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Clinical Sociology and Adolescent Medicine: The Design of a Program¹

David J. Kallen

ABSTRACT

This article describes the uses of sociological theory and knowledge in the design and operation of an in-hospital program for the care of physically ill and injured adolescents. The central tasks of adolescence — resolution of the conflict between autonomy and dependency, the development of intimacy and competence, the ability to take on adult roles, and the development of the self — may be hampered by a total institution which depersonalizes patients and fosters dependency. The development of normative structures which encourage autonomy, continuity of role development, appropriate levels of intimacy, and continued development of the self are encouraged by appropriate modifications of usual hospital routine. Normative support for these modifications is developed through educational programs for house staff (residents and interns), nurses, and others involved in the program. While the article emphasizes sociological concerns, the success of the program depends on contributions from an interdisciplinary team drawn from medicine, nursing, social work, and sociology.

Introduction

Clinical sociology has been defined as “the application of a variety of critically applied practices which attempt sociological diagnosis and treatment of groups and group members in communities” (Glassner and Freedman 1979:5). This paper discusses the ways in which sociological theory has been brought to bear on the development and operation of an in-hospital program in adolescent medicine. The presentation is purposefully biased in that it ignores the important contributions of psychology, medicine, nursing, and other disciplines to the program. Three areas are discussed: patient care; education of house staff (residents and interns), nurses, and others; and other uses of sociological theory in the program. Finally, some of the problems of program operation are discussed.

The program is run by a team that includes physicians, nurses, hospital administrators, social service personnel, and the sociologist. The entire group influences the decisions that are made, and the program could not be operated without the cooperation and collaboration of the entire group.² However, the attempt has been to give this program a distinctly sociological flavor: the sociological viewpoint influences both patient care decisions and the education of residents.

The Development of Adolescent Medicine

Adolescent medicine is a relatively new health care specialty. Although the Medical Officers of Schools Association was formed in England in 1884 by physicians caring for public school students, specialization in adolescent medicine per se did not occur until after the end of the Second World War. The first inpatient unit for adolescents was established in 1951. The Society for Adolescent Medicine was not organized until 1968, and its journal published first in 1979 (Gallagher 1982). Physicians who specialize in adolescent medicine are drawn primarily from pediatrics and from family medicine. Three major trends within American society contributed to the development of the field. These are: the separation of adolescents into a social category, the recognition of the special health needs of the group, and more general demographic changes.

Development of Adolescence as a Social Category. In American society adolescents are marginal persons (Park 1950) who have neither the full rights and responsibilities of the adult nor the freedom and lack of responsibility of the child (Kett 1977). Educational requirements that extend beyond puberty and hence delay entry into full adult roles and statuses set adolescents aside as a separate group in society. For reasons related to social and psychological development, adolescents are often loud, self-centered, and boisterous, and they behave in ways that adult society often regards as both inconsiderate and disturbing. These behaviors may be merely annoying in other situations. In the hospital, where the actors in the situation may be desperately ill, these behaviors may have serious negative consequences. At the same time, adolescents are often uncomfortable being with either sick adults or sick children. This mutual lack of comfort is, in part, the consequence of the marginality of the adolescent in American society. Thus, both adolescent and adult health care is seen as benefitting from the provision of special organizations for the care of the adolescent.

Adolescent Health Needs. During the 1960s the changing behavior of adolescents, particularly the increase in the numbers of adolescents living away from home and the increase in adolescent sexual behavior, led to the

development of special clinics for this age group. Many of these clinics were started to provide care for drug users and birth control to adolescents. This initial concern with specialized health care led to a recognition of other, more general health needs of this age group, and hence to the development of inpatient and outpatient facilities for them.

Demographic Changes. Changes in the age structure of society and the reduction in family size have resulted in fewer infants and children requiring care, while the aging of the baby boom generation has meant there are more adolescents and young adults seeking medical care. At the same time the development of family medicine as a specialty that offers primary care from birth to death has created increased competition for pediatricians, requiring them to seek new areas in which to provide care. Because pediatricians are familiar with problems of development, they see the provision of health care to adolescents as a logical extension of their work.

