1955

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

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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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A Thesis Submitted in Partial Fulfillment
of the Requirements for the Degree of
Master of Social Work in Loyola
University

June

1955

Presented with the permission of the Chief Medical Director, Department of Medicine and Surgery, 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.

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CHAPTER I

INTRODUCTION

The Veterans Administration has long been concerned about the number of patients who leave their hospitals against medical advice. The reasons for this are clear; it is expensive both in human lives and administrative costs. When a patient leaves against the advice of medical personnel and then, because of continued illness is forced to return, the medical examinations, tests, X-rays, etc., must be repeated. In addition, the patient's condition may and in many cases has, deteriorated.

Hines is a multiple service hospital with a bed capacity of 2300. In addition to the doctors and nursing personnel, there are physical, occupational and corrective therapists, psychologists, social workers, psychiatrists and other specialists. There are recreational facilities and accommodations for vocational re-training. However, in spite of the efforts of these various disciplines, during a 19 month period an average of 32 patients left each month against the advice of their doctor.[1] These patients left knowing they could not return for at least 90 days except on an emergency basis. This penalty is used by the Veterans Administration to discourage Irregular Discharge.

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[1] Information obtained through daily population sheets.

"At times a patient will insist on being discharged when, in the opinion of the hospital and the attending physicial such discharge is inadvisable; and unless the patient is under legal commitment he has this right. The hospital has no authority to detain him against his wishes, yet it must have protection against slander and possible suit for damages."[2] This protection for the hospital is provided in the form which the patient signs when he leaves against medical advice.

"An Irregular Discharge is defined as any termination of hospitalization of a living patient which is not medically sanctioned by professional authority."[3] There are three types of Irregular Discharge, AWOL, (absent without official leave), Disciplinary, (given for the infraction of hospital rules), and AMA, (against medical advice). For the purpose of this study, Against Medical Advice Discharge was defined as "One in which the patient had been advised by his physician that he should remain in the hospital and he refused to stay."[4] Hereafter this will be referred to as AMA Discharge.

The objectives of this study were: (1) to learn why patients left Hines Veterans Administration Hospital AMA, (2) to evaluate what could be done to prevent the AMA discharges.

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[2]Malcolm T. MacEachern, Hospital Organization and Management, 2nd ed. (Chicago, 1946), p. 132.

[3]William B. Tollen, Irregular Discharge: The Problem of Hospitalization of the Tuberculous, (Washington, 1948), p. 1.

[4]Julia Hall Garth, "Leaving Against Medical Advice", Unpublished study, (Hines, 1953), p. 1.

Julia Hall Garth, in her unpublished study of the Tuberculous patients who were discharged AMA found that the patients left because of psychological and social problems.[5]

Tedesco, in his study of Irregular Discharges in a Veterans Administration Tuberculosis Hospital, found that factors leading to Irregular Discharge fell into 3 main divisions: (1) those originating outside the hospital related to personal, social and economic factors; (2) those originating within the hospital, and (3) those emanating within the personality of the patient.[6]

In a study of Irregular Discharge of Tuberculous patients from all Veterans Administration Hospitals it was found that the reasons divided evenly between the 3 categories given above.[7]

The writers planned to study the records of those patients who left the hospital AMA and who were known to Social Service during the period decided upon for the study. Originally, the period of the study was to be July 1, 1953, through July 31, 1954. However, it was decided to extend this period to April 1, 1953, through October 31, 1954, in order to obtain a larger sampling of cases.

This study included male patients from all sections of the hospital, except Blind, and was not limited to any one diagnostic group. Blind patients were excluded because of their small

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[5]Garth, p. 12.

[6]Joseph F. Tedesco, "A Study of Irregular Discharges in a Veterans Administration Tuberculosis Hospieal", American Review of Tuberculosis, Vol. 68, No. 3 (September, 1952), pp.393-398.

[7]Tollen, p. 24.

number within the total hospital. The study was concerned only with patients who left AMA.

The primary source material for this study was the medical charts and the Social Service records of the patients included in the study. No effort was made to contact the patients for personal interviews to supplement the information in the records.

