unrecognised until the fracture occurs, and in addition many present social problems that are brought to light only on their admission for hospital care. It is in these cases that the close association between the orthopaedic, geriatric, and social services departments of a hospital are of the greatest importance. All these patients need a full medical and social assessment at a relatively early stage, and many need a planned period of rehabilitation not only for the hip fracture but also for general medical care before they are fit to return home. An active and energetic geriatric rehabilitation unit is essential if these patients are to return to full activity, and with such a service most in fact will do so. In the postoperative period the orthopaedic aspects of this type of injury play only a small part.

Prevention

Clearly in many patients a hip fracture is in fact a pathological fracture through osteoporotic bone, and its prevention, if this

were possible, would be a major improvement in the care of the elderly. A few patients with hip fractures will in fact be found to be suffering from osteomalacia and a correction of this may prevent a similar injury on the other side at a later date. There is some evidence that giving oestrogens to postmenopausal women reduces the risks of senile osteoporosis and might therefore be expected to diminish the incidence of hip fractures, but in general it seems unlikely that in an aging community much can be done to diminish the incidence.

Over 30 000 people each year in England and Wales, almost all elderly, and most of them women, are admitted to hospital after a fracture of the hip. Some will die as a result of the injury or the treatment, or more commonly from intercurrent disease. Some will inevitably end their days in a long-stay bed or in sheltered accommodation, but with good surgical treatment and a high standard of geriatric and nursing care most can return to their place in the community with no additional disability caused by the injury.

Aspects of Student Health

Psychological problems of students

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A consideration of the psychological problems of students must take place against a complex and changing background. Rapid social and technological changes are taking place in society. Values are changing, or under challenge; uncertainty pervades increasing areas of life. Whether changes are seen as adverse or beneficial, they are likely to contribute to a climate of conflict and stress that individuals will react to in their own personal ways.

Within higher education there have been major and continuing changes. The 1960s saw rapidly rising student numbers and the development of new universities. Within institutions knowledge has exploded, courses have diversified, and options have increased. More has been questioned than ever before. Ironically, economic recession has brought a reduction of subsequent vocational opportunities. How such complex factors may influence late adolescent development and identity formation must largely be a subject for speculation, but they are likely to have contributed to the various modes of unrest and disturbance that have been enacted in universities in recent years, and which find their counterpart in the consulting room.

Those working with students in clinical services have themselves, over the years, experienced change and confusion, as conceptual models of "health" and "illness," "normality" and "disturbance" have lost the illusory clarity of earlier years. The development of new therapeutic approaches has added to the range of possible provision for such problems, but theoretical

confusion and difficulties in evaluation have contributed to uncertainty.

Developments this century

To understand the present position it will be useful to recapitulate briefly some of the important developments of the past few decades. A more fully documented account of some of the earlier aspects is provided by Mair.¹

The Boer War led to a recognition of a deplorably low standard of physical health among recruits. The concern evoked eventually resulted, after various commissions and inquiries, in the establishment of the school health service. A subsequent royal commission in 1902 commented on the lack in universities of facilities comparable with those in schools. The emphasis at this time was exclusively on detecting physical illness and promoting health by physical recreation. So far as the universities were concerned, all other student problems were regarded as educational or spiritual and the concern of tutors and religious advisers. For many years, therefore, medical activities were confined to detecting physical illness (particularly tuberculosis) and to promoting health by physical exercise, to which end many universities appointed directors of physical education. Thinking continued predominantly on these lines in the years between the two world wars.

The Goodenough report (1944)² and reports from the Social and Preventive Medicine Committee of the Royal College of Physicians (1943 and 1946)³ advocated the further development of this preventive approach, with its implicit notion that physical health was something separate from intellectual and personal maturation. Thus by the mid-1940s the structure envisaged was that services should be attached to departments of preventive and social medicine. It was thought that NHS facilities would

meet all therapeutic needs, and no one saw that mental health problems would become an area of major concern.

