The role of the school medical officer in secondary schools

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SUMMARY. This paper describes the children seen during a typical morning session in a London girls' comprehensive school. Although many of the problems are similar to those encountered in general practice, it is argued that these children, who give rise to considerable anxiety among teaching staff, would not present to their family doctors. The way in which they are managed requires particular skills and an understanding of the complicated interaction between adolescents, their families, and their educational environment. With the move towards primary care child health surveillance, and the appointment of consultant community paediatricians, the future of the school health service is under debate.

Introduction

THE school medical officer has existed in one form or another since the Education Act of 1893, but, increasingly, the justification for a medical input into secondary schools is being questioned by district health authorities looking for potential areas for economy. These children already have general practitioners, some are attending hospital clinics, so do they really need a third source of medical care? If so, what should the service be and who should provide it?

The aims of the school health services have been summarized as 'to maintain the health of school children, to identify and treat the handicapped and, by working closely with teachers and psychologists, to promote the study and understanding of the area where sensory, physical, intellectual, emotional and cultural factors merge and contribute as variables to specific learning disabilities and to general educational failure or success'.[1] However, the role of doctors in secondary schools has never been clearly defined, which has meant that attempts to evaluate the service they provide have ignored the way in which most doctors work. It may well be that the service provided is inappropriate to the needs of some school populations, but before we can discuss the value of any service, we have first to begin to identify the types of problems and the ways in which they may present or be detected. For example, emotional disorders can be identified by teachers in at least 7% of the adolescent school population,[2] but many more may pass unnoticed in the classroom or at home unless accompanied by attention-seeking behaviour. This is particularly true for girls (Crouchman MR, unpublished), who have fewer behaviour disorders than boys[3] and it underlines the inadequacy of relying on traditional routes of referral to identify many major problems in this age group.

The wide range of skills required by the school doctor dealing with adolescents is illustrated by this account of a typical school medical session conducted by the author in the upper house of a girls comprehensive school in inner London. It is unusual for children to present in school with a single problem, or for that problem to be as straightforward as it seems. The author's interventions in these nine girls show just how inappropriate it can to be 'compartmentalize' the management of adolescents.

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Case studies

Case 1. A 16-year-old girl referred by her teacher because of concern about home circumstances

This girl is the elder child of working professional parents, and a few weeks before had presented to her teacher with the story that her father had hit her hard across the shoulders the previous evening. He is an alcoholic and frequently verbally and physically abuses her and her mother. She had been receiving counselling from her tutor, in whom she had confided the details of her home life. He had become increasingly concerned about the use of physical violence against her, the effects this unhappy and tense environment was having on her and her younger brother and her worries about a medical condition for which she was attending a hospital outpatient department. Her tutor had gone through the usual procedure in such cases and had informed the education welfare office, but also sought help via the school doctor, who, unlike himself or a social worker, could communicate directly with the general practitioner and hospital doctors.

During our first interview we had talked about her problems at home, and also about the chronic eczematous condition of her breast areola. She said that she had been told that she 'must either stay on treatment forever or have the nipple cut out'. In spite of the continuous stress, her mock GCE 'O' level examination results were good. However, she had a miserable Christmas at home and I planned to speak to her general practitioner, check the diagnosis of her breast condition, and arrange an interview with her mother.

In our first interview, when she was talking about her father's violence, I asked her whether he had ever sexually abused her. She said he had not, but our conversation was recounted to her close friend (case 5).

Case 2. A 14-year-old girl referred by her teacher for breathlessness and dizziness over the past four days

I observed this girl from the other side of the medical room while she was talking to the school nurse. She was obviously anxious and hyperventilating. I was told that her parents had separated about a year previously and her mother was expecting a baby in six months time. They lived in a two-bedroomed flat, and she was still sharing a room with her 18-year-old brother. Apart from rather dilated pupils and slight tachycardia, there were no abnormal physical findings and no evidence of solvent abuse. I thought she had an anxiety state triggered off by the recent realization that her mother was pregnant and by the chronic stress of overcrowded living conditions. I arranged to see her in two weeks time with her mother, and said I would write a letter to the housing department if her mother wished me to.

Case 3. A 15-year-old girl with a painful right knee

This young girl referred herself, saying that her knee had been hurting her since earlier that morning. There was no abnormality on examination apart from slight tenderness over the lateral ligament. On questioning her, I discovered that she had spent the

previous evening dancing in a disco, and I advised her to rest the knee over the next few days (but to come into school).