Information contained in the Medical Chart consisted of reports of examinations, admitting and discharge summaries, doctors' and nurses' daily progress notes, consultation reports, social service activity reports as well as social histories. The Social Service record contained more complete information regarding Social Service activity.

Background information for the study was obtained from various types of reading including medical social work, previous studies of AMA discharge and hospital organization. This was augmented by personal interviews with Miss Jenness Eertmoed, Chief of Social Service and Miss Faye Bates, Supervisor of Social Service in the Tuberculosis section of the hospital.

In selecting cases for the study, daily population sheets were examined to obtain the names of patients who left AMA. These lists were then checked against the Social Service file and if the patients were known to Social Service during the period of the study the case was included. A schedule (see appendix) was devised to collect uniform data on each case that would be pertinent to the study. The schedule included identifying

information, hospitalization, the AMA discharge and Social Service activity. A schedule was completed on each patient and the information was tabulated.

The three students undertaking the project assumed equal responsibility for the initial gathering and tabulating of material and thereafter each worked independently in analyzing, interpreting and presenting the findings.

It should be noted that a large number of patients who left AMA had been known to Social Service during a prior hospitalization period but were excluded from the study because they had had no contact with Social Service during the time period of this study. Therefore, data could not be available as to their reason for leaving AMA.

During the period of the study there was a total of 606 AMA discharges, from all sections of the hospital. Of this number, 138 patients were known to Social Service during the period of the study. However, 25 of these records were not available for the study as they had been transferred to other Veterans Administration hospitals. This meant that these 25 patients had sought hospitalization elsewhere following their AMA discharge from Hines. An additional 13 case records had to be excluded because they were not available for use.

The effects of AMA discharge reach the patient, the hospital, the patient's family and the community. It is a serious decision which may and has in the past resulted in the patients' death. Hopefully, at least a partial solution may be found.

CHAPTER II

THE HOSPITAL SERVICES

"The effects of illness on an individual, his family, and his close associates can have as many different meanings as there are possible combinations of such factors as personality development, social conditions, environmental pressures, ways of becoming ill or handicapped, methods of treatment, and possible end results. In general we know that illness, as a life experience, can mean that a person gets to know himself in a new and better way, that families are reunited in a stronger and more positive relationship, that friendships are deepened, or it can mean that a person who is ill embarks upon a tyrannical reign over the lives of others or withdraws from association with others or shows increased hostility, frustration and resentment towards others or resigns himself to impending death."[1]

"The unique features of Medical Social 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 multi-disciplines in medical settings. (3) It serves as liaison in coordinating the medical and social services of a community."[2]

Thus it is the responsibility of the Social Service Department to help the patient adjust to his illness and to assist in

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[1]Caroline H. Ellege, "The Meaning of Illness", AAMSW Vol. 2, No. 2, April, 1951, p. 49.

[2]Grace White, "Distinguishing Characteristics of Medical Social Work", AAMSW, Vol. 1, No. 1 September, 1951, p. 34.

alleviating problems which might interfere with recovery. This includes problems within the patient and within the environment.

In a multiple service hospital, such as Hines, there is a multi-discipline approach to illness. Each discipline has a particular contribution to make in the interest of the recovery and well-being of the patient.

As a result of a reduction in the federal budget, effective July 1, 1954, the Social Service staff, as well as the staffs of other hospital departments were reduced. Prior to the reduction in force, there had been one Chief of Social Service with five supervisory units and eighteen caseworkers. Following the reduction, there was a Chief of Social Service with three supervisory units and eleven caseworkers. Before July 1, 1954, each of the main sections of the hospital--Medical, Surgery, Tuberculosis, Psychiatry and Neurology--had a supervisor of Social Service. Following that date, one supervisor was assigned to Medical and Surgery sections, one to Neurology and Psychiatry and the third to the Tuberculosis, Paraplegia and Blind sections.

The Medical section with a bed capacity of 809, and Surgery with a bed capacity of 535 are served by one supervisor of Social Service and four social workers. In these sections of the hospital patients are seen by Social Service by referral only. The referral may come from medical personnel, the patient, or relatives. Psychiatric services are available to Social Service on a consultative basis.

