarify their values. Less able students perform as well in games as brighter students; however, the latter learn more as measured on a final exam. I have found that some exercises can be used as supplements to class discussion while others are complete in themselves.

Health Games Students Play, by R. Engs, S. E. Barnes and M. Wantz (Kendall/Hunt Publishing Co.: Iowa, 1975), provides a combination of structured experiences, simulation games and experimental exercises. Structured experiences are activities directed by the teacher in which students play themselves in a classroom. The experiences presented last five to ten minutes and can be used to stimulate discussion or introduce a

(continued on page 14)

(continued from page 13)
new concept. During a simulation game, participants usually play a designated role in a make-believe world that is similar to the real world. Most games in this book can be completed in one class session and are used to clarify values, examine attitudes or introduce factual material. Experiential exercises take students into the real world to make observations and gain knowledge through experience. Categories include mental health, substance use, human sexuality, death, aging, personal health, nutrition, diseases, consumer health, first aid and ecology and the environment. Many of the activities can be easily adapted to other topics and to your specific textbook. If only one book is used, I recommend this one.

Student-Centered Health Instruction: A Humanistic Approach, by Jerrold S. Greenberg (Addeson-Wesley Publishing Co.: 1978), opens with a thoughtful presentation comparing the student- and teacher-centered classroom as it relates to teaching health education. The author believes that students must first learn human relation skills in order to benefit fully from the student-centered educational process and to function effectively as a group. Consequently, the opening exercises are designed to teach these skills. The goals of many of the activities are value clarification and the solicitation of opinions and positions from students. Content activities include mental health, drug education, human sexuality, nutrition, physical health, environmental health and emerging health concerns. Many of the activities can be adapted to other topics and your text.

Women's Health Care References

Boston Women's Health Collective. *Our Bodies/Ourselves,* Simon & Schuster: New York, 1985.

Leavitt, Judith Walzer, ed. *Women and Health in America,* University of Wisconsin Press: Madison, Wisconsin, 1984.

Marieskind, Helen. *Women in the Health System,* Mosley: 1980.

Letter to the Editor

Dear Ms. Anderson:

The fall '85 special issue newsletter was most impressive. There was relevant, current information on issues we are dealing with daily.

Please find my membership subscription enclosed.

Keep up the good work.

Sincerely,
Janet Smith
The College Preparatory School
Fairfield University

(continued from page 2)
teaching them how to *be* a friend: our society stresses *having* a friend. We are, in fact, over-emphasizing friendship, the warm fuzzies.

The second troubling attitude is pragmatism, a gift from the English philosophers. Its present distorted form says that if it works, it's good, that anything is okay as long as you don't get caught. Our national obsession with efficiency has fed into pragmatism, the efficiency that has led to payoffs, kickbacks, bribes, the "practical" way to get things done. Part of our educational process is and must be intensely practical with objective standards of measurement. Yet the attitude can lead to an emphasis on product over process, on grades over learning, on college admissions over the educated heart.

Pragmatism, of course, underlies cheating in schools, (*Highwire* magazine says 80 percent of our students cheat. Hierarchy of values: exams, tests, copying homework.) Thus, we have the student attitude that says it's all right to cheat if you get a higher grade, which is the same as saying that it's all right to steal as long as you get rich! We can counter this attitude in three ways:

1. Clarify, explicitly and frequently, at a school-wide level, what the school means by "cheating." Splitting assignments, homework shared, looking over a friend's paper for ideas are cheating just as plagiarism and exam crib notes are cheating. Explain why both the giver and receiver are guilty, why stealing ideas is wrong. Let's communicate our assumptions.

2. We must diminish our emphasis on negative competitive values. We are making it so risky for them to fail that they cheat and we're making failure a disgrace. We need assemblies on the glory of goof ups, on the need to practice, on the excitement of ideas. We need to insist that work is not pressure but intellectual adventure, and if we're serious about rewarding independent thought, we have to make it safe for them to mess up. We need posters in all classes that say "Success isn't final and failure isn't fatal." Or, "If you can't be right, be wrong — at the top of your voice!" We need to talk about excellence rather than success. Or are we saying that smarter is better?

3. Let's counter their arguments head-on: "Everybody does it," "It doesn't hurt anyone," "What's wrong if I don't get caught?" We need to be explicit that not everybody cheats; that two wrongs don't make a right; that cheating is a form of peer pressure; that the point is not what we get away with but the wrong that we do that damages our moral fibre, our integrity; that stealing ideas is worse than stealing money; that we need to grow intellectually on our own; that principles are more important than grades; that cheating a little is the same kind of act as cheating a lot.

Pragmatism also underlies the lying youngsters sometimes do to get out of trouble. We need to do more to help them accept the consequences of their acts, which is, of course, the definition of true freedom. For instance:

1. Teach the necessity of suffering and show them that they have the courage to endure it. Tell that sometimes we have to stand and hurt a little.

2. Talk more about will rather than feelings, of doing things we don't want to do.

3. Help them sort out of two kinds of hurt. No one wants to be hurt but we need to help them see that all humans can and sometimes must endure pain, which is preferable to damage to the integrity.