Case 4. A 14-year-old girl with behaviour and hearing problems

This young girl is from a large family, and her parents have consistently failed to attend appointments to discuss her problems. Her teachers queried a recent recurrence of her long-standing, intermittent hearing loss. I had seen her a few weeks previously, had thought her hearing was slightly reduced, and had referred her back to the ear, nose and throat department, where she was prescribed a course of treatment. This had been forgotten over Christmas, and had ended up in the dustbin. I told her that she had wasted a lot of time and money. I gave her a letter to her general practitioner to complete the treatment before follow up at the hospital next month, and checked with her teacher that help for her in the form of tutorial classes was being sought.

Case 5. A 16-year-old girl referred by her teacher for premenstrual tension

She had told me at the first interview (one month previously) that she was hoping to train as a doctor and was concerned about arrangements being made for her science curriculum. She had been away in Pakistan for the past two-and-a-half years and had had difficulty in readjusting since her return. I had said I would talk to her teacher but that she must also ask her parents to push for a place in the 'O' level mathematics set. I had also given her a letter to her general practitioner about her vaginal discharge. On this follow-up visit, she said she was pleased because she had been moved up in mathematics. Her discharge and periods were better and she had not gone to the general practitioner. She then said 'you know when you asked my friend (case 1) about her father?' and went on to tell me that during her stay in Pakistan (at the age of 13 years) she was raped violently on many occasions by her mother's brother, over a period of six months. When her mother found out, she called her a 'slut'. Since then the matter has never been discussed, although her mother occasionally refers to it during arguments. Her father, however, knows nothing about the incest, and she thought he would kill himself out of shame if he ever found out. She was adament that neither parent should know of our conversation. On the other hand, she said that these events were the main cause of her initial problems on return from Pakistan and although she was now coping better, she acknowledged that she needed further help. She also wanted her male teacher to understand what her problems had been, so that allowances could be made for her poor performance during the previous term. I undertook to discuss this with him and to see if the Department of Psychiatry would accept her as an individual referral. I have since arranged for her to be seen by a female Asian psychotherapist.

Case 6. A 14-year-old girl whose teachers were worried that she was withdrawn

When I looked through her medical notes, her withdrawn affect was commented on as far back as her primary school days. I asked her about herself, and how she spent her time. I thought she led a rather lonely, boring existence, but did not think that she was formally depressed. She did not want to join the youth club although she had no close friends other than her two siblings. I discussed her with her general practitioner, who thought psychotherapy would be unacceptable to the family. I told her teachers that I did not feel we had any more to offer but would see her again if they continued to be worried by her behaviour in school.

Case 7. A 14-year-old girl, referred by the special needs teacher, who thought her hands were very clumsy

I had been asked to assess this girl the previous term in my role as developmental paediatrician. I agreed that her manipulative skills were very poor and had referred her to the occupational therapist. There had been very little progress, however, and her handwriting was still illegible. Her work was otherwise quite good, but she would need a typewriter for examinations and I suggested that we begin the procedure for preparing a statement of special educational needs in this girl.

Case 8. A 16-year-old girl referred by her teacher for dizzy spells

On the first occasion she had shown me some enormous iron tablets prescribed for these by her general practitioner. She had not taken any because they were too hard to swallow. I had diagnosed 'pre-mock- 'O' -level anxiety state' (a well-recognized syndrome in school medicine) and had advised her about the number of hours she should work in the evenings. She returned to say that she felt better and that her examination results were good. We discussed treatment for her acne and I left it open to her to return to see me as necessary.

Case 9. A 16-year-old girl with partial hearing

This girl was reviewed routinely as having 'special educational needs'. We discussed her hearing aids and her curriculum. She was complaining of a right-sided earache for the past 24 hours. The eardrum was not inflamed but she had injected fauces. I explained to her how a sore throat could give her earache, but stressed again the importance of seeking proper medical attention for earache in her case. I suggested that she should take pain-killers when she got home.

Discussion

The provision of a good medical service in schools leads to a steady stream of self-referrals, and referrals from teachers. Not all these problems, however, are strictly medical. These clinical examples reflect the various roles the author is typically asked to undertake — the cases were not selected to represent particular areas but form an account of an actual morning in the school.