In the Paraplegia section, which is a division of Neurology, patients are seen routinely by Social Service because of the many problems associated with the handicap. Paraplegia section has a bed capacity of 239 and is served by 2 social workers. The remainder of the Neurology section has a bed capacity of 213. These patients are not seen by Social Service upon admission, but only on referral. They are served by 1 social worker.

The Tuberculosis section, with a bed capacity of 374 is served by 1 supervisor and 2 workers. In this section all patients are interviewed by Social Service as soon as possible after admission, which is hopefully within 48 hours after arrival in the section. The worker makes an effort to determine how the patient will adjust to hospitalization and to help with any problems which might work against satisfactory hospital adjustment. Because of the extended period of hospitalization for the tuberculous patient, sometimes as long as three years, the cases may be closed after the initial interview unless there is a problem at that time. It may be reopened at any time should a problem develop. A psychiatrist from the Psychiatry section is available to physician for consultative service. A Clinical Psychologist is also available for a limited amount of testing and therapy.

A social worker is assigned to each patient admitted to the Psychiatric section. This section has a bed capacity of 110 and is served by 1 supervisor and 2 workers. A team approach

is utilized in treating these patients.

There are other areas of Social Service activity not directly related to this study. There are social workers available in the Referral section which assists veterans who are not admitted to Hines because they are not considered in need of hospital care. There is also a social worker in the Blind section, which has a bed capacity of 20.

Each discipline has its contribution to make to the welfare of the patient. The contribution of the Medical Social Worker is one of integration; she is a liaison person who coordinates medical and social services. Although the means of referral to Social Service may vary on different services, the objective, which is the well-being of the patient, remains the same.

CHAPTER III

CHARACTERISTICS OF THE STUDY GROUP

The patients who left AMA and were included in this study had been known to one or more of the five main sections of the hospital. The few patients who were known to more than one section were listed under the service from which they left AMA. This in every instance corresponded to the service of major import for the patient. Thus a patient admitted to Medical for treatment of an ulcer, and then transferred to Psychiatry for treatment of emotional illness, would be included under Psychiatry service rather than Medical.

TABLE I

DISTRIBUTION BY SERVICE OF PATIENTS KNOWN TO SOCIAL SERVICE WHO LEFT AMA DURING THE PERIOD APRIL 1, 1953 THROUGH OCTOBER 31, 1954

SERVICE	NO. OF PATIENTS
Psychiatry	34
Tuberculosis	25
Medical	25
Surgery	10
Neurology	6
Total	100

Of the entire group, 68 patients were white, 30 Negro and 2 were of other race.

There did not seem to be any relationship between religious preference and AMA Discharge; 35 patients were Roman Catholic, 57 Protestant, 2 Jewish, 2 other, and 4 gave no religious preference.

Although information was obtained regarding the admitting and discharge diagnoses of the patients no effort was made to compare or contrast the diagnoses as such, nor to evaluate the patients condition at discharge from the standpoint of determining whether these factors may have influenced the patient to leave AMA. It did not seem that such information would be too meaningful. For example, it would seem in the case of a patient with advanced Carcinoma whose condition was diagnosed as "unchanged" from the time of admission, this diagnosis in itself would not be as significant as the fact that the illness would become progressively worse. Thus the Discharge diagnosis would not give an accurate picture of the patient's prognosis.

The vast majority of the patients, actually 82%, were between the ages of 20 and 45 years of age which may be explained by the fact that the greatest percentage of the group were veterans of World War II.

TABLE II

DISTRIBUTION OF THE STUDY GROUP ACCORDING TO AGE

AGE	NO. OF PATIENTS
20 through 24	10
25 through 29	17
30 through 34	25
35 through 39	19
40 through 44	11
45 through 49	5
50 through 54	4
55 through 59	8
60 and over	1
Total	100

In the total group, 33 had a service connected disability while in the remaining 67 cases the illness was considered non-service connected.

When a veteran has a disability which has been adjudicated by the Veterans Administration to be service-connected, he is eligible for financial compensation in proportion to the disability. In addition such a veteran would be eligible for out-patient treatment from the Veterans Administration as well as medication and physical appliances. Thus the 33 patients were receiving compensation in varying amounts. Of the non-service connected group 19 were receiving a pension. Pensions may be allowed on a non-service connected basis if the disability is considered of a permanent nature.

