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A Study of Patients Known to Social Service and Discharged Against Medical Advice from Veterans Administration Hospital, Hines, Illinois, From April, 1953 Through October 31, 1954

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A STUDY OF PATIENTS KNOWN TO SOCIAL SERVICE AND DISCHARGED AGAINST MEDICAL ADVICE FROM VETERANS ADMINISTRATION HOSPITAL HINES, ILLINOIS, FROM APRIL 1, 1953 THROUGH OCTOBER 31, 1954

by

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PRESENTED WITH THE PERMISSION OF THE CHIEF MEDICAL DIRECTOR, VETERANS ADMINISTRATION, WHO ASSUMES NO RESPONSIBILITY FOR THE OPINIONS OR THE CONCLUSIONS DEDUCTED BY THE WRITER*

*In compliance with Section 3, VA Circular 214, 1946.

TABLE OF CONTENTS

Chapter		Page
I.	INTRODUCTION	1
	Statement of problem--Purpose--Method--Sources--Plan of presentation.	
II.	SETTING AND FUNCTION	7
	Setting--Medical staff-Psychology service--Social service--Physical Medicine and Rehabilitation service--Nursing service--Vocational Rehabilitation--Special services.	
III.	THE STUDY GROUP	14
	Identifying information--Marital status--dependents--Length of hospitalization--Condition of illness--Previous admissions--Previous irregular discharges--Reasons for irregular discharge.	
IV.	DISCHARGE AGAINST MEDICAL ADVICE	29
	Patient's reason--Medical-social reason--Referral to social service--Source--Reason--Contact with patient--Contact with relatives.	
V.	CONCLUSIONS	45
BIBLIOGRAPHY		50
APPENDIX I. THE SCHEDULE		52

LIST OF TABLES

Table		Page
I.	DISTRIBUTION AMONG SERVICES	15
II.	AGE DISTRIBUTION	16
III.	RACE	17
IV.	RELIGIOUS PREFERENCE	18
V.	OCCUPATION	18
VI.	MARITAL STATUS	19
VII.	NUMBER OF DEPENDENTS	20
VIII.	LENGTH OF HOSPITALIZATION IN RELATION TO TYPE OF SERVICE	22
IX.	LENGTH OF HOSPITALIZATION IN DAYS	23
X.	CONDITION OF ILLNESS	24
XI.	PREVIOUS ADMISSIONS	25
XII.	PREVIOUS DISCHARGES	27
XIII.	REASONS FOR PREVIOUS DISCHARGE	28
XIV.	PATIENT'S REASON FOR DISCHARGE	33
XV.	MEDICAL-SOCIAL REASON FOR DISCHARGE	36
XVI.	SOURCE OF REFERRAL TO SOCIAL SERVICE	37
XVII.	REASON FOR REFERRAL TO SOCIAL SERVICE	39
XVIII.	SOCIAL SERVICE CONTACT WITH PATIENT	40
XIX.	PURPOSE OF CONTACT WITH PATIENT	42
XX.	SOCIAL SERVICE CONTACT WITH RELATIVES	42
XXI.	PURPOSE OF CONTACT WITH RELATIVES	43

CHAPTER I

INTRODUCTION

The problem of irregular discharge has been of concern to the Veterans Administration for several years. Administratively this type of discharge has posed at least two problems: (1) the patient who leaves with an irregular discharge is a potential patient for another hospital in the future, and (2) from a financial standpoint the cost of caring for these patients in a hospital is high. Therefore, a veteran who leaves irregularly has caused an expenditure for services which have not been completely utilized.

Veterans Administration tuberculosis hospitals and wards have been especially plagued by the problem of irregular discharge. From one-third to one-half of the tuberculosis patients who enter Veterans Administration hospitals leave irregularly. It has been estimated that in money terms alone, each irregular discharge represents an average lost treatment investment of more than ten-thousand dollars.[1]

In an effort to determine some of the possible reasons for irregular discharge, one aspect, discharge against medical advice, has been the focus of several studies by the Veterans Administration. These include a study

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[1]Veterans Administration, Annual Report for the Fiscal Year Ending June 30, 1952, (Washington, 1953), 14.

in 1952 of irregular discharges among tuberculosis patients.[2] This study pointed out the seriousness of the problem for the well-being of patients in both VA and non-Va hospitals. Another study was made in 1953 by Julia Hall at Hines Veterans Administration Hospital. This study concluded that tuberculous patients must be treated within the limits of their total personalities, and that social and emotional needs of the veteran must be taken into consideration in helping him to sustain hospital treatment necessary for his recovery.[3]

Need

At Hines Veterans Administration Hospital from April, 1953 through October, 1954, there were 675 discharges against medical advice.[4] National statistics for Veterans Administration Hospitals indicate that for the fiscal year 1953, 23,586 or 5.5 per cent of all hospital dispositions were irregular discharges.[5] (Irregular discharges include patients who left against medical advice, were absent without leave, and were discharged through disciplinary action). With these figures in mind, it was felt that a study of one aspect of irregular discharge, namely that of "against medical advice," would be significant in achieving a better understanding of

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[2]Joseph F. Tedesco, "A Study of Irregular Discharges in a Veterans Administration Hospital," Am. Revue of Tuberculosis, LXIII (September, 1953).

[3]Julia A. Hall, "Discharge Against Medical Advice," Unpublished Work, (VAH Hines, Illinois, 1953).

[4]Unpublished data from Registrar's Office, VAH Hines, Illinois.

[5]Veterans Administration, Annual Report for the Fiscal Year Ending June 30, 1953, (Washington, 1954), 158.

the problem.

Purpose, Scope, and Focus

The purpose of this project, undertaken by three students in the Loyola University School of Social Work, was to determine and evaluate the factors involved in the against medical medical advice discharge of one hundred veterans who were known to Social Service at Hines Veterans Administration Hospital, from April 1, 1953 through October 31, 1954. An investigation of these discharges from the Psychiatric, Tuberculosis, Medical, Surgical and Neurology Services were made in an effort to reveal contributory factors and to indicate measures that might possibly lessen the incidence of this type of release. In this study, consideration was given to the patient's reason for termination of hospitalization, the medical-social interpretation of the reason for the discharge, and Social Service contact with the veteran and his relatives.

This study differs from the earlier studies made by Tedesco[6] and Hall[7] in scope and time interval involved in the study. The two previous studies are concerned with only one Service, while the present one covers five Services.

Limitations

The study group included hospitalized veterans from the Psychiatry, Tuberculosis, Medical, Surgical and Neurology Services who left the hospital against medical advice. Veterans who were discharged against medical

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[6] Tedesco

[7] Hall

advice from the remaining Services (Blind Rehabilitation, Dental Service, and Diagnostic Center), were not included because of the limited cases available from each of these Services that were applicable to the study. All cases in the study were known to Social Service through direct contact of the social worker with either the veteran and/or his relatives during some period of the hospitalization. Social Service contact with the patient was not necessarily maintained in all cases at the time of the discharge.