4. Tell them it's okay to stand there like idiots and say, "Yeah, I did that. I can't believe it. I really did that. Wow!" Tell them to take responsibility for their goof ups and to stop asking their parents to lie for them.

Pragmatism also underlies "borrowing without permission." In order to create a climate of expectation, we need to say frequently, "We do not borrow without permission." And because notebooks belonging to better students often disappear before exams, we need to help all students keep better notes. (Today we call them orderly storage and retrieval systems.)

A third troubling attitude is relativism, which we hear reflected in such statements as "Everyone's opinion is as good as anyone else's," "Right and wrong are up to the individual," or "That's just your opinion!"

Such statements, of course, are nonsense. There are absolute rights and wrongs, invisible, objective realities, universals. We discover them, we do not invent them. Morality is not up to the individual; moral action is. There is a difference between individual conviction acting on the truth and individual subjectivism as the norm of truth. This attitude may be the result of our recent emphasis on individualism and our failure to teach the moral realities because of our fear of the moral specifics.

Jim Craig, of Northfield Mount Hermon, says that in relativism Kierkegaard's chickens have come home to roost, and I say that we have to move out of the hen house.

Kids today are drowning in relativistic moral trash. They think that God is their personal feelings and that morality is whatever they feel as individuals.

Relativism underlies the idea that it's all right to steal from the supermarket or phone company but not from friends. Stage debates to counter that view with one position being that stealing is stealing.

Relativism underlies the breaking of all laws. ("I can run a red light," "I can handle liquor at 14," or "Because pot laws are unfair, it's okay for me to break them.") In this view, right is up to the individual. Teach something about anarchy — its sources, problems, results. Draw also on the fact that sports require rules as do communities.

To counter relativism, we have to teach the reality of universals by teaching religion, philosophy, ethics with its classical modes of thought. We need to watch our own language and avoid the false humility that says, "It seems to me — ," or "I don't know all the answers, but — ." We must say what is right and what is wrong. And we must counter the illogic in relativism. For it boils down to meaning that everyone is right — bullies, bigots, rapists. In this view, even Hitler was right because he thought he was right.

We must say, over and over, that some things are wrong even if everybody does them and some things are right even if nobody does them, that always and everywhere, selfishness and deceit and bullying are wrong; that always and everywhere, fairness and kindness and consideration are right; that a wrong action is not made right simply because we do it for our comfort or convenience.

Relativism means that right is what each person approves of, acts on, so no one is ever wrong. You can't say, "You're wrong," because right is simply what I choose to do. "It's right for me." Yet students say, "I knew it was wrong, but I did it anyway."

Relativism means that we cannot appeal to any commonly understood standards as we do when we say, "That's not fair." Relativism spills over quickly into privatism, our fourth troubling attitude, and I suspect that is Bishop Berkeley's gift to us.

Privatism is the intense isolation of the individual; it is individualism run amok. In privatism, selves are unconnected, disengaged. Like the state of privation, they are deprived, destitute, solitary selves who don't pick up the trash because they didn't drop it. It is the confusion of saying, "It's not my fault" as if that meant "It's not my responsibility." (Its symptom, I suspect, is the walkman: solitary people listening alone to civilization's most corporate invention — music — that which was created by the community for the community. Our appeals to community and to corporate action and fellowship are not understood — even if they are heard.)

The real and most dangerous symptom of privatism is the increasing susceptibility of youngsters to peer pressure, which works because of insecurity. Then the pressers start "fronting" (putting on an act) and "frying" (putting others down). The pressees start "covering" (smarting off, acting tough or blasé and looking grungy). Both end up giving in, doing things they don't want to do, going along to get along, feeling more inadequate.

We can counter peer pressure by requiring students to participate in some activity in which they can build confidence, such as arts, crafts, interest groups, sports or the wide range of volunteer service in school or beyond in the larger community. We need to build the adviser-advisee structure because the easy, open, listening, caring adult-student relationship is the best antidote to peer pressure.

I have seen remarkable results when time is set aside to discuss peer pressure: no one likes it; all want out. Ask for three things that students can do to resist negative peer pressure. The act of talking makes it acceptable to say "No," and peer pressure diminishes immediately, for at least a week. Upper schoolers need more time to identify and recognize the more subtle kinds of peer pressure with which they deal.

The final troubling student attitude is hedonism, the idea that pleasure is the greatest good, a contribution of Epicurus and John Stuart Mill. But pleasure is simply the name we give to some feelings. And feelings are internal, with little reference beyond themselves. Ideas and judgments refer to something beyond: I have an idea of something. Hedonism tends, therefore, to exclude the higher faculties of intelligence and imagination; feelings alone are simply not a valid guide to the good life.

Hedonism makes the good life animal sensations; it stresses experience rather than the significance of experience. And, of course, feeling is no measure of value, yet we are making emotions, pleasure, self-gratification the norms. (I am disturbed when I ask someone what they think and the response is, "I feel —" or "I'm not comfortable with that —.") In this view, goodness is what makes us feel good.