Prior to hospitalization, the majority of the study group had been employed in a skilled or semi-skilled position. Only 3

patients were professional people while 9 were white collar workers and 28 were skilled workers. There were 38 semi-skilled patients and 19 unskilled. One patient had no work history prior to hospitalization and 2 patients had been students.

The marital status of the group was interesting. A large percentage (49%) of the patients were either single or had experienced marital discord.

TABLE III

DISTRIBUTION OF THE STUDY GROUP BY MARITAL STATUS

Single	25
Married	48
Separated	14
Divorced	10
Widowed	3
Total	100

It was not always possible to obtain information as to the exact number of dependents since the records were sometimes incomplete in this area. However, those dependents mentioned in the records were tabulated. In cases in which the veteran was married and his wife had been employed prior and during hospitalization she was not counted as a dependent. This differentiation affected only those cases of veterans who had no children.

TABLE IV

DISTRIBUTION OF THE STUDY GROUP BY NUMBER OF DEPENDENTS

0 dependents	43
1 dependent	15
2 dependents	18
3 dependents	9
4 dependents	8
5 dependents	2
6 or over	5

It would seem that the patient with fewer responsibilities was more likely to leave AMA. It will be noted that 76% of the study group patients had 2 or less dependents.

The early days of hospitalization were the most critical with respect to AMA discharge. A majority of the patients, actually 67, left before 90 days had expired. Before six months had expired, 84% of the total study group had left AMA. All 8 of the patients who remained more than 1 year were from the Tuberculosis section of the hospital.

TABLE V

DISTRIBUTION OF THE GROUP BY DAYS OF HOSPITALIZATION

NO. OF DAYS	NO. OF PATIENTS
0 to 90	67
90 to 180	17
180 to 270	1
270 to 360	7
over 1 year	8
Total	100

TABLE VI

DISTRIBUTION OF PATIENTS WHO LEFT AMA BEFORE COMPLETING 90 DAYS OF HOSPITALIZATION

NO. OF DAYS	NO. OF PATIENTS
0 to 30	42
30 to 60	17
60 to 90	8
Total	67

Of the 42 patients who left before completing 1 month hospitalization, 9 remained less than 10 days; 18 patients left between 20 and 30 days. In the group of 67 patients who left AMA before 90 days of hospitalization had been completed, 26 were from Psychiatry section, 4 from Tuberculosis, 24 from Medical, 8 from Surgery, and 5 from Neurology. It should be noted that of the 33 patients who remained in the hospital more than 90 days, 21 were in the Tuberculosis section. The vast majority of the Psychiatric patients left AMA before they had completed 90 days of hospitalization, while the Tuberculosis patients with four exceptions remained longer than three months.

In the group of 42 patients who left within the first month of hospitalization, 16 had a history of previous Irregular Discharge. Of the total study group of 100 patients, 26 patients had a history of previous Irregular Discharge. Twenty-two of these patients had at least 1 previous AMA Discharge.

TABLE VII

NUMBER OF PAST IRREGULAR DISCHARGES OF 26 PATIENTS

NO. OF PATIENTS	NO. OF IRREGULAR DISCHARGES
13	1
8	2
2	3
1	4
2	6

In this group of 26 patients there was a total of 38 AMA Discharges, 8 AWOL's, and 5 Disciplinary Discharges. During the study period 3 patients left AMA on 2 occasions, while 1 patient left 3 times.

On the 22 patients who had a history of past AMA Discharge, 4 were noted as having made a poor hospital adjustment, 3 had family problems, 5 refused treatment and 3 left to avoid a Disciplinary Discharge. There was no specific reason given for the AMA Discharge in 6 cases although it had been noted that the patients did have difficulty adjusting to hospitalization. Dissatisfaction with hospital personnel was given by 1 patient as his reason for leaving.

It was interesting to note that the type of reason for AMA Discharge in this group of patients tended to be repetitious. The problem seemed to be within the patient rather than caused by environmental factors. Thus if the patient left previously because of poor hospital adjustment, he continued to have this difficulty or something closely associated as alcoholism,

refusal of reasonable treatment, or restlessness.