Definition of Terms

For purposes of this study, an"against medical advice" discharge is defined as one in which the veteran requests and receives a discharge when the physician advises the patient can, by remaining, derive further benefit from the medical treatment available.

"Veteran" refers to male adults honorably discharged from the armed service. This includes veterans who are both service connected and non-service connected. A veteran whose illness has been determined by the Veterans Administration as service-connected receives, by law, financial compensation according to the extent of his disability.[8] Patients in the study group were admitted to the hospital according to regulations and procedures governing Veterans Administration Hospital admissions. All admissions, including psychiatric cases, were voluntary.

Method

The design of this research project was that of the case study method.

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[8]Red Cross Handbook, Sec. 1, Par. 1325, 13-10A.

A listing was made of all available cases known to Social Service in which a veteran was discharged against medical advice from July 1, 1953 through July 31, 1954. The clinical charts of these veterans were obtained from the closed files. Cases in which the clinical charts were unavailable were excluded from the study. A schedule was then devised for the collection of uniform data from cases studied. This schedule included comprehensive information concerning identifying information, patients' reasons for the discharge, medical-social evaluation of the reason for discharge, and social service contact with patients and relatives. A schedule was then completed on each of the cases included in the study. The time period of the study was then extended to obtain a larger and more representative sampling of cases.

The collection and complilation of data was done by the author in collaboration with the two other students working on the project. The compilation involved use of a master schedule on which data were tabulated. The data were then analyzed, interpreted, and presented independently by each of the three students. In cases in which a veteran was discharged against medical advice two or more times during the period of study, the last discharge was the one focused on primarily for the purpose of this study, i.e., ascertaining the patients' reason for leaving "AMA". All prior "AMA" discharges were included as "Previous Discharges," and will be discussed under that heading.

Focus

The patients' reasons for the discharge and the role of Social Service

with the study group was used as a focal point in the study.

Sources

The primary source material for the study was the Social Service record and clinical chart of the patients included in the study. Other background and interpretive material for the study was obtained from a review of pertinent literature, including books, periodicals, and bulletins related to the fields of the various Services where patients were hospitalized, and the field of Social Work. Additional information was secured from personal interviews with members of the hospital staff concerning procedure and policy.

Plan of Presentation

The study will present a description of the setting and function of the five Services at Hines VAH, and will include a discussion of the role of Social Service in the hospital. Consideration will be given to the social attributes of the study group, and statistical facts concerning their present and past hospitalizations. The patient's and the medical-social evaluation of the reason for discharge will be evaluated along with the role of Social Service in helping the study group in their hospital adjustment. Conclusions based on the findings of the study will be presented in the final chapter.

CHAPTER II

SETTING AND FUNCTION

Hines Veterans Administration Hospital is a general medical-surgical unit located on the outlying boundaries of a large metropolitan center and surrounded by several small suburbs. At present the hospital has a bed capacity of 2300.[1] In addition to its function as a medical-surgical unit, the hospital is also a training and research setting for various professions including medicine, psychology, social service, occupational therapy, corrective therapy, nursing, and dietetics.

The hospital is physically divided into two parts. One side, referred to as Unit II, houses the specialized services which include Neurology, Tuberculosis, Psychiatry, Paraplegia, and Blind Rehabilitation. The Psychiatry Service accomodates 110 patients and is located in a separate building. In this section patients are housed in one of three wards, the assignment being contingent on extent of illness. Psychiatry Service is medically staffed by a Chief Psychiatrist, staff psychiatrists and residents in Psychiatry who are assigned to the Service for varying periods of time.

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[1] Statistical information from the Registrar's Office, VAH Hines, Illinois.

Tuberculosis Service accomodates 378 patients and is located in two adjacent buildings. Neurology Service is housed in a separate building and has a bed capacity of 217. In the Tuberculosis and Neurology Services, staff consists of the Chief of the Service, staff doctors, and residents in training.

The other side of the hospital which is commonly termed Unit I, consists of one large building housing the Medical and Surgical Services. Medical Service has a bed capacity of 535, and Surgery, 809. Staff for these Services included Chiefs, Assistant Chiefs, staff doctors, and residents. Medical consultants are also available for all Services heretofore mentioned. The Neuropsychiatric Clinic, also located in Unit I, consists of resident and staff psychiatrists and neurologists whose services are available for patients in need of them on the medical and surgical wards.

Psychology Service administratively functions as a part of Psychiatry Service. In both practice and research this Service contributes to the care of patients. In the Psychiatry Service, the function of the psychologist includes testing and psychotherapy under the supervision of a qualified psychiatrist. In addition to their function in Psychiatry, clinical psychologists have been increasingly useful in helping patients deal with special emotional problems precipitated by disabling disorders such as tuberculosis, neural disturbances, and paraplegia.

The impact of social factors, personal relationships, and family attitudes have a marked effect upon the results of treatment of hospitalized veterans. Means, in describing the impact of these social factors on the

illness, writes:

> The complete diagnosis must be an epitome of all elements that either the clinical picture, social as well as biologic. It must include not only the disease, but an understanding of the patient who has it...The evidence upon which a truly complete diagnosis must rest may be biologic, psychologic, or social. Often it is all three.[2]

The chief responsibility of Social Service is to assist hospital patients to establish a life situation favorable to good health, and to gain the peace of mind that fosters recovery.

In Psychiatry Service, the general function of the psychiatric social worker is to help the patient make effective use of treatment given in the hospital. All patients on that Service are routinely seen by the social worker. Each worker is assigned to one or more service teams consisting of staff psychiatrist, resident, psychologist, social worker and nurse. The team is usually augmented by psychology, social work and nursing students. The psychiatric worker's case load consists of all patients assigned to his team(s). As a member of the team, the worker contributes pertinent social information and evaluates its relationship to the patient's background, intra-familial, and other inter-personal relationships. In addition, the psychiatric worker, as well as medical workers on the other Services, give interpretation regarding the patient's illness and the hospital to relatives, and extends help to the patient and his family with problems which have resulted from the illness. A further responsibility of social workers

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[2]J. H. Means, "The Clinical Teaching of Social Medicine," Johns Hopkins Hospital Bulletin, LXXVII (Baltimore, 1946).

includes interpreting community resources to the veteran and relatives, and helping them avail themselves of such resources as are appropriate to their needs. The psychiatric social worker may also, on the recommendation of the psychiatrist, and under guidance, do psychotherapy. All of the cases on this Service are known to Social Service throughout the length of hospitalization.[3]

Medical social workers are engaged in helping the patient toward adjustment on Services other than Psychiatry. In describing the nature of medical social work, Grace White writes:

> The unique features of medical work might be stated in terms of problem, setting, and process:
> 1. It is concerned with the social needs and problems related to illness, physical handicap and medical care.
> 2. It is practiced in collaboration with other professional personnel, as an integral part of multidiscipline services in medical settings.
> 3. It serves as laison in coordinating the medical and social services of a community.[4]

The function of the social worker in Tuberculosis Service is similar to that of the worker in Psychiatry except that patients are not regularly assigned to a formal team. However, the teamwork approach is utilized by the treatment team of doctors, social workers and nurses, for purposes of evaluation hospital adjustment and post-hospital discharge plans. On

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Information from a personal interview of the author with Rachel Calloway, Social Service Supervisor, Psychiatry Service, VAH, Hines, Illinois.