Yankelovich, in *New Rules*, says that we've gotten so we think we have to do what we want to do. Our national ethic, in his analysis, is one of a search for self-worth: jobs as means to self-fulfillment at a loss of the virtues of thrift, productivity, sacrifice, hard work, loyalty, and perseverance that led to an abundant and expanding economy. Sociologist Amitai Etzioni, in *An Immodest Agenda*, goes further: he says that the search for self-fulfillment is crippling the family and is the cause of divorce and laxity toward authority.

Hedonism underlies students' lack of commitment, their tendency to change activities when something better comes along. When pleasure is the highest value, then sex is not an expression of love but a substitute for it. When pleasure is the highest value, then students tend to separate the work week from the weekend, to see work as pressure, a chore to be gotten through. They talk of the need to relax, to blow off steam, to get away from it all. Hence the national increase in marijuana and cocaine and alcohol use, in underage drinking, in "field parties."

We can help them to find joy in work, to live with stress, to see tension as a healthy stimulus rather than a negative to be overcome. We need to watch our own language and not say things such as "Thank goodness, it's Friday," "It's Monday and we're all tired from our heavy weekend," and "I know we're looking forward to the weekend." Let's not make the weekend real life. Expect weekend work, expect discipline, expect competence.

We can challenge them to commitment; we can insist that happiness is the result of service. We can stand against their desire to "do what they want as long as no one is hurt" and insist that they do what is right even if it does hurt. We can stand with them as they learn about frustration, inconvenience, not getting their own way. Kids want, need and deserve some straight talk. Kids want expectations clarified and enforced. In Grant Simpson's words: "They not only need discipline; they seek it." So whenever we say, "Do what you think best," We are saying, in effect, "There are no standards" or "I don't know the standards" or "I don't care about the standards" or "I don't care about you, kid."

Generally, then —

- Don't be afraid to say no and stick to it. Don't chicken out: Faith, Hope, Mary-Ellen.
- Keep promises or don't make them.
- If you're going to threaten, keep the threats reasonable and carry them out.
- Teach, witness to, insist on self-discipline, that inner organization that trains our psyches.
- Deal with moral issues concretely in courses and programs.
- Help kids develop a sense of occasion and a hierarchy of events.

(continued on page 16)

(continued from page 15)

- When they say, "What difference does it make?," realize that that's a real question. They want to know, at some profound level, what difference *they* make in this insane world. Tell them and show them that *they* make a difference — not their acts or accomplishments. They matter.

Should we teach by example? Of course. But students don't see us in the crunches of life, so we also have to speak the words. The moral structure must be visible and explicit, consistent and reiterated. Kids need to hear words like duty, loyalty and courage. I often think that education is largely a matter of building appropriate vocabularies, and the moral vocabulary of students needs enrichment, too. Let's also reward good citizenship regularly and make it acceptable and desirable.

Help students see that living takes practice, and that mercy, justice and charity will lead them to the good life. Give them places to act out the good in tutoring, work details, community service programs. Students deserve support for the heroic, the courageous, the courteous. Students deserve to be held accountable for their own acts and those of their friends.

Give them respect, real responsibility. Give them praise and a pat and, when they need it, a hug. Give them what you want them to be: confident, truthful, diligent, fair, patient, humane persons. Our students will be worthy adults, independent and principled human beings whose lives will bless those around them, people at home in the universe, if we speak our ethical expectations with authority, clarity and charity.

They are worth it, aren't they?

A response to the keynote address:

Suzanne Casey, R.N., Bancroft School, Worcester, MA

Refreshing, thought provoking, scintillating . . . at last, ideas being shared without embarrassment or excuses. These were some of the thoughts racing through my mind as Barbara Jones opened the ISHA Fall Conference. I was afraid to blink; I might miss something. Her delivery was executed with the precision of a drill sergeant, with the staccato effect of a rapid-fire weapon.

Dr. Jones defined morality as the ability to discern right from wrong. It is a word which is not accepted comfortably by many people as it is identifiable with organized religion, and that is not a safe area. The word ethics is a far better choice and becomes more widely acceptable. Her advice was to teach moral principles both by example and by speaking the words, for the words have to be heard and repeated. The refusal to speak on moral attitudes has engendered dangerous social attitudes.

One of these attitudes facilitates drug use with the supposition: "I'm supposed to feel good so I can do . . . (alcohol, drugs, etc.)." Dr. Jones then went on to expand on the value assumptions contained in this message; i.e., simplistic absolutism, pragmatism, relativism, privatism and hedonism.

The final statements of the address presented the audience with challenge for future action. *It is important* to impose our views on students, for if we do not pass on civilization's moral truths, they will not be known. *It is important* for students to know that it is okay to feel guilty, to fail, to suffer. *It is important* to keep promises, not to be afraid to say no and to teach self-discipline. The most important factor, however, is to do all with authority, clarity and charity.

ISHA
Independent School Health Association
Emma Willard School
285 Pawling Avenue
Troy, NY 12180

Non-Profit
Organization
U.S. Postage
PAID
Permit No. 164
Albany, New York