In summary it has been noted that the vast majority of the patients in the study group were between 20 and 45 years of age. A large percentage were lone men, either single, separated or divorced. The early days of hospitalization were the most critical since 67 patients left before completing 3 months in the hospital. Of the 100 patients, 26 had a history of previous Irregular Discharges.

CHAPTER IV

FACTORS RELATING TO AMA DISCHARGE

From the reasons given by the patients it would seem that the majority left because of personality problems. In 2 instances the patients felt they were being discriminated against by hospital personnel. Eleven patients felt their condition was improved to the extent that further hospitalization was unnecessary. It was interesting to note that 5 of these patients were on the Psychiatric service. In order to avoid a Disciplinary Discharge, 4 patients left AMA. A Disciplinary Discharge is given for the infraction of hospital regulations. Five patients left because they felt they would not recover. It should be noted that in these 5 instances it was a realistic evaluation on the part of the patients.

Dissatisfaction with medical treatment on the Psychiatric wards in almost every instance was associated with the patients' refusal of Electro-shock Therapy. On all other wards, however, this meant refusal of prescribed medication or other types of treatment not including surgery. A total of 17 patients gave refusal of treatment as their reason for leaving.

TABLE VIII

DISTRIBUTION BY HOSPITAL SERVICE OF REASONS GIVEN BY PATIENTS FOR AMA DISCHARGE

REASON	TOTAL	PSYCH-IATRY	TUBER-CULOSIS	MEDI-CAL	SUR-GERY	NEURO-LOGY
Dissatisfied with hospital personnel	2	1	1	-	-	-
Sufficient improvement	11	5	1	2	1	2
Pending disciplinary action	4	-	2	2	-	-
Restlessness	7	5	1	-	1	-
Poor prognosis	5	-	1	2	1	1
Financial problems	15	3	2	8	2	-
Family problems	10	2	3	3	2	-
Dissatisfied with medical treatment	17	9	2	3	1	2
Unknown	15	4	6	5	-	-
Preferred other hospital	3	-	2	-	1	-
Refused pass request	6	1	4	-	-	1
Preferred own home	3	2	-	1	-	-
Refused discharge plan	2	2	-	-	-	-
Rejected surgery	5	-	1	2	1	1
TOTAL	105	34	26	28	10	7

* Total number of reasons over 100 because some patients gave more than 1 reason for leaving.

Two patients from the Psychiatric service left AMA because they did not approve of the discharge plan arranged by the hospital with the family.

A total of 7 patients stated they were merely restless and could not accept further hospitalization. Refusal of a pass to leave the hospital for a short period of time was the reason for the AMA in the cases of 6 patients. Four of these patients were in the Tuberculosis section of the hospital.

There were interesting variations between the reasons given for the AMA by the patients and by the hospital as evaluated by Medical and Social Service staffs. A total of 30 patients left AMA according to hospital personnel, because of inability to accept treatment. Of the 30, 11 patients were in the Psychiatric service. The most common reasons for leaving on the Psychiatric wards as interpreted by Medical and Social Service staffs were personality problems, poor hospital adjustment, and refusal of treatment.

In the Tuberculosis section, poor hospital adjustment was given most frequently by the hospital as the patients reason for leaving. One of the patients who preferred another hospital wishes to enter a Veterans Administration Hospital in California because he felt the climate would be beneficial. His doctor agreed that the climate would help but actual release from Hines had to be on an AMA basis.

TABLE IX

DISTRIBUTION BY HOSPITAL SERVICE OF MEDICAL-SOCIAL REASONS FOR AMA DISCHARGE

REASON	TOTAL	PSYCH-IATRY	TUBER-CULOSIS	MEDI-CAL	SUR-GERY	NEURO-LOGY
Alcoholism	3	-	1	1	-	1
Personality problems	9	4	2	-	1	2
Poor hospital adjustment	20	7	8	2	1	2
Poor prognosis	2	-	1	-	1	-
Family problems	11	2	5	4	-	-
Financial problems	9	1	-	8	-	-
Preferred other hospital	5	2	2	1	-	-
Refused treatment	30	11	2	8	8	1
Preferred own home	4	3	-	1	-	-
Refused discharge plan	2	2	-	-	-	-
Pending disciplinary action	4	1	3	-	-	-
To attend court hearing	1	1	-	-	-	-
Unknown	6	2	2	2	-	-
TOTAL	106	36	26	27	11	6

* Total more than 100 because in some cases more than 1 reason was given for the discharge.