Grace White, "The Distinguishing Characteristics of Medical Social Work," Journal of Medical Social Work, I (September, 1951), 34.

Tuberculosis Service, patients are seen routinely by the social worker. An effort is made to patients as soon after admission as possible. Preference is given by social workers to referrals by physicians, nurses, relatives, or the patient, when problems arise that require immediate attention. On Tuberculosis Service, all patients are seen by a staff nurse soon after admission. Frequently this nurse is able to detect problems and make referrals to Social Service.[5] After a referral or problem has been taken care of, a case is usually closed until the patient is in further need of service.

In contrast, Social Service in the Neurology, Surgical, and Medical Services operate similarly to Tuberculosis Service, except patients are seen on referral instead of routinely. Referrals are made by the doctor, nurses, patient himself, and sometimes by the attendant of the ward. In Neurology, the social worker attends medical consultations in order to share social information with the medical profession, and to gain information which will be helpful in planning and interpreting the illness. Additional consultations with the medical profession on these three Services are usually held in private consultations with the worker.

On all Services excepting Psychiatry, Social Service records are closed when the patient is no longer in need of service, although he may continue to be hospitalized. Therefore if a patient is discharged against medical advice during the time that the Social Service case is closed, unless the

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[5]Information from a personal interview of the author with Faye Bates, Social Service Supervisor, Tuberculosis Service, VAH Hines, Illinois

worker is specifically notified of the action by the doctor or members of the other disciplines, he will not have contact with the veteran at the time of discharge. However, in Psychiatry Service, the worker is notified in the team meeting concerning the fact that a patient's request for discharge is being considered.

Additional Social Service coverage is available on Blind Rehabilitation, Paraplegia Service and Admission Referral Service. Although the paraplegic wards operate medically under Neurology Service, Social Service workers on the paraplegia wards are under the jurisdiction of the Supervisor in Tuberculosis. The Social Work Supervisor in Psychiatry supervises the worker in Neurology Service.

During the period which this study encompassed, there was a reduction in force of Social Service staff in 1954. Prior to that time staff consisted of one Chief of Social Service, five supervisors, and eighteen workers. After July, 1954, and through the end of the study, there was one Chief, three supervisors, and ten workers.[6]

The Nursing Service operates as a "right hand" to the medical profession. In addition, through their contact with the patients, nurses are able to provide an emotional climate which is often very meaningful in terms of hospital adjustment.

The activities of Physical Medicine and Rehabilitation Service are de-

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[6]Information from a personal interview of the author with Jenness Eertmoed, Chief of Social Service, VAH Hines, Illinois.

signed to facilitate more prompt adjustment of patients with acute medical or surgical problems. In addition, this Service helps in the adjustment of the long-term or handicapped patient to his post hospital economic and social environment in order to reduce the possibility of rehospitalization. Through the therapies which are a part of this Service, much progress has been made in rehabilitation of patients. Corrective therapy, educational therapy, manual arts therapy, and physical and occupational therapy are all available and widely used throughout all medical services of the hospital. "The concept rehabilitation is consistently extended to emotional as well as structural disabilities."[7]

The Vocational Rehabilitation and Education Service is an integral part of the hospital staff. For hospitalized patients, vocational rehabilitation is considered an intrinsic part of the treatment program.[8]

Special Services available to the patient include the Chaplain's Service and the library.

The effectiveness of the various services in meeting the psycho-social as well as the physical needs of the patient will largely determine whether the patient will sustain medical treatment until he has attained maximum benefit, or whether he will terminate his hospital stay against medical advice.

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[7]Veterans Administration Department of Medicine and Surgery, Information Bulletin 10-22, (Washington, May, 1952), p. 29.

[8]Ibid

CHAPTER III

THE STUDY GROUP

In this chapter an attempt will be made to describe the study group with reference to social data, duration of hospitalization, status of illness at the time of discharge, and information concerning adjustment during previous hospitalizations. It is hoped this chapter will provide a framework to evaluate material to be discussed in Chapter IV.

During the period of the study, 606 veterans were discharged against medical advice at Hines VAH. Of this group, 138 were known to Social Service during some period of their hospitalization. The records of thirty eight of these 138 were unavailable for use in this study, twenty-five having been transferred to other hospitals and thirteen having been in dictation during the compilation of statistics. The one hundred remaining cases were used as a basis for the present study.

Table I shows the distribution of patients according to the Service on which they were hospitalized. Of the veterans discharged, 34 per cent had been hospitalized on Psychiatry Service, 25 per cent on Tuberculosis, and 25 per cent on Medical Service. These three services accounted for 84 per cent of the discharges, with the remainder released from Surgery and Neurology, which had ten per cent and six per cent respectively.

TABLE I .

DISTRIBUTION AMONG SERVICES

Service	Number of Patients
Psychiatry	34
Tuberculosis	25
Surgical	10
Medical	25
Neurology	6
Total	100

The age group of the veterans, as shown in Table II revealed information which appeared rather significant. The largest number of patients were World War II veterans in the age group from 30 to 40. This grouping comprised 44 per cent of the patients discharged. When this figure is combined with the age group 20 to 30, representing 27 per cent, it is noted that 71 per cent of the veterans were between the ages of 20 and 40 years. This may indicate that certain factors in the hospital adjustment of the age group from 20 to 40 were perhaps significant in causing a higher rate of discharge among this group. Of the remainder of the study group, sixteen were between 40 and 50 years, twelve were between 50 and 60 years, and only one was over 60.

TABLE II .