The Inpatient Unit at St. Lawrence Hospital

The development of the adolescent inpatient unit at St. Lawrence Hospital is the result of all these trends. St. Lawrence Hospital is one of three allopathic (MD) and one osteopathic (DO) hospitals in the Lansing, Michigan, area; together, the four hospitals serve a community of about 400,000. As a Catholic hospital, it has a long tradition of providing humane, patient-centered care, particularly in pediatrics. St. Lawrence is affiliated with the College of Human Medicine at Michigan State University³ and is a training site for pediatric and family practice residents.

The adolescent unit was established in 1980,⁴ partly to provide a service not then available in the community and partly to provide training in adolescent medicine to residents in both residency programs. Underutilization of pediatric beds at St. Lawrence contributed to their interest in the development of the unit. It was hoped that the provision of a needed community service would also alleviate the financial burden that unused beds created for the hospital.

The unit itself is a combined adolescent-pediatric ward in a community hospital. It has seventeen beds in one single and eight double rooms on a single corridor, with a children's playroom at one end and an adolescent recreation room at the other. The number of beds allocated to adolescent or pediatric patients varies depending on patient care needs.

The adolescent room has been clearly structured as a place where adolescents can go to be adolescents. It is equipped for their use with a Ping-Pong table, pool table, jukebox, etc. Access to the room is restricted to adolescents and their friends. Neither younger patients nor adults may enter the room without the permission of adolescents who are using it. No medical

procedures are ever conducted in the adolescent room. Hence, it can be a refuge from the trials of the hospitalization experience.

St. Lawrence Hospital was designed for patient-centered nursing. Nurses are expected to spend their time in the rooms with patients. Instead of the traditional nurses' station there is only a small conference room to serve as a central gathering place. Charts are kept in cabinets accessible from the hallway and from the patient's room. The rooms were designed to provide considerable privacy to the patient. This is ideal for the adolescent but less useful for the critically ill infant. At any given time there is a variable mix of adolescent and pediatric patients on the floor.

Unit and Program Goals

I was asked to help develop the adolescent program as an extension of pre-existing educational responsibilities in the pediatric residency program. It was clear from the beginning that the program would have to fit within the existing normative structures of the hospital and the residency programs.

In this community hospital, patient care decisions are ultimately made by the admitting physician, either directly or by the resident acting for him or her. Therefore, any impact on what happens to patients would have to be the result either of the way in which the program is formally structured or of an ability to influence those physicians who have the formal authority and responsibility for the patient's care. The influence might be direct or might be the result of educating physicians. Sociological interests and concerns led me to consider ways in which the program might focus on the social development of the adolescent, with less concentration on the psychological dynamics that are of concern to more traditionally organized programs (Hofmann et al. 1976). In fact, I began with the idea that the unit could be designed so that the social arrangements would forestall many of the psychological problems others see associated with the hospitalization of adolescents. At the same time, participation in this new program would provide new opportunities and challenges for resident education.

Two major goals were developed initially, and a third after the program began. They are: (1) To establish a structure in which the provision of health care to physically sick or injured adolescents would enable and encourage them to continue working on the major tasks of adolescence. To do this, three subgoals were developed: (a) to develop and mobilize a set of resources that would be brought to bear in the service of the adolescent; (b) to change the adolescent patient role to be much more self-directive and active; and (c) to develop a strong social structure in which social norms could be a major means of achieving unit goals. (2) To educate health professionals about social life in general, and specifically about social structures, normative behavior, and ad-

olescent social development, so that they would act in ways that would support the goals and purposes of the unit. (3) To develop system maintenance activities that would insure the smooth operation and continuation of the program. This third goal was developed after the program began. These three goals will be discussed in turn.

Goal Implementation

Program Objectives and Adolescent Development. Hospitalization, particularly long-term, has the potential of interfering with the developmental tasks of adolescence. The St. Lawrence program has been designed to permit the adolescent patient to continue with normal development to the greatest extent possible. To do this, it may be necessary to deny the patient certain traditional aspects of the sick role (Parsons 1958), particularly the exemption from normal activities. It may also require a renegotiation of the traditional health care worker-patient relationship to permit the patient to take a much more active role.

Adolescence is a time of rapid physical, psychological, and social development. Two cognitive developments complicate the problem of designing appropriate social environments to permit continuing development. These are the development of the ability to think abstractly (Adelson 1975) and the development of the adolescent myth (Cvetkovich et al. 1975). The adolescent myth refers to the adolescent's belief that he or she is the center of the world, that everyone is paying attention to him or her, and that his or her reactions and experiences are unique (McKinney, Fitzgerald, and Strommen 1982).