Role of the school medical officer

A source of primary medical care. These cases illustrate the point that adolescence is often associated with a reduction in contact with the family doctor, at a time when childhood illnesses are disappearing and when these children are not yet confident enough to present themselves at the surgery as adults, with a right to privacy and confidentiality. In theory, primary care should not be provided in school. In practice, however, many young people do not make appropriate use of their family doctors (cases 2 and 3) or do not succeed in presenting the real problem underlying their symptoms (cases 5 and 8). The close internal community of the secondary school allows word to spread that such matters can be discussed in the school medical room.

An advisory and support system for teaching staff. All but two of these nine girls were referred to me by worried teachers. Secondary comprehensive schools are very stressful places for those who work in them and are asked to carry an increasing burden of pastoral care. Unfortunately, many teachers are still poorly informed of school health services as a resource,[4] and doctors must be prepared to initiate the dialogue. The availability of a doctor who will not only see the children, but also provide feedback to the teacher is vital to the efficient functioning of the school. It is this supportive and coordinating role that is largely unrecognized by conventional methods of evaluation.

A specialist referral system. In addition to general paediatric skills, the school doctor needs to be trained in the detection and management of hearing losses (cases 4 and 9), mental state examination (cases 1,2,5,6 and 8) and neurodevelopmental assessment (case 7). He or she also needs to be aware of the special problems associated with adolescence, for example drug or solvent abuse. This was an important differential diagnosis in the girl who presented with strange behaviour in class (case 2). Furthermore, familiarity with the Special Education Act and the facilities available locally for children with various types of special needs (cases 4,7 and 9) is essential.

A liaison service. One element of the school doctor's role is liaison between child, school, parents, general practitioners, hospital departments and social services. This is particularly important for children with chronic medical conditions (cases 4 and 9) or adverse home circumstances (cases 1, 2 and 5) which are impairing the child's educational functioning. The school doctor is in the unique position of having access to a wide range of professional colleagues, in particular other doctors. The need to maintain confidentiality in the management of school children and their families often means that he or she has the most balanced view of the interaction between the factors in the internal community of the school and those which affect the child in the wider external community, including the home.

A counselling service. Even in those secondary schools which have a school counselling service on site, the school doctor is asked to 'talk to' pupils whom the teachers feel have emotional problems. An assessment of the mental state is often necessary to screen out those children requiring psychiatric help rather than supportive counselling. Moreover, a large number of children needing counselling present initially with physical symptoms which 'open the door' to the medical room (cases 2, 5 and 8).

Health education. Although most health education in schools is carried out by teachers and the school nurse, the doctor has an important advisory role to play. The ability of a doctor to be explicit about sexual matters is invaluable in sex education, and enables adolescents to talk more freely about their own experiences and feelings in this area (cases 1 and 5).

The future for the school health services

Although some of these functions of the school doctor (for example, counselling and primary medical care) can be appropriately redirected, there remains an important role for a doctor experienced in educational medicine who can provide the framework for the complicated and specialized nature of this work. However, the gradual emergence over the next few years of a community child health service based upon the primary health care team and the consultant community paediatrician does not readily encompass this concept of school medicine. If clinical medical officers are phased out, who will have the necessary skill, experience and time to do the work of the school doctor? The 'general practitioner paediatricians' proposed by the Court report[5] might have taken over this role, but they have failed to emerge for various practical reasons. In any case, the report of the Royal College of General Practitioners[6] makes it clear that school health is seen as a specialty distinct from developmental surveillance and general practitioners do not intend to include it as part of their primary health care responsibility. This is disappointing, since an interested, suitably trained, general practitioner could provide continuity of care, a knowledge of the local community and perhaps a better relationship between the school medical service and general practitioners, many of whom are worried by the fragmentation of primary care and the potential for misunderstanding and manipulation of the system by children and their families. Much of this would be prevented if they themselves were part of the school medical services.

The demands upon the time of the newly appointed consultant community paediatricians will not permit them to become involved more than in an advisory capacity, at least until they have been appointed in sufficient numbers in each district. If junior paediatric staff are to rotate to cover the schools, how long will it take them to train, and, more pertinently, who will train and supervise them? What will happen to continuity of care, and the gradual accumulation of experience that is essential to all specialists? Is community paediatrics (like general paediatrics) such a large specialty that we will eventually have to have sub-specialties, with consultants in educational medicine, supervising and training their junior staff in a career structure? There is an urgent need for doctors experienced in the practice of secondary school medicine to discuss these issues and draw up realistic objectives for the service, to present to their district management teams.

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