AGE DISTRIBUTION

Service	Total	Age				
		20-30	30-40	40-50	50-60	over 60
Psychiatry	34	11	15	7	1	
Neurology	6	3	2		1	
Tuberculosis	25	4	13	4	4	
Surgical	10	3	3		4	
Medical	25	6	11	5	2	1
Total	100	27	44	16	12	1

The figures for race in Table III show 68 per cent of the study group were white, 30 per cent Negro, and 2 per cent Mongoloid as represented by the category "other." The ratio of Negro to white patients on Tuberculosis Service was fourteen to eleven. This figure becomes significant when it is compared with the national ratio of seven white veterans to one Negro patient on Tuberculosis Services in Veterans Administration Tuberculosis Services and Hospitals.[2]

[2]Veterans Administration Annual Report, (1952), 160.

The same number of Negro patients as white were on the Medical Service. The ratio of Negroes to white on Surgical Service was one to nine and the ratio of white to Negroes was more than four to one on Psychiatry Service. One patient on Neurology and one on Medical were of the Mongoloid race.

TABLE III

RACE

Service	Total	Race		
		White	Negro	Other
Psychiatry	34	28	6	
Neurology	6	5		1
Tuberculosis	25	14	11	
Surgery	10	9	1	
Medical	25	12	12	1
Total	100	68	30	2

Table IV points out patients affiliated with the Protestant religion numbered fifty-seven, and thirty-five veterans were Catholic. The combined total represented 92 per cent of the study group. Of the remaining eight patients, 2 per cent were Jewish, 2 per cent had other than the above mentioned religious preferences, and 4 per cent had not indicated a religious preference. The religious preference of the study group, as would be expected, did not reveal any contributory factors toward the reason for the discharge against medical advice.

TABLE IV

RELIGIOUS PREFERENCE

Religion	Patients
Protestant	57
Catholic	35
Jewish	2
Other	2
No preference	4
Total	100

Table V shows 28 per cent of the veterans had previously been employed as skilled laborers, 19 per cent were unskilled, and 28 percent were semi-skilled. These three categories accounted for 75 per cent of the total. The other categories, representing 25 per cent of the total included nine white collar workers, three professional persons, two students, and one unemployed veteran. Occupation did not seem to have a significant bearing on the discharge request.

TABLE V

OCCUPATION

Occupation	Patients
Skilled	28
Semi-skilled	28
White collar	9
Unskilled	19
Professional	3
Student	2
Unemployed	1
Total	100

Marital status is often indicative of the outside pressures that may be brought to bear on a veteran during hospitalization. He is sometimes temporarily unable to care for his relatives financially due to interrupted earning power. This, coupled with the emotional ties one usually has with the family, may perhaps have bearing on some veterans requesting discharge.

Table VI shows 75 of the study group had a marital status which would perhaps indicate responsibilities, both financial and emotional, toward persons outside of the hospital. Forty eight patients were married, fourteen separated, ten divorced and three were widowers. The remaining twenty five veterans were single.

TABLE VI

MARITAL STATUS

Status	Patients
Married	48
Single	25
Separated	14
Divorced	10
Widower	3
Total	100

The number dependents which the patients had, as given in Table VII, gives a better indication of the family responsibilities which continued for the study group during their period of hospitalization. Forty three

veterans had no dependents. However, this figure includes those patients who were married but whose wives were not financially dependent on them, as well as twenty five veterans who were actually single. Therefore, of the forty three patients listed as having no dependents, eighteen are included in a category other than single.

Veterans having one or more dependents numbered fifty seven. Of these, fifteen had one dependent, eighteen patients had two, and three veterans had nine dependents. Patients in the categories "four", "five", and "over five" dependents numbered eight, two, and five respectively.

TABLE VII

DEPENDENTS

Dependents	Patients
None	43
One	15
Two	18
Three	9
Four	8
Five	2
Over five	5
Total	100

The fact that a person has to be hospitalized necessarily means a great deal of adjustment on the part of not only the patient but also his

family. If the veteran feels the pressures on his family are great, he tends to become dissatisfied with the length of hospitalization that is required in terms of his illness. Another factor bearing on a discharge request is possibly the patient's unwillingness to accept his illness, and consequently the hospitalization itself.

Table VIII shows that 67 per cent of the veterans discharged were hospitalized for less than ninety days. Of the remaining 33 per cent hospitalized for a longer length of time, 21 per cent were on Tuberculosis Service and 12 per cent were distributed among the remaining Services. It is generally recognized that the nature and course of tuberculosis usually requires a relatively lengthy hospitalization. A discussion of this in a Veterans Administration bulletin gives the following information: "There are certain characteristics that distinguish tuberculosis from most other diseases, insofar as effect upon the total human personality is concerned. One of these is that treatment for tuberculosis disrupts normal living to an abnormal degree, because of the relatively long period of hospitalization it requires."[3]

Approximately 31 per cent of all patients on Psychiatry Service remained in the hospital more than ninety days. On Medical Service only one of a total of twenty five patients was hospitalized more than ninety days. On Surgery two patients, and on Neurology, one patient

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[3]Veterans Administration, Irregular Discharge: The Problem of Hospitalization of the Tuberculous, Information Bulletin (Washington, 1948), 45.

remained for more than ninety days. It can be concluded that the majority of patients on all Services excepting Tuberculosis left against medical advice within ninety days of being admitted to the hospital.

TABLE VIII

LENGTH OF HOSPITALIZATION IN RELATION TO TYPE OF SERVICE

Days	Total	Service				
		Psychiatric	Tuberculosis	Medical	Surgical	Neurology
0 - 90	67	26	4	24	8	5
90 - 180	17	7	10			
180-270	1					1
270-360	7	1	4		2	
over 360	8		7	1		
Total	100	34	25	25	10	6

Because the largest percentage of veterans (67 per cent) were hospitalized less than ninety days, it was felt closer investigation of this total would be significant. It can be seen in Table IX that forty one patients, representing over two-fifths of the study group, were discharged before thirty days. Nineteen veterans were discharged between thirty and sixty days, and seven were discharged between sixty and ninety days. From this it can be concluded that most patients request discharge before ninety days, and the majority of these do so before thirty days.

TABLE IX

LENGTH OF HOSPITALIZATION IN DAYS

Service	Total	Days		
		0-30	30-60	60-60
Psychiatry	26	12	9	5
Tuberculosis	4		3	1
Medical	24	18	5	1
Surgical	8	8		
Neurology	5	3	2	
Total	67	41	19	7

The progress which a patient has made in terms of his illness often influences his willingness to complete treatment. It would be expected that a veteran who was aware he was getting better might be more willing to remain and complete further treatment. Table X, however, points to evidence contrary to expectation. There were fifty two veterans whose diagnosis at the time of discharge indicated an improvement in condition of illness. It is especially noteworthy that nineteen of the 25 in the study group hospitalized on Tuberculosis Service had improved conditions at the time of discharge. The condition of forty nine patients was unchanged, and only one veteran's condition was considered to have regressed. It is assumed that the veterans who submitted the discharge request were cognizant of the improvement, or lack thereof, in terms of their illness.