In the Medical section as well as Surgery, the most frequent reasons for AMA were financial problems and refusal of treatment.

The patients leaving AMA from Neurology showed an inability to accept hospitalization. The reasons for leaving were associated with their own personality problems.

In 6 instances Social Service contact was initiated by relatives and the patient was not seen.

TABLE X

REASON FOR REFERRAL TO SOCIAL SERVICE OF PATIENT GROUP

REASON	NO. OF PATIENTS
To discourage AMA	6
Financial problems	16
Routine	12
Family problems	9
Social history	13
Referral	5
Interpretation of illness	6
Consent for Electro-shock	3
Personal items	11
Secure pass	2
Transportation	3
Health and welfare report	2
Discharge planning	8
Other	4
Total	101

* The total number of referrals was more than 100 because 1 patient was referred for more than 1 reason.

A number of patients requested Social Service help in securing personal items such as shoes, luggage, etc. Three patients wished to be given funds so they could go to Chicago

for clothing or to settle family matters. Health and welfare reports were requested on 2 patients by their families through the Red Cross. In some cases in which patients left AMA, discharge had been scheduled for the near future.

A total of 38 patients were interviewed by Social Service on only 1 occasion. Nine were seen twice and 47 were interviewed 3 or more times. In 64 instances, the relatives of the patients were not interviewed. In 18 cases relatives were interviewed on 1 occasion while in another 18 cases they were interviewed 2 or more times. Relatives were interviewed by Social Service mainly for interpretation of the patient's illness, modification of attitude on the part of the family, and discharge planning. The families of 21 patients on the Psychiatric wards were interviewed, 6 in Tuberculosis, 4 in Medical, 2 in Surgery and 1 in Neurology. The need for a social history on patients in the Psychiatric section accounted for relatives being interviewed by Social Service.

It was interesting to note that of the 16 patients who came to the attention of Social Service because of financial problems, the families of 13 were referred for financial assistance. It should be recalled that 15 patients gave financial problems as their reasons for leaving AMA so that there appeared to be a valid basis in fact for the patient's expressed reason for termination of hospitalization.

A total of 22 patients discussed family problems with Social Service. In another 8 cases the social worker attempted to discourage the patient from leaving AMA. When the worker was unable to dissuade the patients from leaving she acquainted the patient with facilities in the community. Social Service activity in Discharge planning also included services to those patients who were scheduled for discharge but left before plans could be completed. The total number of patients seen for Discharge planning was 19.

Of the total study group, the families of 10 patients were already known to Social agencies in the community at the time of the AMA. In 10 instances the families were receiving some type of financial assistance. In 1 instance there was the additional problem of child placement involved.

Thus an analysis of the patients' reasons for leaving AMA and the explanation given by the medical and social service staff as to their impression of the factors motivating the patient to leave against medical advice lead to the following conclusions: a large number of patients left AMA because of their own personality problems. There were other cases, however in which there were realistic difficulties in the home situations which caused the veterans to leave. A few patients feeling that they would not recover left either to die at home or seek hospitalization elsewhere.

CHAPTER V

SUMMARY AND CONCLUSIONS

The significance of AMA Discharge can hardly be overemphasized. The affects of it on the patient, his family, and the community should not be minimized. It should be remembered that 25 patients in the study group left from the Tuberculosis section of the hospital. These individuals who left before their condition warranted release could be considered a danger not only to themselves but to their families and the community. Certainly many of the patients from the psychiatric service, who left AMA, would experience difficulty in adjusting to the community. Not all cases of the AMA discharges could be considered so dramatic as those from the two services just mentioned. The problem, however, remains a serious one.

It was found that patients left AMA because of psychosocial problems. A large percentage of them were lone men. Of the married group there were many who had experienced some type of marital difficulty.