Crucial tasks in social development include the resolution of the conflict between dependency and autonomy, the development of intimacy and competence, the ability to take on adult roles, and, of course, the development of self. Adolescents face specific problems because of their hospitalization and often face life adjustment problems in general. Various aspects of the program have been designed to encourage progress in each of these developmental tasks.

The resolution of the conflict between dependency and autonomy is one of the major areas that can be negatively affected by the hospitalization experience. The hospital is a total institution that depersonalizes the patient (Goffman 1961). Set routines reduce patient autonomy and infantilize the sick person while providing care and nurturance. This lack of autonomy and infantilization may be an appropriate implementation of the sick role (Parsons 1958) for critically ill adults but may be counterproductive for many adolescents. In the unit, autonomy rather than dependence is encouraged by giving the patient as many opportunities as possible to make his or her own decisions about what happens. These decisions are of various magnitudes,

ranging from involvement in the choice about whether or not to continue treatment to prolong life to something as trivial as whether a shot should be given in the left or right arm, or before or after lunch. A major attempt is made never to make a request if a negative answer to that request is not acceptable; for example, a patient will not be asked whether he or she wants a medication but may be given a choice of the medication now or after lunch. Patients are encouraged to do as much as they can for themselves, including many of the routine maintenance tasks often provided by nurses.

At the same time, unit policy and procedures recognize that many adolescents require a period of nurturant care, particularly during the early stages of an acute illness. Adolescents who have left their parental home and are living independently may especially benefit from a period of dependency during the initial acute stages of an illness.

Staff Roles Role discontinuity between the hospital and home may also interfere with appropriate development. To limit the impact of hospitalization and to provide role continuity, the adolescent patient is encouraged to continue to do schoolwork and to do as much self-care as possible within the limits set by the disease. The need for continuity of life experience also has led to the formalization of a clear division of labor among the staff. Thus, for example, parents, the visiting teacher, and the child/adolescent life worker have responsibility for supervision of schoolwork; nurses provide nursing care and are not encouraged to help with or supervise schoolwork. The child/adolescent life worker does not become involved in nursing care. These role distinctions help patients understand their own as well as the adult role responsibilities at a time when social control, nurturance, and intimacy might become confused. At the same time, the development of intimacy is not dependent on the formal role of the alter, and strong friendships may develop between patients and staff. Hence, the formal assignment of roles does not interfere with the development of special supportive relationships between individual patients and individual staff.

Norms and Limits on Behavior The opposition adolescents often show toward formal authority is a consequence of both their struggle with dependency-autonomy and their newfound cognitive skills that permit them to see multiple sides to every issue. The unit, however, must have clear regulations about permitted and not permitted behavior. Hence, smoking is limited to certain designated areas. Nonprescribed drugs and certain forms of sexual behavior are prohibited, and visiting hours for friends are limited. The regulations are presented to the young person on admission as part of the normal — and normative — structure of the unit. Much conflict is avoided through communication to the patient that these are the rules of the house, implemented for reasons of health and for the consideration of other patients and not for moral reasons. At the same time, the rules are not rigidly and arbitrarily enforced;

visiting hours are flexible and a patient with a special visitor of the opposite sex may be permitted limited stay.

Group Process and Individual Intervention Hospitalization may interfere with the development of the self by removing the adolescent from usual daily routines, and the illness-hospitalization experience may make the adolescent feel vulnerable in new and unique ways. Thus, adequate development may be foreclosed. While individual counseling from social workers and psychologists is available, group process is also used to help the adolescent deal with the stresses of illness, hospitalization, and the new awareness of his or her own mortality. When there are enough patients in the unit and sufficient interest among them, group lunches are held in the adolescent recreation room. All adolescent patients are invited, though it is made clear to each patient that he or she has a choice of whether to attend. The discussion is initially structured around issues dealing with the illness and hospitalization experience, but it may move on to other areas of life. Because of the adolescent myth, adolescents are particularly vulnerable to the belief that no one else has ever had their experience or could understand it. The group discussions often demonstrate a similarity of experience, which helps the patients integrate the experience into the continuity of individual and social life.

At the same time, the other patients and the staff function as strangers; that is, the young person feels confident in sharing with these strangers ideas and concepts that would not be shared with those whom the adolescent expects to know after the hospitalization. This sharing with strangers is enhanced by their coparticipation in a situation in which the roles expected of and demands on the adolescent patients are ambiguous to them. Hidden or unrealized aspects of the self are often revealed in these situations, in part because those with whom they are shared will not continue to be part of the life of the adolescent. They will be left behind when the hospitalization ends, and the parts of the self here revealed will not provide feedback to the adolescent about other parts not revealed in the nonhospital situation. Thus, other persons in the situation act as Simmelian strangers (Wolff 1950).

It is also possible that the safety of this interaction with relative strangers enables the adolescent to experiment with new aspects of the self in ways that are not possible with persons with whom the patient will continue to interact. It is interesting to note that the adolescents are conscious of the importance of their initial presentation of self in these meetings. They will often make sure, for example, that they are well groomed in order to present as favorable and normal an external self as possible.

The adolescent lunches were started during a period when there was no child/adolescent life worker, and they were well received. For reasons which are not clear, interest in them dropped when a more individualized recreation program was started with the employment of a child/adolescent life worker.

Individualized Intervention The stress and strain of the hospital experience, or events in the life of the adolescent before hospitalization, may require individualized intervention. Both social service and psychological personnel are available to provide individual counseling. To discover which adolescents would benefit from these interventions, when resources permit, the social worker routinely visits each patient. The routinization of this initial interaction establishes it as a normatively appropriate experience which occurs on the unit. This significantly reduces the possibility that the adolescent in need of individualized help will be stigmatized by himself or herself, by the health care system, by peers, or by others as a result of the help-seeking behavior. Even when resources do not permit routine visitation of each patient, frequent visitation and response to informal referrals ensure that a visit from the social worker is not regarded as an unusual or remarkable event.

Social Intervention Some adolescents behave in ways that create problems for themselves and for others, particularly in their refusal to behave in socially acceptable ways and in conduct which disrupts the social order or disturbs others in the social environment. This acting out may be continuous with pre-hospitalization behavior or may be specific to the hospital experience. When the source of the behavior is regarded as psychological, appropriate psychological therapy is provided in an attempt to change the internal psychological structure of the individual and thus modify behavior. This individual therapeutic approach is often slow and expensive. But behavioral change can also be achieved by the use of clear social controls in clearly defined social structures. One example of this social intervention began one Friday afternoon when the nursing staff requested assistance with a 15-year-old female whose behavior was causing problems. Unacceptable behaviors included throwing her food tray across the room, ripping her bed apart, and refusing to communicate with the nurses. The nurses involved in her care felt that her behavior was not good for her, and they were also angry about the additional work her behavior caused them. They were unsure about how to modify her behavior. The patient appeared to be responding to a lack of a clear social structure to guide her behavior, with no clear negative sanctions applied when she behaved in unacceptable ways. The intervention chosen was to control her living situation in a way that would make it clear that her own inappropriate behavior had negative consequences for her. That is, if she threw her food tray, she would be expected to clean up after herself; and if she ripped her bed apart, she would sleep in an unmade bed. Thus, norms about appropriate behavior were made clear to her, and the consequences of norm violation became self-correcting by her choice. Over the course of two or three days her problematic behavior significantly decreased as she took responsibility for the consequences of her own behavior in a clearly structured situation.⁵ This regimen, of course, violated the expected caring and nurturing role of the

nursing staff. The nurses needed some initial reassurance that this change in their traditional role would be in the best interests of the patient. It is to the credit of the unit staff that they were willing to try this intervention. As the patient's behavior improved over the weekend, the nurses became highly supportive of the regimen. Program staff have continued to look at ways in which structural elements can be used to reduce problematic behavior on the unit.

Educational Programs. The second major goal is the education of health professionals, including house staff and attending physicians, social service staff, and others, including myself. Two major processes are used: grand rounds and regular ward teaching rounds.

Grand Rounds Grand rounds are formal conferences in which one or more individuals present a topic of interest to the attending physicians and house staff. Traditionally, these grand rounds are medically oriented, often reviewing a specific disease or new treatment regimen, occasionally reviewing a complex case. Adolescent grand rounds are held once a month. Because it is necessary to meet the normative requirements of a group in order to bring about a change, adolescent grand rounds have been a modification of and not a departure from the traditional format.

Behavioral concepts have been included as part of a more general discussion rather than being the exclusive focus on the conference. Thus, for example, in a conference on short stature in adolescence, the major presentation was on the endocrinological causes of short stature and its treatment, but the social, psychological, and behavioral consequences of height deviance also were discussed. Another presentation about an adolescent who attempted suicide by hanging herself included brief presentations on the physiology of neck injury, the psychiatric view of adolescent suicide, the social setting of the adolescent and her family, and the in-hospital care of the suicidal adolescent. These conferences have a general educational aim; attempts to teach pure sociology — or even to focus exclusively on behavioral concerns — would meet resistance from the house staff and the physicians for whose benefit they are presented. At the same time, it has been possible to integrate behavioral information in meaningful ways.

Ward Rounds Ward rounds and ward conferences deal with the day-to-day business of the unit and with patient treatment. They are usually attended by a number of individuals, including the house staff, one or more attending physicians, nursing staff, social work staff, and myself. Attendance and topic are very much a function of the particular patients receiving care in the unit on a given day. The primary purpose of the unit is the medical care of the adolescent, and purely medical issues may take priority in these conferences.

When it is appropriate to discuss the behavior (as opposed to the physiology or medical condition) of the patient, I often try to be self-

consciously sociological, without labeling my input as such. One major use of sociological perspectives is to help house staff become aware of the alternative definitions of normality and deviance that must be applied to social life and social events. Following Durkheim (1938), sociologists define normal in normative terms; normality and deviance are thus statistical and related to the social life of a given social organization. Medical theory and medical practice have a very different definition of deviance: deviance refers to difference from an absolute standard. A body temperature of 100 degrees is deviant; normal temperature is 98.6 degrees. A hemoglobin of six is dangerously below the normal range of twelve to sixteen. These are absolutes; deviations from these biological normals are deviant in all societies. (It is true that a whole population may have a deviant biological value — that is, a low hemoglobin. While the individuals may adapt to this, medically they are still abnormal and therefore ill.)

Medical personnel are more comfortable with the definition of deviance as absolute difference from an absolute standard, rather than viewing it as a difference from arbitrarily or statistically defined norms that may shift from subgroup to subgroup. Understanding patient behaviors and responding adequately to them may depend on the health care personnel learning the social definition of deviance. Education on the extent to which behavior is rooted in social life and social experience, and why normality and deviance may vary from patient to patient, is a constant theme of these discussions. This education is best accomplished through the use of examples, although sometimes it is possible to introduce small amounts of data (such as differences in the proportions of adolescents involved in coital relationships between 1950, 1960, 1970, and 1980 as a way of indicating that behavior which was deviant in one era is normal today).

Mini-lectures often provide a useful way of giving additional information and knowledge. Busy ward staffs do not have the time nor the inclination to listen to long lectures with the usual sociological qualifications about generalizability or applicability, which are so much a part of academic sociology. A three-minute discussion of some aspect of social life and a two-minute discussion of how this knowledge may affect some aspect of patient care are appropriate in this situation. The challenge to the clinical sociologist is in translating sociological knowledge into behavioral applications that are useful in the care of a particular patient with a particular disease at a particular time with a particular physician. Thus, brief discussions of the development of the social self and the extent to which children's and adolescents' behavior is based on the reactions they receive from others helps the health care staff to understand the responses they receive from given patients. Similarly, a brief discussion of the extent to which hospitalization is depersonalizing and of the importance of an appropriate presentation of self in such settings helps the

staff to see why it may be more important to the adolescent to be permitted to wash her hair than to provide an additional bit of history at the convenience of the staff.

Ward conferences also deal with the day-to-day business of operating the unit. It may be necessary to examine sociological issues involved in the unit organization and structure (although, again, without labeling the discussion as sociological). Role relationships between residents who come from two different residencies may need to be negotiated. It may be necessary to review how and why certain decisions were made or to examine the structural reasons for a breakdown in patient care. It is sometimes necessary to examine why a patient was admitted, or not discharged, and the extent to which social and psychological factors entered into these decisions. The consequences of these decisions for the patient and for the unit are reviewed. This process aids in establishing the limits of care to be provided on the unit. As Erikson (1966) has pointed out, the definition of what is regarded as deviant establishes the limits of normality. The review of unit decisions helps define the scope of the program to be offered and helps identify structural problems in implementing the program.

System Maintenance Activities. No system operates automatically, and the adolescent unit is no exception. A good deal of attention has to be paid to system maintenance activities. I am struck by the extent to which it has become my role to be concerned with certain recurrent processes. One of these is the failure of the workers in the system, if unreminded, to provide the patients with the opportunity to participate as much as possible in normal life activities and do as much as they can for themselves. While part of the sick role is to participate in activities which improve health, part of the role of being hospitalized is to be passive and to be acted upon rather than acting. Physicians are socialized to command and direct, nurses to care for and nurture, sociologists to study and analyze. It is often counternormative to have the patient highly involved and active in his or her own care. It has become my role to remind the health care staff of the importance to the adolescent of having as much control over his or her own destiny as possible. This is often accomplished by a simple review of activities; or by asking, for example, whether the patient has been to the adolescent room, or has been encouraged to make his or her own bed.

I must also constantly remind the staff of alternative realities that affect both patient and staff behavior. Behaviors that make sense to staff may not make sense to patients, considering their total life situation, and vice versa. Health care staffs' assumptions about normal behavior, acceptable morality, or deviance must be constantly questioned and examined. Social trends and social reality must continually be presented. For example, the statistics on adolescent pregnancy in the United States indicate that because of the risk of

harm to the fetus, every pubescent female must be considered pregnant until demonstrated not to be, although that demonstration may be by history rather than by laboratory examination. Failure of the health care providers to consider the possibility of pregnancy could put some patients at risk by using procedures that could harm an unborn child. At the same time, health care staff, and particularly physicians, often need to be reminded that sexual behavior is normal for these adolescents and a mere report of sexual activity does not indicate the adolescent is deviant.

My presence at rounds also serves to remind the health care staff of dimensions of patient care that should be considered and that they know are important but may overlook under the press of dealing with more physiological issues. This reminding function is not unique to the role of the sociologist but is the result of the presence at rounds of any behavioral scientist in our program. I do think, however, that the concerns about deviance and the sick role are relatively unique to the sociological perspective.

Some Limitations on the Sociologist's Role

In this paper I have not discussed issues of direct patient care by a sociologist because in my program I do not provide direct care. There are several reasons for this. First, my training as a sociologist did not prepare me for direct personal counseling or other forms of individual intervention, and I am aware of the dangers of amateur intervention and feel uneasy about it. Second, there are structural reasons for working with and through other people, rather than directly with patients. The most important of these is that in the present system the admitting physician, the house staff, and various hospital employees have the formal legal authority and responsibility for the care of the patient. Because of this I feel obliged to defer to the judgment of these others even when I do not agree. At the same time, I think that one of the reasons that I can have an impact on the program is that I have been willing to leave the protective ivory tower of an academic office to work side-by-side with residents, nurses, and attending physicians, attempting, just as they do, to translate what I know into a healing process for the patient.

As indicated in the beginning, the description of the program is somewhat idealistic. For a variety of reasons, including the economic situation in the state, the absence of a physician specially trained in adolescent medicine, and competition from other hospitals that offer specialized medical care for specific illnesses, the number of patients hospitalized at any given time has often been less than desirable for the optimal operation of the program. While the program can provide a better socioemotional experience for the physically sick or injured adolescent, the total welfare of the patient may indicate hospitalization in a unit where specialized treatment (for cystic fibrosis or

leukemia, for example) is both available and routine, rather than on the adolescent unit. Economic problems of the region have resulted in a general decrease in the seeking of health care, including that among adolescents. These problems, which are external to the operation of the unit, still significantly affect what can be done within it.

Conclusion

In this report, the role of the sociologist and the contribution of sociological theory in the design and operation of the program have been emphasized, and the contributions of other disciplines and specialties relatively ignored. In actuality, the program functions because of the contributions of individuals from a number of disciplines who have learned to work together toward the common goal of providing a better environment for the ill or injured adolescent. If I have been able to teach some aspects of sociological theory to my colleagues that might be used to help guide decisions in the unit, I have also learned a great deal about medicine, nursing, social work, ways of providing meaningful leisure-time activities to the hospitalized patient, and so on. The sociological perspective may add a unique character to this particular program, but in the final analysis it is the interdisciplinary team that enables it to function.

ADDENDUM: Two years later: the failure of the promise

In the spring of 1984 the program was considerably reduced in scope and intensity. This addendum briefly describes the present situation and the reasons for this reduction in program scope.

The major unsolved problem was to maintain sufficient patient volume in the unit to enable the program to operate continuously and effectively. This problem was discussed in the original presentation, but was never solved. (The reasons for low patient volume were suggested earlier.) The lack of sufficient patient volume has had a number of negative effects on the program. First, cost considerations have led the hospital to utilize empty beds on the unit for adult orthopedic patients. Although the hospital administration has supported the adolescent program, the shift to diagnostically related groups (DRGs) for reimbursement increased pressure on hospitals to control costs; this made it impossible to carry empty beds in the hope that adolescent patients would use them. Filling the unit with adult (and often quite aged) orthopedic patients has, in turn, resulted in nurses and the child and adolescent life worker having increased responsibilities for the care of older patients, hence less time to devote to the adolescents. The adolescent room has been reorganized to serve

the leisure time needs of adult patients as well; it is no longer available as a safe haven for the adolescent.

Hospital cost considerations also reduced the presence of the social worker in the unit. Instead of being able routinely to visit every adolescent patient, the social worker now responds primarily to requests for consultation. Making up for the reduced presence of the social worker is the increased presence of the child and adolescent life worker, whose role has been expanded to include helping adult orthopedic patients. These changes are the result of decisions by the hospital administration about the most effective utilization of scarce resources for the entire hospital.

A major shift has occurred in the educational program offered to the pediatric and family practice residents, partly as a result of low patient volume, and partly as a result of an inability to provide adequate resident involvement with many of the patients on the unit. In the early stages of the program, an attempt was made to have the resident assume some level of responsibility for *all* patients on the floor, not just those being cared for by pediatricians and family practitioners. Many of the adolescents are surgical or orthopedic patients, and while there is no problem in involving them in program activities, arrangements were never made to have house staff involved in their care. As a result, the educational emphasis moved from in-hospital to outpatient, with the resident on adolescent rotation spending a good deal of time in clinics which treat adolescents rather than in the hospital. As of this writing, the resident educational program in the hospital consists of two weekly conferences, one concerned with patient management and one primarily didactic.

I attend and help organize the two weekly ward conferences, but no longer routinely make rounds on the ward because of the decision to have the resident on adolescent rotation spend most of his or her time outside the hospital. Patient management rounds are no longer made in the way they used to be, and the team has reduced involvement in patient care.

Does this mean that the program has failed? No. Good things are still more likely to happen for adolescents at St. Lawrence than in other hospitals in the community. At this point, however, the program is not the success that it was two years ago. Perhaps the promise that it showed then will never be reached. A number of things could have been done differently, the most important being to ensure that residents were involved in caring for all patients on the floor. Such adjustments would probably have resulted in only marginal improvement. The crux of the diminution of the program is the failure to have adequate patient volume; this problem is beyond the control of the sociologist working within the hospital.

NOTES

1. This is a revision of a paper given at the session on Clinical Sociology at the Tenth International Congress of Sociology, Mexico City, August 1982. The author thanks Andrea Doughty, William Rittenberg, and Patricia See for their helpful comments on earlier versions of this paper. Any shortcomings are, of course, the responsibility of the author.
2. It is impossible to give adequate recognition to all the people who played a major role in the development and operation of the program. However, there are three people who deserve special recognition: Andrew Hunt, MD, who serves with me as co-director of this program (Dr. Hunt recently returned to the program following the completion of his fellowship in adolescent medicine; he was away during the time period discussed in this article); Satish Gupta, MD, who has provided invaluable daily support to the program and a great deal of advice and support to me personally; and Marge Kizlowski, RN, chief nurse of the unit. I must also mention the nursing staff who have made the program work.
3. Michigan State University has three colleges of medicine: veterinary, human, and osteopathic. Human medicine trains Doctors of Medicine while osteopathic trains Doctors of Osteopathy. Neither college has its own hospital; rather, students and residents are trained in affiliated independent community hospitals that have various degrees of affiliation with the College of Medicine and in the university's outpatient Clinical Center. The pediatric residency program is operated by an independent corporation in which the College of Human Medicine and the three allopathic hospitals are equal partners. The family practice residency program is jointly operated by the College of Human Medicine and St. Lawrence Hospital.
4. St. Lawrence had an adolescent unit, run by a single physician, from about 1974 to 1977, when the physician left the community. Much of the architecture, including the design of the adolescent room, is a result of plans made during this earlier period.
5. Had this intervention not worked, the consulting psychologist suggested that a strict behavioral modification program be instituted. In such a program, the patient would have been placed in a "token economy," earning privileges through "good" behavior and losing privileges for "bad" behavior.

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