With the introduction of the National Health Service in 1948 debate began about whether services should continue to have a solely preventive approach or whether facilities for treatment should be included. There was considerable discussion and disagreement, but the subsequent trend was for services to be integrated with the National Health Service and to establish a comprehensive pattern of preventive and treatment care, a structure endorsed by the third report of the Royal College of Physicians (1966).⁴

ENTRANCE OF PSYCHIATRY

Psychiatry entered the scene rather dramatically in the early 1950s with the publication in 1951 of a paper by Parnell,⁵ then at Oxford, on mortality and prolonged illness among Oxford undergraduates. His report of a suicide rate allegedly 11 times that of the general population evoked shock, surprise, doubts, and conflicting explanations. It was a stimulus to further research, however, and subsequently Carpenter⁶ and Rook⁷ produced further disconcertingly high figures for Oxford, Cambridge, and seven other British universities (contemporary rates are unknown).

That year, 1951, was also the year the British Student Health Association of physicians and psychiatrists working in higher education was founded. The medical model now unashamedly expanded to include states of psychological disturbance, and workers embarked upon a nosologically oriented psychiatric exploration. Such questions were canvassed as: What was the prevalence of disorders? How could they be described and classified? What were their causes? How should they be treated? There were hopes for agreed methods of classification, aspirations towards comparative studies, and hopes of aetiological understanding. Though these hopes have been only incompletely realised, much useful clarifying work was done in the 1950s. It was recognised that formal psychiatric illness affected probably 2-4% during a three-year period and was probably little different from the general population.⁸ Nevertheless, these disturbances shade off into a heterogeneous assortment of psychological and psychosomatic problems that fluctuate in duration and severity and affect a further 10-20% of the population.

PSYCHOSOCIAL DISTURBANCES

The second group, better termed psychosocial disturbance than psychiatric illness, was recognised as apt to occur at particular times: in relation to entering university; often in relation to study or examinations or both; and in relation to important events in personal and family life. These disturbances are perhaps as prevalent in non-student populations but they are of special importance in students because of the demand for sustained intellectual work. University physicians gradually came to realise that many such problems could be looked at less as "illness" and more as the emotional reactions of personalities developing from adolescence to adulthood, and that it might indeed be appropriate sometimes to regard "disturbance" in relation to an important life event or task as "healthier" than its absence.

The growth of interest in development was highlighted in the 1956 international conference, held in Princeton, USA, under the chairmanship of Erik Erikson.⁹ This conference helped to promote a shift of interest away from concentration on description of symptom patterns to an understanding of processes. Interest grew in the psychological problems and conflicts resulting from establishing vocational and sexual identity. It was recognised that developmental crises related to such conflicts may occur, and that these might proceed to adaptive or

maladaptive resolutions. It seems likely that the contemporary social changes referred to earlier will add to the intensity of many such crises, and in the vocational area in particular may add to the difficulty of satisfactory resolution.

CHANGES IN SEXUAL BEHAVIOUR

During the 1960s and subsequently, whatever the reasons, there were important changes in patterns of sexual behaviour as more students had sexual intercourse. The contentious controversies surrounding the provision of contraception for the unmarried have largely faded, but a consequence of increased sexual permissiveness has been a rise in numbers seeking advice for psychosexual problems, such as impotence, premature ejaculation, frigidity, and dyspareunia. These constitute therapeutic problems of growing importance, and in late adolescence an important area in terms of identity development. Despite the ready availability of contraception, there continues to be an unwanted pregnancy rate among the student population of 2-3/100 girls a year, the social and psychological reasons for which need further clarification.

Practical management

The considerations outlined are relevant to the practical management of student problems. Specific problems will be dealt with in more detail in subsequent articles, but a brief account of general principles will be given. Liaison between university doctors and others concerned is of the greatest importance; these may include fellow students, tutors, wardens of hostels, family, doctors and psychiatrists outside university health services, and counsellors. Confidentiality must be fully respected, and any contact made may only be with the students' full-hearted consent. Liaison is much more relevant for some problems—for instance, work and examinations or behaviour that disturbs others such as alcohol abuse in shared accommodation—than others.

Overt psychiatric illness is often known to have occurred before university entry, and the stress of transition may sometimes provoke relapse early in the first year. Hence advance notice from the general practitioner or psychiatrist to the university health service may be of the greatest value, enabling early contact to be made. Should breakdown recur and necessitate withdrawal from college the best arrangement may sometimes be day-centre treatment or admission near the student's home, and careful liaison is again essential when return to college is planned.

Psychosocial problems often declare themselves with difficulty in studying (though it must be emphasised that highly disturbed students may function extremely well academically). Symptom patterns related to studying are highly complex and include psychoneurotic and motivational aspects.¹⁰ Liaison with tutors is helpful not only in providing additional academic support but also in clarifying the realities of work performance. Depressed students, for example, may be severely overcritical of their performance and may plan unwarranted withdrawal.

PSYCHOSOCIAL PROBLEMS

An important acute group of psychosocial problems may occur on entering college in students who were apparently previously well adjusted. Distress may be so severe that the student impulsively decides to return home. Such problems will usually be detected and helped by college tutors, counsellors, or physicians. Such students, however, occasionally turn up on the doorstep of their family doctor, perhaps accompanied by agitated parents.

The family doctor may well find himself during vacations, or at other times, dealing with, for example, crises such as bereavement or parental divorce, distress after a broken love

affair, unwanted pregnancy or the fear of it, bad reactions to a trip leading to fear of brain damage, or crippling anxiety reactions before or during an important examination. Having known the student and his family for some years, he is often in a good position to help, but to do so effectively he will need, with the student's permission, to contact college-based academic and medical personnel. Special help can often then be arranged—for example, examinations may be written in the health centre.

After the crisis the underlying problems may be appraised more leisurely, and some plans worked out for tackling them. These may include individual or group sessions with a therapist or counsellor (likely to be indicated when there is evidence of recurring neurotic difficulties); behavioural approaches in relation to specific problems; social skills training when there is a deficit in this area and skilled personnel are available to help; or intermittent supportive contact, enabling the position to be kept under review and further measures implemented subsequently if indicated. Drug treatments, in particular the benzodiazepines, are often invaluable for short-term help through a crisis, though little is known of their effects on academic performance. Any medication used during an examination should be thoroughly familiar to the student in terms of its effects, wanted and unwanted. No drug will control overwhelming anxiety, and temporary withdrawal from studies may be wiser.

Conclusions

The contemporary picture emphasises the interactive effects between the individual and the institution. The late adolescent

is engaged in complex developmental tasks. The institution provides recourses and makes demands which facilitate his development; but stimulus may become stress, particularly when the personal life of the individual becomes, for the time being, problematic. There is greater realisation of the differences in personality reactions to stimulus and stress, since each person interprets his life situation in a highly individual and complex way. Provision of help needs, therefore, concern and flexibility on the academic side, combined with individual therapeutic help using a range of methods.

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For Debate

The general practitioner's role in the management of labour

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The Cranbrook Report¹ recommended that all general-practitioner obstetricians should have access to general-practitioner beds and that these should be close to consultant maternity beds. Since then there has been a progressive increase in hospital deliveries as a proportion of all deliveries, rising from just under 65% in 1960 to 80% in 1972.^{2,3}

During 1963-72 there was a linear regression in confinements managed by general practitioners, as indicated by a fall in the percentage of claims submitted for complete obstetric service (including confinement) expressed as a percentage of all claims.⁴ Nevertheless, in evidence to the subcommittee on domiciliary and maternity bed needs,⁵ general practitioners agreed overwhelmingly that they should be able to provide maternity services for their patients in hospitals or maternity units. While

many of them suggested that they should be integrated into the hospital maternity service to deal only with normal cases, most visualised themselves as working in totally separate units with overall responsibility for their patients.

The policy of making hospital maternity beds available for use by general practitioners continues to receive support. The philosophy underlying this policy is that suitably trained general practitioners should have the opportunity to look after their own "low-risk" patients not only in pregnancy but also in labour. This philosophy seems to be based on the assumption that those patients who are identified as being at low risk are unlikely to develop serious maternal or fetal complications in labour. We report the results of a retrospective study designed to determine the incidence of unexpected maternal and fetal emergencies arising during labour in low-risk patients.

Patients and methods

In 1973-5 the obstetric unit at Queen Mary's Hospital delivered babies to a total of 4106 patients. Of these women 1557 (37.9%) had undergone induction of labour for various obstetric indications and were therefore excluded from the study. The 2549 women who went into labour spontaneously remained in the study and constituted the estimated total number of low-risk patients. Those whose labours had

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