Over one-half of the study group left with conditions improved, but before recovery, and an almost comparable number left when the condition for which they were being treated was unchanged or had regressed.

TABLE X

CONDITION OF ILLNESS

Service	Total	Condition		
		Improved	Unchanged	Regressed
Psychiatry	34	16	18	
Surgery	10	2	8	
Neurology	6	1	5	
Tuberculosis	25	19	5	1
Medical	25	14	11	
Total	100	52	47	1

In determining contributing factors to discharge against medical advice, it was considered that previous hospitalizations of the study group might be of significance. Discharges from Veterans Administration Hospitals, other than those recorded as maximum hospital benefit discharge, are an indication of difficulty in adjustment of veterans during previous hospitalizations. Therefore, a "previous admission," for purposes of this study, is defined as one which resulted in an irregular discharge from a Veterans Administration Hospital. As shown in Table XI, there were seventy four veterans with no previous admissions, that is they either had never been

in a Veterans Administration Hospital, or had been discharged from such a hospital as having received maximum hospital benefits. Of the remaining twenty six veterans, thirteen had one previous admission and nine had two admissions. Therefore of the twenty six veterans previously admitted, twenty two had either one or two previous admissions. Of the remaining patients, two had three previous admissions, and two had either four or over.

TABLE XI

PREVIOUS ADMISSIONS

Admissions	Patients
None	74
One	13
Two	9
Three	2
Four	1
Over four	1
Total	100

Investigation of the type of irregular discharge of patients with previous admissions is shown in Table XII. There were twenty six veterans who had a combined total of forty nine irregular discharges. Thirty seven, or the majority of these discharges were against medical advice. Patients on Psychiatry and Surgical Services had no other types of discharge. Seven of the eight previous discharges on Neurology Service were against medical advice. Thirteen discharges on Tuberculosis and five on Medical were also

of this type.

A discharge AWOL (absent without leave), is defined as one in which the patient has not reported back to the hospital within twenty-four hours after expiration of a grant of leave, and has not supplied any excuse for the absence.[4] Eight of the previous discharges were AWOL. Tuberculosis Service had the largest number of such discharges with five, Medical had two, and Neurology had one.

Four of the previous discharges resulted from disciplinary action. All of these were on Tuberculosis Service.

The figures for previous discharges indicate that twenty-six veterans of the 100 in the study group had been unable to make a satisfactory adjustment during previous hospitalizations. The largest percentage of the total of their combined discharges were against medical advice. In other words, these twenty-six veterans had exhibited a pattern in the past which would possibly be an indication of their maladaptation during the present hospitalization.

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[4]Veterans Administration, Medical Regulations and Procedures, (Washington, 1945), par. 6950

TABLE XII

PREVIOUS DISCHARGES

Service	Total of Veterans	Total of Discharges	Type		
			AMA	AWOL	DISC
Psychiatry	7	11	11		
Surgery	1	1	1		
Neurology	2	8	7	1	
Tuberculosis	11	22	13	5	4
Medical	5	7	5	2	
Total	26	49	37	8	4

The records from which the statistics were obtained were not set up specifically in terms of the present study. However, as shown in Table XIII, it was possible to obtain some significant information concerning the reasons for against medical advice discharges during previous hospitalizations. Of twenty-six patients who had a combined total of forty nine previous irregular discharges, 37 were discharges "against medical advice." The medical-social reasons given for this type of discharge shows seven discharges were caused by pending disciplinary action which is further evidence of poor hospital adjustment. Five veterans refused treatment, four were listed as having made a poor hospital adjustment, three had family problems, and one was dissatisfied with the hospital personnel. In seven cases the reasons for leaving were unknown. One record in Psy-

chiatry Service listed two reasons for the discharge, namely poor hospital adjustment and refusal of treatment. It can be concluded that the majority of the reasons for previous against medical advice discharges were caused by factors indicative of poor hospital adjustment.

TABLE XIII

REASON FOR PREVIOUS DISCHARGE

Reason	Total of Cases[a]
Pending disciplinary action	7
Refused treatment	5
Poor hospital adjustment	4
Family problems	3
Dissatisfaction with hospital personnel	1
Unknown	7
Total	27

[a]One case listed two reasons for the discharge.

Summary

Several factors in this chapter, age group, marital status, number of dependents, length of hospitalization, and previous irregular discharges of the study group, appeared significant and will be evaluated in Chapter V in terms of their bearing on the present against medical advice discharge.

CHAPTER IV

DISCHARGE AGAINST MEDICAL ADVICE

The preceding chapter discussed the social information which served as an identification of the study group. In the present chapter, the patient's reason for the discharge will be compared with the medical-social reason. Social Service contact with the patient and his relatives will be evaluated to determine how effectively it met the individual needs of the veterans in terms of their reason given for the discharge.

A veteran who is discharged against medical advice is not eligible for treatment within the Veterans Administration until ninety days after the discharge. An exception to this ruling is made in emergency cases. If, after the expiration of that length of time, reapplication is made, preference is given to service-connected veterans. The significance of this regulation can be appreciated when it is realized that the major portion of all discharges against medical advice will seek readmission for completion of necessary treatment at some time after they leave the hospital. It can be seen therefore that in terms of the patient's welfare, especially those with serious illnesses, this type of release is undesirable.

A patient hospitalized on Tuberculosis, Neurology, Surgical or Medi-

cal Services who desires a discharge against medical advice makes his request to medical personnel on his Service, and the doctor discusses this request with him. When the veteran insists upon leaving despite all persuasion to remain until completion of treatment, he is allowed to do so. Certain precautionary measures are taken in that only patients who are able to travel are allowed to be released even after a request has been submitted.[1]

On Psychiatry Service, the procedure for this type of discharge is somewhat different because of the complicating factors caused by the emotional nature of the illness. Patients who request discharge on this Service must submit a statement to that effect in writing to the Chief of the Service. According to the law, action must be taken within fifteen days after the date the request was submitted. The doctor has the choice of releasing the veteran in the custody of a relative who agrees to accept him into the home, releasing him in his own custody, or recommending commitment to a state institution.[2]

The physician or social worker in talking with a patient is usually able to gain some clue as to his reason for wanting the discharge. In the study group eighty-one veterans gave at least one reason for wanting the discharge, and four patients gave two reasons; representing a total of

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[1]V. A., Regulations, par. 6949.

[2]Information from a personal interview of the author with Dr. Alfred Green, Assistant Chief, Psychiatry Service, VAH Hines, Illinois.

eight-nine reasons. As seen in Table XIV, the most frequent reason given was "poor medical treatment". which was the basis of seventeen discharge requests. This can possible be attributed to an inability of the patient to face the fact that he is ill or in need of further treatment. Eleven patients felt they had made sufficient improvement and, therefore, were in need of no further hospitalization. Five veterans were not willing to undergo surgery, and four patients felt their prognosis was so discouraging that there would be no advantage in remaining in the hospital.

Reasons which can be classified as "poor hospital adjustment" accounted for twenty-seven of the discharge requests. Seven claimed restlessness, six were dissatisfied because they were not granted passes, and four were facing disciplinary action for violation of hospital rules. Three veterans preferred another hospital, three preferred to convalesce in their own homes, and two felt they were discriminated against by hospital personnel. The two patients who refused discharge planning when it had been determined they had received maximum hospital benefit were on Psychiatry Service.

Reason for discharge given by twenty-five veterans involved social problems, in fifteen instances, financial problems, and in ten, family problems. It is possible that social service contact with the patient or relatives might have reduced this number considerably. In fifteen cases, the patient's reasons for requesting discharge were unknown; either because they were not recorded, or the patient did not wish to make the reason known.

It is noteworthy that nineteen patients hospitalized on Psychiatry Service wanted to leave because they felt sufficiently improved, were restless, or felt the medical treatment was poor. Patients who are suffer-

ing from emotional disorders, by reason of the nature of their illness, are often unable or unwilling to admit their need of hospitalization or treatment. On Psychiatry Service, a request for an AMA discharge is viewed as a part of illness in much the same way a schizophrenia or depressive reaction is a part of illness. In other words, the patient wants to be discharged because he is unable to recognize his own illness. For this reason, it can be seen the problem of AMA discharges in Psychiatry Service presents a different type of problem to the physician than it would on the other services.[3]

On Surgical, Neurology, and Tuberculosis Services, the patients' reason for discharge were fairly evenly distributed. On Medical Service the reason given by most patients was financial problems. Again it is possible that contact with social service may have alleviated this problem and eliminated a reason for the discharge. It can be concluded the most frequent reason given by the patient for the discharge fall into the general categories of "refusal of treatment" and "poor hospital adjustment."

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[3]Information from a personal interview of the author with Dr. W. David Steed, Chief of Psychiatry Service, VAH Hines, Illinois.

TABLE XIV

PATIENTS' REASON FOR DISCHARGE

Reason[a]	Total	Service				
		Psychiatric	Medical	Tuberculosis	Neurology	Surgical
Poor medical treatment	17	9	3	2	2	1
Financial problems	15	3	8	2		2
Sufficient improvement	11	5	2	1	2	1
Family problems	10	2	3	3		2
Restlessness	7	5		1		1
Refusal of pass request	6	1		4	1	
Rejected surgery	5		2	1	1	1
Poor prognosis	4			2		2
Pending Disciplinary Action	4		2	2		
Preferred private hospital	3			2		1
Preferred own home	3	2	1			
Poor treatment by personnel	2	1		1		
Refused discharge planning	2	2				
Unknown	15	4	5	6		
Total	104	34	26	27	6	11

[a]Four cases had two reasons given for patient's discharge.

Table XV shows the medical-social evaluation of the reasons for discharge numbered 106. This includes six cases in which the reasons were unknown and six cases in which two reasons were cited for the discharge. Medical-social reason is the evaluation of the physician or social worker as to the reason the patient requested the discharge.

Thirty-nine reasons can be classified under the patient's inacceptance of illness as manifested by thirty veterans who refused treatment, five who preferred another hospital and four who preferred their own home. In addition, poor prognosis accounted for two discharges.

Poor hospital adjustment was shown in various ways: twenty patients were classified as having made a poor adjustment to their illness, and therefore, to the hospital, and four patients were facing disciplinary action for violation of hospital rules. Also included under poor adjustment were two patients with emotional illnesses who refused discharge planning which was oriented toward readjustment in society.

Nine patients had personality problems and three had a diagnosis of alcoholism, both categories indicating possible emotional problems. Twenty one patients had difficulty in areas of social problems. Of these, eleven had family problems, because of which they wanted to return to the home, nine had financial problems in terms of supporting their families, and one veteran left to attend a court hearing. In six cases a medical-social evaluation of the patients' reason for leaving was not given.

When comparison is made of the patient's reason for the discharge with the medical-social reason, it can be seen the most frequent causes are dissatisfaction with treatment, inacceptance of illness and poor hospital

adjustment. Social problems do not appear as prominent as might be expected.

TABLE XV

MEDICAL-SOCIAL REASON FOR DISCHARGE

Reason[a]	Total	Service				
		Psychiatric	Medical	Tuberculosis	Neurology	Surgical
Refused treatment	30	11	8	2	1	8
Poor hospital adjustment	20	7	2	8	2	1
Family problems	11	2	4	5		
Personality problems	9	4		2	2	1
Financial problem	9	1	8			
Preferred other hospital	5	2	1	2		
Preferred own home	4	3	1			
Pending Disciplinary Action	4	1		3		
Alcoholism	3		1	1	1	
Poor prognosis	2			1		1
Refused discharge planning	2	2				
To attend court hearing	1	1				
Unknown	6	2	2	2		
Total	106	36	27	26	6	11

[a]Six cases had two medical-social reason for discharge given.

Mention has been made in Chapter II of the role of Social Service in the hospital. At Hines, attention is given to all referrals which indicate assistance is needed in order for the patient to make a more satisfactory adjustment during hospitalization. In Table XVI, it is seen that the majority of referrals are made by medical personnel, including doctors and nurses. These referrals accounted for fifty five per cent of the total number. The fact that thirty three patients made self referrals indicates they were at least aware of some areas in which Social Service could be utilized.

A family referral is usually based on the desire of a family to obtain information concerning the patient's condition. Members of the patients' families accounted for six referrals. Two patients became known by referrals from other agencies. Four veterans became known to Social Service through other sources than those heretofore mentioned.

The large number of referrals from medical personnel indicate that they were aware of, and are using, the facilities of Social Service to help the patient make a better adjustment while in the hospital.

TABLE XVI

SOURCE OF REFERRAL TO SOCIAL SERVICE

Source	Total Referrals
Medical	55
Self	33
Family	6
Other Social Service	2
Other	4
Total	100

The reason for referral to social service possibly can afford some clues as to problem areas with which the veterans were concerned and which subsequently proved to be at least part of the reason for the discharge request. Table XVII shows that in fourteen of the referrals, of which eight were for discharge planning and six were to discourage the request, contact was not initiated with the patient until the time of discharge. Financial problems were the reason for sixteen referrals, and family problems accounted for nine referrals, indicating that social problems were definitely in evidence. This is further substantiated when it is noted that five veterans were known to Social Service because a referral to another agency was indicated.

In line with the workers' function in other areas not necessarily indicating any overt social problems, with which the veteran needed help twelve referrals were routine, thirteen were for social histories, and six required interpretation of illness to either the veteran or relatives. Other reasons included obtaining consent for electro-shock treatment from relatives of three patients, and Health and Welfare Reports requested by the American Red Cross concerning two veterans.

Sixteen patients requested the assistance of Social Service with small personal matters; eleven, aid in securing their personal items, two who wished to discuss a possible pass, three who desired transportation funds, and one who wished to contact his lawyer. Four reasons for referral were not recorded and thirteen referrals were routine. In one case, two reasons were given for the referral.

In can be concluded that the reason for referral to social service

is indicative only of the fact that social service might assist in certain areas, thereby facilitating the patient's hospital adjustment. The only significant correlations between the reasons for the referral to social service and the reason given for the discharge, either by the patient or medical-social, were in the categories "financial problems" and "family problems."

TABLE XVII

REASON FOR REFERRAL TO SOCIAL SERVICE

Reason[a]	Total
Financial problem	16
Social history	13
Routine	12
Secure personal items	11
Family problems	9
Discharge planning	8
Discourage request	6
Interpretation of illness	6
Agency referral	5
Consent for treatment	3
Transportation funds	3
Secure pass	2
Health and Welfare Report	2
Contact lawyer	1
Other	4
Total	101

[a]One case had two reasons.

The number of social service contacts with the study group, as seen in Table XVIII, showed that six veterans were not seen by the worker, although there was contact with the relatives. Thirty eight patients had only one interview with the worker, nine had two contacts, and forty seven had three or more recorded contacts. It is significant that the majority of cases in which the patient was seen three or more times were in those

Services that patients were seen routinely by Social Service. The number of interviews is indicative of extent of the problem with which Social Service dealt. Over half of the study group had two or fewer interviews. Although it is recognized that contact with the worker was interrupted in some cases by the release request, still the problems in other cases were sufficiently resolved as to require relatively few interviews with the patient.

TABLE XVIII

SOCIAL SERVICE CONTACTS WITH PATIENT

Interviews	Patients
None	6
One	38
Two	9
Three and over	47
Total	100

In Table XIX, it can be seen that the major types of services rendered by the worker on behalf of the patient fall into three general classifications: (1) Those concerned with AMA discharge, (2) Social problems, and (3) routine procedures or services directly provided for the patient while he is in the hospital. While it is recognized that the scope of Social Service activities is far in excess of the aforementioned services, the present study is more concerned with what the author considers as the major function of the worker in dealing with the study group.

In Table XIX, the major function of the Social worker in dealing with the patient is noted. The purpose of the contact with ninety four patients is recorded. Twenty seven of these veterans had two major reasons for the contact, bringing the total to 121 reasons.

Sixty two contacts were concerned with problems which can be termed social. Of these, nineteen were for family problems, thirteen for financial problems, and thirteen for casework treatment in which the effects of feelings and attitudes of the patient were discussed in relation to his illness. Referrals to other agencies comprised seventeen of the services rendered; twelve were to other VA agencies for psychotherapy, four were for casework, and one was to a public financial assistance agency.

Thirty two contacts were considered routine and were not especially indicative of any underlying social problem. These included fifteen explanations concerning the administrative procedures in the hospital, eight social histories, five veterans for whom personal items were secured, contacting the relatives of two patients, and two Health and Welfare Reports requested by the Red Cross.

In twenty seven contacts, Social Service had a role in dealing with the request for release. Of these, the worker attempted to persuade eight patients to withdraw the request, and nineteen contacts were concerned with discharge planning.

TABLE XIX

PURPOSE OF CONTACT WITH PATIENT

Purpose	Contacts[a]
Discharge planning	19
Family problems	19
Administrative procedures	15
Casework treatment	13
Financial problems	13
VA agency referral	12
Discourage discharge	8
Social history	8
Personal items	5
Casework referral	4
Health and Welfare Report	2
Contact relatives	2
Other agency referral	1
Total	121

[a]The purpose of the contact with ninety four patients is recorded. Twenty seven veterans had two reason for a total of 121.

Eighteen per cent of the relatives had one contact with Social Service, eight had two interviews, and ten had three or more contacts. Sixty four, or the majority of the relatives had no contact with Social Service.

TABLE XX

CONTACTS WITH RELATIVES

Interviews	Relatives
None	64
One	18
Two	8
Three and over	10
Total	100

Investigation of the nature of contacts with relatives as shown in Table XXI reveals only 36 per cent of the total had one or more interviews. The major services rendered by the worker totaled fifty seven for thirty six relatives. This was irrespective of whether contact was for one or more interviews.

The largest number of contacts with relatives was for interpretation of the patient's illness; this represented 29 per cent. Discharge planning was the purpose of thirteen contacts, and modification of attitude was the reason for eleven relatives being known to Social Service. Social histories were taken in eight of the contacts, financial problems discussed in three, and casework treatment given in one contact. Three contacts were for miscellaneous reasons. There is no evidence to indicate the Social Service contact with relatives had bearing on the subsequent AMA request of the patient.

TABLE XXI

PURPOSE OF CONTACTS WITH RELATIVES

Purpose	Contacts
Interpretation of illness	17
Discharge planning	13
Modification of attitude	11
Social history	8
Financial problems	3
Casework treatment	1
Other	4
Total	57

Summary

In this chapter, the AMA discharge, and the role of Social Service in working with the study group was discussed. Of significance was the fact that there was a correlation between the patient's and the medical-social reason for the discharge. In addition, Social Service contact with the patient revealed no overt clues as to the patient's subsequent discharge request. In Chapter V, the above information will be evaluated in terms of the entire study.

CHAPTER V

CONCLUSIONS

The present study has attempted to acquaint the reader with the study group who were discharged against medical advice, in order to determine some of the factors involved in this type of release. An evaluation of these factors yields some significant conclusions which are of value in gaining a better understanding of the problem.

1. The largest number of these patients, thirty four, were hospitalized on Psychiatry Service. Medical and Tuberculosis Services were next with twenty five patients each. Surgical Service had ten veterans, and Neurology Service had six. There was a proportionately larger number of patients on the first three services, in that they represented 84 per cent of the study group.

2. The majority of the study group were in the age group from twenty to forty years of age. This is the age group, more than any other, in which a veteran probably has more responsibilities for persons other than himself. Because of this, hospitalization, despite its significance in terms of the patient's welfare, is perhaps viewed by the patient as a discouraging interruption of long range goals for himself and his family.

3. In further substantiation of the above conclusion, three quarters of the veterans had a marital status which would in all probability indicate responsibilities in the home. It is significant to note that these responsibilities were often not overt in that they were not related to specific problems in the home. Rather, they perhaps affected the patient because they necessitated separation from the family.

4. The largest number of patients were hospitalized less than ninety days, and two-fifths of the entire study group were hospitalized less than thirty days. It can be concluded that the veterans submitting discharge requests usually did

so relatively early in their confinement. The notable exception was Tuberculosis Service, and this may in part be explained by discouragement engendered by the length of treatment required because only sixteen percent on that service requested discharge before ninety days.

5. At the time of discharge, over one-half of the patients were considered by their physicians to have improved and 47 per cent had had no change in their condition. This fact indicates that improvement of condition was not of sufficient significance to the patient to persuade him to remain for further treatment. Rather, this points toward other factors than the illness per se, for further explanation of the problem.

6. Of the study group, approximately one-fourth of the patients exhibited previous patterns of irregular discharges. One-half of this number had had two or more irregular discharges. It can be concluded that the veterans who previously had an irregular discharge are predisposed to a similar type of release in subsequent hospitalizations.

7. The predominant medical-social reason for the previous AMA discharge suggested a poor hospital adjustment. Although there was inadequate data to prove if this were valid, it becomes significant when compared with reasons for discharge during the present hospitalization.

8. The majority of the patient's reasons for requesting the present release fall into categories of refusal of treatment and poor hospital adjustment. It is felt that refusal of treatment is either a manifestation of inacceptance of illness, or results from the veteran being threatened by his responsibilities in the home. Poor hospital adjustment can be related to emotional factors within the veteran, which could also be responsible for inability to accept illness.

9. It is of particular significance that the medical-social reasons for the discharge correlate closely with those given by the patient. Although the medical-social evaluations in many cases were not specifically the same as those given by the veteran in each case, they still fall into the general categories of inacceptance of illness, and poor hospital adjustment. It is felt this particular correlation substantiates the fact that these discharges were partly caused by factors within the patient.

10. There was no significant correlation between the reasons

given for the discharge and the reason for referral to Social Service. However, the fact that a referral was necessay was indicative that problems existed which were of sufficient significance to have an effect on the patient's hospital adjustment.

11. Social Service was able to function adequately in giving the study group and their relatives services which would ordinarily contribute to the patient's adjustment. These services were often interrupted by the discharge request although some patients did not become known to Social Service until the request was submitted. The services performed in contacts with the patient were, in order of frequency in the areas of social problems, routine procedures, and discharge planning. It is felt the prevalence of social problems, although not revealed in the overt reason for discharge, did have an effect on the patient's decision to leave the hospital.

12. Relatives were seen in Social Service in only thirty-six cases. There was little indication that contact with relatives was in any way correlated with the discharge request. None of the reasons for contact with the relatives could be specifically connected with the patient's subsequent decision to leave.

It is the impression of the author from the above conclusions that a patient's request for a discharge against medical advice can be attributed to both emotional and social factors. This combination is often a difficult one with which to deal. However, it is felt some suggestions, both realistic and ideal, can be offered which would perhaps contribute to lessening the incidence of this type of release.

Active attempts to reduce all types of irregular discharges through patient education should be the responsibility of every discipline involved in working with the patient during his hospitalization. Through this type of education it is possible to help obtain cooperative attitudes and responses from the patient which will help in total hospital

adjustment. This concept was discussed in an article by Dr. Beauchamp concerning patient education in hospitals.

> Patients who fail to cooperate with treatment, either by leaving against medical advice, or by delaying recovery through their reactions and behavior, are a major hospital problem. . . Patient education, generally regarded as the means for dealing with this problem, must, if it is to be effective, have as its aim the development of desirable attitudes of understanding and cooperation. The patient education program is not successful merely because it imparts information. Only if it creates desired attitudes has it accomplished its proper aim.[1]

All patients with records of previous irregular discharges, by virtue of the pattern they tend to establish in this type of release, should be seen by Social Service routinely. A discussion by the worker with the patient might possibly provide clues as to the veteran's previous grievances, and thus help to provide a more satisfactory emotional climate for adjusting to the illness.

Because the majority of requests for discharges occur during the first three months of confinement, Social Service contact with the patient should be established within that time. Realistically it is recognized that this would require more social workers. However, the need for workers in dealing with the multitudinous problems of the hospitalized, in the author's opinion, more than justifies this increase. A satisfactory hospital adjustment of the patient is contingent on his being able to mobilize his energies toward recovery from his illness, but this can only be done

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[1]George E. Beauchamp, Patient Education and the Hospital Program, Veterans Administration, Bulletin 10-88 (Washington, 1953), p. 16.

when other pressures are reduced to a minimum.

The problem of irregular discharge will, no doubt, continue as long as patients are hospitalized. However, this does not lessen the responsibility on the part of hospital staffs to expend every effort to prevent this type of release.

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SCHEDULE

I. Identifying Information

A Name_____Address_____

B Age_____Race: White_____Negro_____Other (specify)_____

C Religion: Catholic_____Protestant_____Jewish____Other_____

D Occupation: Professional_____White Collar_____

Skilled_____Semiskilled_____Unskilled_____

E Present Marital Status: Single_____Married_____Separated_____

Divorced_____Widower_____

F Number of Dependents_____

G Service Connected_____Non-Service Connected_____

H Pension_____Amount_____; Compensation_____Amount_____

II. Hospitalization

A Hospital Service: NP_____TB_____Medical_____Surgical_____N_____

B Admitting Diagnosis_____

_____

C Treatment Plan_____

D Discharge Diagnosis_____

_____

III. Against Medical Advice Discharge

A Length of Hospitalization_____days; Season Left_____

B Number of Previous Admissions_____Hines_____Other VA_____

C Number of Previous Discharges:

AMA_____AWOL_____MHB_____Disciplinary_____

D Reasons for Previous AMA Discharges_____

_____

E Patient's Reason for Present AMA Discharge_____

_____

F Medical-Social reason for Present AMA Discharge_____

_____

IV Social Service Activity

A Source of Referral

VA:Med____Other VA Soc Serv_____Contact Rep_____Other_____
Non VA: Self_____Family_____All Others

B Reason for Referral to Social Service

Financial_____
Routine_____
Family Problem_____
Social History_____
Other_____

C Social Service Contact with Patient: No. of Interviews___

Services related to admin procedures
_____
Therapy_____
Agency Referral:
VA_____
Non VA:Finan_____Case Work_____
Other_____
Family Problems_____
Discharge Planning_____
Other_____

D Social Service Contact with Relatives: No. of Interviews___

Interpretation of Illness_____
Modification of attitude_____
Referral to other agency
Finan_____Case Wk_____Other_____
Dischatge Planning_____
Other_____

E If Family Known to other Social Agency_____
Name of Agency_____

V NOTES: