MEDICAL PRACTICE

Aspects of Student Health

Student health services

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The provision of medical services specifically designed for university students is, in the main, a development of the past 30 years. Before 1945 some rudimentary services existed. Thereafter, stimulated by a series of critical reports produced by student organisations and the Royal College of Physicians in the mid-1940s, there has been a steady increase in the number of university health services established on a formal basis. Practically every university now has some officially recognised arrangement that offers students various forms of medical care and supervision.

Need for health services

This pattern contrasts with the paucity of services available to students attending other centres of tertiary education. There are some teacher-training colleges and polytechnics that have accepted the need and offer an excellent service, but generally the authorities have not yet been convinced of the necessity to budget for maintaining the health of their students.

Since the advent of the National Health Service in 1948 arguments have waxed and waned over whether special provision should be made for what is generally supposed to be a fit and healthy age group. The discussions, acrimonious at times, still continue, with local prejudice within and without the institute being a major factor in helping or preventing the establishment of a service. The variation in the provision of such services in the universities in Britain and Northern Ireland is also related to the

age, size, and structure of the university, the presence or absence of a medical school, and the financial position at the time of decision making. The subsequent development has depended much on the personality of the first appointed medical officer and his relation with his university. Given so many factors, it is not surprising that no two units are identical, even though their aims tend to be broadly similar.

Organisation of the unit

The organisation of the unit tends to reflect the medical ethos of the first occupant of the post. Some university services are biased to occupational health, others to psychotherapy, while most tend to steer a middle course of offering a primary care service with special emphasis on emotional disorders and environmental health and safety problems.

SPECIAL OCCUPATIONAL HEALTH NEEDS

Malleson¹ pointed out that there are three principal ways in which students have special occupational health needs. Firstly, their ordinary illnesses can quickly have repercussions on their course work. An illness that keeps a student out of the university for three or four weeks when he is doing a highly structured course with a large practical element can open up such a void that it is difficult for him to catch up adequately by the end of the session. More troublesome is an illness occurring just before or during the examination period, be it physical or psychological. Urgent medical action is needed to decide what help can be given. Close liaison with the appropriate university department is essential to ensure that all concerned are aware of the potential difficulties, and usually a reasonable solution can be evolved without lowering academic standards.

Secondly, the pressure of work is more likely to precipitate patterns of emotional disorder in a considerable percentage of

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students who are also undergoing the normal psychological adjustments of late adolescence. To deal adequately with such problems takes time, together with a specific interest in these difficulties that can often include complex psychological mechanisms and social factors. At a practical level it is necessary to have some knowledge of the various courses, examination procedures, and regulations, together with a personal feel of the differing philosophies of the faculties and departments concerned.

Thirdly, students tend to be either living in colleges or halls of residence en masse or scattered about in various lodgings, flats, or multioccupancy houses of very varying standards. They tend to move around at the start of each academic year, and often irregularly thereafter. In either case it is more practical for them to have a central health centre on the university campus to visit and to feel that it offers them continuity of care during their period of study. It is also more likely that such an organisation will tolerate the constant shifts of address over a wide area than would the average practice that quite reasonably has a more circumscribed area in which it is prepared to accept patients.

MORE GENERAL NEEDS

In addition to the clinical service that is offered specifically and personally to the student, most university services undertake preventive care of a more general nature. There will probably be a simple, pre-entry medical form to be filled in by each first-year student. The aim of this is not to reject any student on medical grounds, but to try to offer as much help as possible if there is a need, particularly so in the case of the occasional seriously disabled student who is admitted to a course. Until recently most universities insisted on a chest radiograph as an entry requirement, but with the efficiency of the BCG immunisation schemes at about the age of 13 this is no longer necessary. The need for care in checking BCG records persists, and medical, dental, and veterinary students need to be reminded of this during their clinical training. Though tuberculosis has almost vanished in the indigenous population, an occasional case still occurs in the overseas students and their families, and special arrangements need to be made to meet this potential risk.

Other tasks that will be undertaken will be medical examinations for people exposed to radiation or laser hazards and students moving to schools of education and other academic centres here or overseas; and various pre-employment examinations for staff joining the institute or seeking employment elsewhere. The necessity for a code of practice in relation to actual or potential health hazards has been emphasised recently by the passing of the Health and Safety at Work etc Act 1974. Most universities have a university safety officer with supporting staff, and close co-operation between his team and the medical one ensures an effective environmental health programme. The aim is to be practical and realistic not officious and legalistic. Though some may regard scientists as absent minded, most are very safety conscious and are only too ready to work with safety advisers for their own and their department's benefit.

Members of the university are constantly going overseas for short or long periods, and to many exotic places. As well as providing an efficient immunisation service, there is a constant demand for advice on precautionary measures to be adopted in many different circumstances. Each service will build up its own network of expert advisers for these and other problems. If in doubt medical officers at other universities are always ready to help, and for over 20 years the British Student Health Association* has held annual conferences to discuss topics of interest and bring like-minded professionals together.

For a student health service to function effectively communication within and without the university must be good.

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The University of Birmingham medical team constantly strive to maintain close and friendly contact with the careers service, the chaplaincy, the educational counselling service, the halls of residence, the lodgings and welfare office, the registry, and with academic staff at all levels. Admission and departmental tutors are encouraged to meet us and talk over general and specific problems whenever they so wish. At times we are faced with problems of confidentiality in such meetings, and it is essential that we do not disclose information without the student's permission if we are to maintain our medical ethic and the trust of the student body.

Over the past few years the numbers of overseas students coming to British universities have steadily increased. Differences in culture and lifestyle, and problems with the written and spoken word, lead to considerable stress in some of them. Proportionately, therefore, it is not surprising that the use of the medical services is higher than with the indigenous student population. The pattern of complaint in such circumstances tends initially to be predominantly somatic in type, but the underlying anxieties are usually very evident. Further problems are caused in many cities by the increasing lack of any suitable accommodation, especially if a family unit arrives. Pressure is mounting each year in most areas to house the influx of first-year students. As a result, this year a leaflet has been issued by the registrar of the University of Birmingham, and this is now sent to all newly registered overseas students explaining in detail some of the problems they will face and suggesting to what extent the university can or cannot offer help, so that they know before arriving in Britain the problems they are likely to face. With the present severe financial stringency, universities are not able to build halls of residence or student flats to the extent that was envisaged a few years ago, and the "student image" means that new lodgings are not so easy to obtain as hitherto. Local bylaws framed in relation to multioccupancy have also caused difficulties in various centres.

Students are invariably short of money, but education is a costly business. In 1974 £4717m was so spent in England and Wales, ranging from £451 a year per child in a nursery school to an average of £1675 a year for a university student. At 1974 costs the State will have spent about £9000 in educating the average student from nursery school to graduation. It would seem a pity, on purely financial grounds, that such an investment may be diminished or lost owing to lack of adequate medical facilities. The universities have, in their various idiosyncratic ways, set reasonable standards. It is to be hoped that the other centres of higher education will be encouraged by the Department of Education and Science to develop on similar lines in the near future.

Reference

- 1 Malleson, N, *A Handbook of British Student Health Services*. London, Pitman Medical Publishing Co Ltd, 1965.

A well-adjusted young mother had a breast reduction operation two years ago. Though pleased with their appearance, she is upset that her breasts no longer react as erogenous areas. Normal cutaneous sensation appears to be intact except for a small area of numbness below each nipple. Is this usual after mammoplasty and can anything be done?

Reduction mammoplasty carries an established risk of loss of erotic sensation from the nipple and areola. The degree of this risk varies with the method of surgical reduction. Techniques using free nipple grafts are almost inevitably followed by complete loss of this special sensation. When the nipple is transposed on a dermal or breast pedicle, or both, the risk is greatly reduced but is still considerable. Spontaneous recovery of erotic sensibility sometimes occurs at a late stage and is more probable if there has been return of normal sensation to the area. No secondary surgical procedure is known to effect a recovery.