The vast majority of the study group were between the ages of 20 and 45 years. The overwhelming majority were veterans of

World War II.

Of the total study group, 26 patients had a history of previous Irregular Discharge. In this group of 26 patients, the reasons for leaving tended to be repetitious. For example, if a patient left previously because of alcoholism, the second AMA might well be to avoid a Disciplinary Discharge. The reasons for the AMA in this group of patients pointed to definite personality problems.

The early days of hospitalization were the most critical in regard to AMA Discharge. The proof of this is overwhelming. Of the entire group, 67 percent left before completing 3 months' hospitalization.

The most common Medical-social explanation of the basis for the AMA Discharge was the patient's refusal of treatment. The reason for the refusal of treatment seemed to be the result of the patient's own personality problems.

Fear seemed to be one of the outstanding components of the study group, whether it was fear of loss of job, estrangement from family or fear of loss of self esteem.

The study did not find any cure-all for AMA Discharge. No doubt there will always be a certain percentage of patients who, despite all efforts, will be unable to accept treatment. However, it is hoped that this number can be reduced.

It might be advantageous to have more complete information in the records regarding the patient's behavior and his reasons

for leaving, as well as the Medical-social reasons. Then, should the patient return to this Veterans Administration hospital or another, this information would prove helpful in indicating those areas in which Social Service might be effective in helping the patient sustain treatment until he attained maximum hospital benefit.

When a patient has a history of previous Irregular Discharge, it might be well to refer him directly to Social Service upon re-admission. Such a patient has shown an inability to adjust to hospitalization and could benefit from special support to complete his hospital treatment. There is, however, the realistic factor of staff limitations to be considered. It would require more social workers than are available at the present time. The long term values of such a program, however, would outweigh the monetary consideration of additional salaries.

The possibility of group therapy might also be considered as a means of helping the patient sustain treatment. In connection with this, on a service such as Tuberculosis, where the length of required hospitalization is long, the hospital might foster a patients' organization with a direct line of communication to the hospital authority. Such an organization would afford patients an opportunity to discuss mutual problems and make known their needs and concerns to the hospital authorities; in addition they could make suggestions as to means of improving the service. In this way, they would feel they

have a contribution to make and would have a feeling of importance. As a recipient, the patient could suggest means of improving service.

It will be recalled that relatives of 64 of the patients who left AMA had not been seen by Social Service. While it would be extremely difficult, if not impossible for Social Service to speak with the relatives of all new admissions to the hospital it is possible that some type of group meetings could be arranged.

The patient, whatever his physical complaint, must be considered as a total personality. His illness, his reactions to it as well as the family situation must be understood and evaluated. Without such consideration a large number of patients will continue to leave against the advice of medical personnel.

BIBLIOGRAPHY

MacEachern, Malcolm. Hospital Management and Administration. Chicago, 1946.

Tollen, William B. Irregular Discharge: The Problem of Hospitalization of the Tuberculous. Washington, 1948.

Tedesco, Joseph F. "A Study of Irregular Discharges in a VA Tuberculosis Hospital", American Review of Tuberculosis, LXVIII (September, 1952), 393-398.

Garth, Julia Hall. "Leaving Against Medical Advice," Unpublished study, Hines Hospital, 1953.

Sell, Cornelia, "Social Factors in Discharges Against Medical Advice: A Study of Patients who were Discharged AMA from Veterans Administration Hospital, Bedford July 1, 1946--June 30, 1947," Unpublished Master's Thesis. Boston University, Boston, 1948.

West, Merle H. "An Analysis of the Dynamic Factors Which Influence the Irregular Discharges from Neuropsychiatric Division of a Veterans Administration Hospital." Unpublished Master's Thesis, University of Buffalo, Buffalo, 1953.

Ellege, Caroline H. "The Meaning of Illness," American Association of Medical Social Workers, II (April 1951), 49-65.

White, Grace. "Distinguishing Characteristics of Medical Social Work," American Association of Medical Social Workers, I (September 1951), 31-39.

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_____
Discharge Planning_____
Other_____

E If Family Known to other Social Agency_____
Name of Agency_____

V NOTES: