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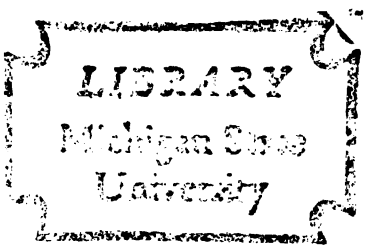
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DISCHARGES AGAINST MEDICAL ADVICE

INGHAM SANATORIUM

1949 - 1951

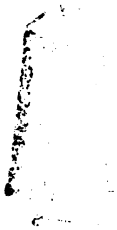
By

Rachel Faude Wood

A PROJECT REPORT

Submitted to the Department of Social
Service, Michigan State College,
in Partial Fulfillment of the
Requirements for the Degree
of
MASTER OF ARTS

1952



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ACKNOWLEDGEMENT

I would like to express my appreciation for the help and encouragement given me by Mr. Bernard Ross, of the Social Service Department, advisor on this project.

Grateful acknowledgement is also made to Mr. Manfred Lillefors of the State Department of Social Welfare for his considerate aid in the statistical analysis, to Phyllis Wilkie, Vocational Counselor at Ingham Sanatorium in helping to gather facts from the medical records, to Ruth C. Lowell, Michigan Tuberculosis Association, in proofreading the content of this study and to Janet Carpenter in typing the charts.

Last, but certainly not least, acknowledgement is made of the co-operation of Dr. C. J. Stringer in allowing the use of records at Ingham Sanatorium, for without them, this study could not have been made.

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INTRODUCTION

Each year, throughout the country, thousands of patients leave tuberculosis sanatoriums against medical advice. The reasons given are various. "He couldn't adjust to hospital life." "He was emotionally disturbed." "His family put too much pressure on him." But few studies have been made to discover why a patient is willing to gamble with his own life and that of others, rather than stay a little longer.

In checking the records of Ingham Sanatorium, it appeared that although discharges against medical advice were lower than in many sanatoria, they were still too high.

There seemed to be many different figures that could be used in determining what percentage of patients left without sanction of the hospital a uthorities. If one considered the total number of patients in Ingham Sanatorium over this three-year period, 1949-51, an approximate 6% left against advice. Of the total number of discharges, it was slightly higher - around 8%. In some sanatoria, walkouts of 25% to 75% of the discharged patients are reported. (1)

In the beginning, it appeared that there were several factors which might be considered. For example, within the age group 20 - 29, adjustment seemed most difficult, family problems most pressing. Those under 19 and over 60 were not so apt to leave before they should. It was assumed that those with more advanced disease might become more easily discouraged and wish to leave. Those who had been hospitalized before and those who had built up a pattern of leaving against advice — going from one sanatorium

(1) Tollen, Wm. "Spotlighting the Patient and his Family"; Decreasing Discharges Against Medical Advice, Nat'l TB Assoc. 1949

to another in search of better conditions or treatment - - also seemed to form a specific group. Many patients are some distance from home and this appeared to be a factor. Enforced bedrest for those who had had an active occupation might be a difficulty. And, of course, there is always the family and the part they play in the patient's life.

METHODOLOGY

There has been little research into the problem of the patient who walks out against advice. A few articles such as "Why Do Patients go AWOL" by Wm B. Tollen, the "Unruly Patient Problem Reviewed" by Robert D. Johnson, M.D. and "Patients are People" by Harry Wilmer, M.D. give mainly the writer's opinions and conclusions. A comparison of discharges from two Michigan sanatoria for a six months period, October 1949 through March 1950 showed that approximately 70% from one sanatorium and 48% from the other either left against advice or abscounded. There were no reasons given. (2)

Because there was so little data, it was felt necessary to go ahead with this study in the way which appeared best to those working with it.

The discharge summary in the medical chart includes the reason for the patient going out against advice as seen by the doctor who was disctating it. The case record did not always give a reason for the actual leaving. However, it did cite problems which had arisen and included the patient's feelings on his cure, the hospital and his own family problems. Where it was possible, the worker talked with patients either when home call was made, when the patient returned for check-up or in some instances when he was rehospitalized. Because there was such a large percentage who had

(2) Study made by Michigan Department of Health in 1950.

moved or gone into other sanatoria, there were many on whom we had no present address. It was not deemed advisable, therefore, to try to interview all patients at this time. Many of the conclusions drawn in this study are necessarily from facts stated in medical and case records.

To get an adequate sample, it was decided to use a three year period, 1949-50-51. Discharges against advice for this period are limited to those who left after an actual diagnosis of tuberculosis. The control group consisted of those discharged during the same period excluding only, those who were not tuberculous, those whose stay was too short to make actual daignosis and those who were hospitalized for a very short interval for treatment (gastric washing, phrenic, bronchogram, etc.) This control group of 267 patients regularly discharged was chosen instead of all patients hospitalized because the latter group was too large - approximately 1700 patients- and lack of time necessitated a smaller group.

Sanatorium monthly lists, showing admittances and discharges were checked on all 377 patients (both A.M.A .(3) and those regularly discharged) and information regarding name, condition of disease on discharge, and date of discharge was obtained.

A schedule was drawn including, name, age,sex, home locale (rural,urban, etc.) position in family, occupation, daignosis, number of readmittances, admittance date, discharge date, number of months in the sanatorium, previous A.M.A.'s, reasons for leaving and present situation. This information was taken from the medical chart, on the 110 patients who left against advice. Also taken from the medical charts was information as to age and amount of time spent in the sanatorium of the 267 patients.

(3) A.M.A . - Against Medical Advice.

The case records were then checked for name, age, home locale, occupa tion and reason for leaving the sanatorium on the 110 patient which comprised the walk-out group.

In the beginning, it had been planned to interview each patient who was out against a dvice, if possible. However, as we could not make individual interviews on all in the time allotted and because there many that had moved and there was not time to trace their present address, this was eliminated. It was noted that in only two cases was the information in the case record given by anyone other than the patient himself. It is possible that afteer a lapse of time, different reasons might be given, had the patient been interviewed now.

Because it was believe that that group of patients in the 20-30 a ge group seemed to have the most family problems, it was decided the age classifications should be as follows: 0-19, 20 - 29, 30 - 39, 40 - 59 and 60 and over. Marital status was also broken down in an effort to show the difference between the patient with family problems and the one with only himself to think of. Thus the classifications: single, married without children, parent with children and in a single classification, those widowed, separated or divorced.

The classification of months spent in the sanatorium was chosen on the basis of the sanatorium rules governing the taking of x-rays and criteria for discharge. X-rays and consideration of the patient in staff conference are every three months. The minimum basic requirements for discharge are two unchanging x-ra ys (6 months) and completely negative tests for six months period. It was therefore decided to use 0 - 5 months, 6 - 11 months, 12 - 17 months and over 18. With the total time of hospitalization decreasing, fewer patients are remaining for over the 18 months period than heretofore.

LIMITATION OF METHODS

It is felt that these methods are somewhat limited. There are records which are very sketchy a s to reasons given for leaving such as the one citing: "J. was having trouble with his family and decided it was to his best advantage to leave." Or such as the one which stated, "Mr. B. left against advice after an argument." Knowledge of whether the argument was with friends, roommates, family, sta ff or personnel, whether it was over his own problems, disagreement as to policy or many other things would have been most helpful.

Actually there may be four reasons for each discharge against advice. First, that given in the hospital (medical) records. Second, that given in the case record. Third, what the patients say. This may include roommates, friends or even the reason given by the one who is leaving. Fourth, the real reason. Many time the underlying facts are such that the patient either does not realize the events and feelings leading up to his walkout or does not wish to discuss them.

Another variation of data would include the change in conditions in the sanatorium from day to day. As long as a study is dependent on human beings and human relationships, there will always be change.

"Consideration of differences or similarities in employment opportunities, welfare department policies, turnover in medical and nursing personnel and many other apparently a ncillary factors which may influence the behavior of current patients must be considered." (4)

(4) Holland Hudson cit. Appendix VI

A patient may feel different from day to day. His feelings about his physical condition may differ and the person he comes in contact with as he becomes more worried, may aggravate him, worry him or help him. His home situation may also change. The family may visit and cheer him up or worry him. They may not visit at all. New problems may arise which he thinks only he can care for. The family may try to keep problems from him and thus make him worry more than ever. The lunch or dinner menu may not include his likes in food and "he has never had such poor meals". The steak or chicken may please him and the meals are excellent!" His roommate may talk when he wants to sleep or vice versa. There may be personality difficulties of which the staff is not aware until too late. All of these limit the comparison from one area to another and are a means of rendering such comparisons statistically invalid.

Because of lack of factual data as above discussed, there is little to compare. In reality, any data which could be comparable would be almost impossible to obtain until such time as there is a unified definition of "Against Medical Advice."

LEGAL AUTHORITY FOR TUBERCULOSIS CONTROL IN MICHIGAN

Under Public Act 341, 1927, a mended by Act 93, P.A. 1937, Act 240, P.A. 1941 and Act 249, P.A. 1949, "An act to protect the people from tuberculosis, to provide for the care, treatment, isolation and hospitalization of persons afflicted therewith, to provide for the commitment of certain persons afflicted with tuberculosis, to provide for their care, custody and discharge and to prescribe penalties for the violation of this act," those with active cases of tuberculosis are hospitalized.

Tuberculosis is declared in the above acts to be a communicable disease dangerous to public health. Because of this, anyone with a known case of a ctive tuberculosis is to be hospitalized until such time as they cannot endanger the public.

According to Section 2a. "If he (health officer or state commissioner of health) shall find that any such person is a menace to others, he shall petition the probate court of the county in which such a person resides or is found, for an order directing the admission of such person to any approved hospital or institution established for the care of persons suffering from tuberculosis." Thus, for that person who is a public health menace, compulsory hospitalization may be effected. In few cases, however, is this significant to the person who leaves against advice, as it includes only known active cases, and this term is usually used when the sputum is proved positive. Therefore, the patient who has improved so that he has converted his sputum to negative but who has not yet stabilized his disease, is not usually brought back under court order, nor can that patient who has not given or will not give sputum for laboratory tests be forcibly hospitalized. When the patient, who is hospitalized under court order, leaves the sanatorium against advice, he usually leaves the state immediately and thus cannot be returned. The hospitalized patient with a family who is under court order will seldom leave without them and as this may be difficult, will usually stay. However, psychologically, the effect of being forcibly restrained may be so disturbing that it is usually used only when other means fail.

Because it is impossible to enforce hospitalization and expect a medically indigent patient to pay for it and because cure for tuberculosis requires long periods of bedrest, this same law provides for free care.

This includes not only hospitalization but all treatment as well and "shall be considered expenditures for the protection of the public health and not as moneys advanced in the nature of welfare or relief. No person shall be under legal obligation to make reimbursement for such expense so incurred unless the state commissioner of health and the county of settlement, after reasonalbe notice and upon fair hearing under rules of procedure to be determined by the state commissioner of health, shall have found that the person so hospitalized or treated, or the person or persons legally liable for his support, are possessed of sufficient income or estate to enable them to make such reimbursement in whole or in part without materially affecting their reasonable economic security . . . ." (Section 3a)

DEFINITIONS OF "AGAINST MEDICAL ADVICE"

As above mentioned, one of the difficulties in comparison of data stems from the fact that "Against Medical Advice" may have almost as many different definitions as the number of sanatoria involved.

At Ingham Sanatorium, a patient is discharged after he has successfully completed the course of treatment as recommended by the medical staff, after optimum home conditions have been effected for each individual patient and approval of his local health department has been secured. In cases where there is no county or city health department, the situation is worked out as satisfactorily as possible between the patient and the social worker. Any patient who leaves before these conditions have been met, is termed out "against medical advice." The patient who leaves to meet an emergency at home, becomes dissatisfied or lea ves because of other pressures is "out against advice."

One administrator may report as against advice, those patients who do not wait for home investigations, while another only those who leave before their term of treatment is completed. One may count disciplinary discharges as AMA while another does not. One sanatorium may discharge patients who are negative by slide, another require negative slide, culture, guinea pig and gastric. To leave before complete conversion would be considered, "against advice." Some sanatoria use the definition "against advice" for those who have not fulfilled all requirements for discharge but leave after advising the staff of their intentions and the term "abscounded" for those who leave without notifing anyone.

Thus, here too, the absence of any uniform criteria is one of the main difficulties in any inquiries that may be made.

The same absence of criteria as to programs and classifications and/or standards of personnel makes it impossible to compare one sanatorium to another, one program or even facilities and resources within the sanatoria. A shortage of personnel or those with inadequate training and/or understanding of the situation may increase the number of early discharges. While a trained social worker may help the patient analyze his reasons for wanting to leave, a sanatorium where there is no social worker or where he is inadequately trained may find that the patient leaves earlier because he cannot observe his problem clearly.

The sanatorium which has adequate, well-trained personnel will meet patient needs better than that operating with a reduced number of workers. The services provided also vary with the number of workers and the type of work done. Outside of the medical and nursing staff, that sanatorium

which can help fill the waking hours of the patient with such activities as occupational therapy, bedside teaching , homemaking and library, presented and supervised in such a way as to be meaningful and interesting, will find fewer walk-outs than those without these services. Those patients who can discuss home problems with a social worker, worry over future jobs with a vocational counselor and feel that a plan of action will be forthcoming will usually do so and not try to carry the entire burden themselves.

Rules and activity allowed are both important in considering the patient who will not or can not wait to complete his full term of treatment. For the inveterate smoker a "no smoking" rule may become an insurmountable difficulty. The very active business man, athlete or teenager may find it impossible to adjust in a sanatorium where he is kept on complete bedrest for a long period of time, but in that sanatorium where they are given more freedom, may be better able to adjust. The fact that some sanatoriums send their patients home when they are up for one meal a day and bathroom priveleges (as they do at Ingham) and other keep them until they are on several hours work activity, also makes a difference in the willingness of the individual to stay until discharged.

REASONS FOR LEAVING AGAINST MEDICAL ADVICE

There are as many reasons for leaving against medical advice as there are patients who leave. No two situations are ever the same and as in everything else, the situation depends on the individual and the adjustment he has been able to make towards life.

The hospital, itself, and the life a patient must lead there breeds dependency. He is told when to get up in the morning, when to wash, brush

his teeth, eat, see people sleep. From the time he was an infant, he has been taught the opposite. He has been taught independence, that he should learn to care for himself and his family, He will get ahead by his use of initiative. Little wonder he is now thrown into a world of conflict. When it becomes so great he can no longer resolves his worries, he returns to his own life or becomes psychotic. Usually a patient will leave before he becomes so emotionally disturbed.

"Emotional instablity" is a nebulous term depending often on the definition by the person who is writing the history. In one case, it may be the family pressures or other difficulties which make the patient unable to adjust to his disease and hospitalization. In another, it may be the disease which accentuates the family pressures. Often the threat of surgery or the vagueness of tuberculosis is far too difficult for the patient who has not already learned to adjust to life. He may withdraw to the point where he will no longer have anything to do with his roommates, may spend his time sullenly staring out the window. He may work rapidly, seldom taking a break, paying no attention to his rest periods. He may complain constantly about many petty things. He may be known as "making a poor adjustment."

At all times we try to remember the statement by Emil Frankel, "Statistics are people. The patient upon admission becomes an individual with a broken body and disturbed mind and not just a pair of lungs sent in for repairs." (5) And also that by Harry a Wilmer, M.D., "It's more important to know what kind of a fellow has the germ than what kind of germ has the fellow." (6)

(5) Frankel, Emil, "The Changing Scene in the State TB Sanatorium Field", The Welfare Reporter, N.J. Dept. Institutions & Agencies (Dec.'51)
(6) Wilmer, Harry M.D. "Patients are People" The Crusader, (1951).

Often lack of proper interpretation of rules or reasons for doing things may increase discontent. These may be purely unintentional or it may be an actual lack. A patient wishes to talk to a staff member but a busy schedule does not allow it as soon as the patient believes it should. A patient may not realize the red tape necessary or the time involved to carry through an operation which he believes should be done immediately. Many times hospital personnel cannot get cooperation from other necessary agencies, particularly within a specified time.

> Mrs. W. was recommended for discharge. A low family income and poor home conditions worried her. Her county of residence, in spite of the law, refused to pay for out-patient treatment and did not immediately complete home investigation. Mrs. W. left rather than wait until the situation was straightened out.

Food is always a reason for "griping". The patient forgets that eating food prepared by the same people may become tiresome, whether at home, in a particular restaurant or in the hospital.

Other patients play a large part in the A.M.A. discharges. Although we try to place patients according to age and interests as well as the amount of disease, there may be a clash of personality. The roommate or friend is all too often ready and willing to "give advice". He will frequently discuss tuberculosis, treatment, surgery, rules, etc. This is not always with the best understanding and may create discontent or fear in the new patient.

Fear of the disease, itself, is a large factor in early leaving. Often when the patient is told he has tuberculosis, it comes as a shock,

he does not realize the other things that are told him at that time. He does not realize the disease is discussed as is his hospitalization. Too often, he is told by his own physician that there is something in his lung and he had better come in for a couple weeks observation. He may have a far-advanced case which will necessitate months of bedrest and treatment but is not properly prepared so he can make arrangements at home.

> Mrs. B., the 25 yea r old mother of 4 small children ranging from 2 to 6 years was found to have far-advanced, bi-lateral pulmonary tuberculosis. In an effort to hurry hospitalization, pressure was effected and she was admitted two days later. She had been the strongest member of a very weak household, yet had been so worried about her condition that she had _one no pla nning for the family. Froblems came, one after a nother. The husband was unable to hold a job; there was no one to care for the babies continuously. Bob, the 6 year old having no supervision was seriously hurt while playing with matches. Five weeks after ad-mission, Mrs. B. left against advice.

In this family, who found it difficult to maintain themselves under ordinary circumstances, the trauma of having the mother leave immediately without taking time for proper planning was far too difficult. When she improved physically to the point where she spent most of the time worrying over what was happening to the children, she realized some changes must be made. The accident to the child only accelerated her walkout.

Often proximity to friends and family make a difference in the length of the patient's stay. In our particular hospital, only about 40% are from Ingham County. The rest may be some distance from home. However it is found that usually the individual and his family are the deciding point, not how often they visit. One patient may leave becuase he has had no visitor, another because the visitor worried him.

> Mr. F., a laborer, in his late forties who had never been more than three miles from his elderly parents and never away from his wife and 7 children, now found himself hospitalized 150 miles from them. They were financially unable to come to see him and he worried constantly as to how they were getting along without him although he knew his wife had always handled all the money and made all decisions. After about 8 weeks, he left to get back to them.
>
> On the other hand, we have Mr. R., whose wife visited several times a week and took every opportunity to discuss the minutest business detail with him. He had owned a grocery store before his admittance and felt no one could take care of it as well as he. He finally became disturbed over his business and left.

In both of these cases, the social worker had discussed the situations and a series of interviews had been arranged. The former had deep seated fears dating back to childhood and a complete dependency on the mother figure. In the latter, Mrs. R. felt totally inadequate to deal with the new responsibilities and refused referral to a case-

work agency. It was felt that the problem could only be resolved by her cooperation.

FAMILY PRESSURES

Members of the family are always important in any decision made by an individual but it is apt to be that age group with young children which seems to worry most. The mother is usually wondering how her children are cared for and if everything is going all right at home. The father about his incapacity with loss of his job and how the family is getting along.

> Mrs. C.W., 29 year old mother of three children had a difficult time adjusting to hospitalization. She had trouble with her mother-in-law who was caring for the children and when her husband called and told her she must come immediately, she left at once.
>
> George D. worried constantly about his 17 year old wife and infant daughter and how they would be able to live on public assistance. He felt that he was not assuming his responsibilities in staying in the sanatorium and letting her work. When almost ready for discharge, he finally left, against advice.

In the former case, the social worker had been trying to help the patient understand why it was necessary her cure come first and how she would eventually be helping her family if she first regained her health. Although she discussed the matter intelligently, she left at once when her emergency came.

In the latter, the young patient had no training for regular work and was under a program planned by the patient and the vocational counselor so

that he would eventually be self supporting. The demands made by an immature wife, playing on his ego made him also walk out even though he knew he unable physically to work at that time.

Members of both sexes seem to be under pressure from their spouse to "leave now or else . . . ." Often there is not a close enough relationship between husband and wife to withstand separation and each is fearful that the other partner of the marriage will leave them. Often this is based on a sense of inadequacy, stemming from fear of the disease. The patient knows it is chronic, reoccurring, contagious. He knows he must always live with the fact that he may break down and infect others. He may have to return to the sanatorium. He knows his friends and even relatives may fear him and he is not always sure of his wife's ability to stand with him against public opinion.

The patient usually makes adjustment to hospitalization much as he does to life. If he becomes upset over minor things, he will find much wrong with the hospital, his treatment and his new way of living. If he is a mature individual with a mature outlook on life, he will eventually find positive features in hospitalization no matter how disturbed he was when the diagnosis was first made.

For one who has left several sanatoriums against advice, it is much easier to leave the next time. If one is always striving for Utopia, no combination of factors will completely satisfy and after once finding that he can be hospitalized at another sanatorium, the chronic walk-out will continue his search from hospital to hospital.

It is believed that often the occupations of the patient made adjustment difficult. For instance:

J.J. had been an oil worker and spent most of his adult life in hard physical labor in the oil fields. He had had little education, had worked hard, played hard. Complete bedrest with only such activities as could be managed while sitting or lying in bed made adjustment most difficult.

Another patient, a former automobile racer and carnival man found bedrest far too confining and the words in most books and magazines much too difficult for his 3rd grade education. Occupational therapy was for others, not for "he-men."

There was also the salesman, who although he had a college education and enjoyed many types of handicraft found bedrest much different than his constant round of calls on customers and week-ends of golf and fishing. Adjustment to a life in bed came slowly although because of his inner resources, was made.

Even the busy house-wife, who has been caring for a home and family, cleaning, cooking meals, washing, planning for the future, may find life futile when viewing it flat on her back in bed.

While bedrest is never easy, that patient who has quieting hobbies and enjoys relaxation, finds that time passes much faster than the others above cited.

REHABILITATION SERVICES AVAILABLE AT INGHAM SANATORIUM

At Ingham Sanatorium, the rehabilitation department, one means of cutting down walk-outs, includes not only a social worker, vocational counselor a nd occupational therapist but also librarian, bedside and homemaking teachers.

The social worker sees many patients referred upon their first diagnosis of tuberculosis. Although not a routine referral, it is made by the medical staff in cases where there are obstacles to hospitalization. This may include help in family financing in which case the family may be referred to public welfare, catagorical relief, veterans organizations, etc. It may include help in planning for the family while the parent is hospitalized. Often it is necessary to find a relative who can be brought into the picture to care for the children, a housekeeper to be found or in some instances, referral to child placement agencies or the probate court.

After the patient is hospitalized, there is a routine interview to help interpret hospital rules and policies. At this time, questions are answered and help given with any problems which the patient feels are pressing. At any time during the hospitalization or afterward, the patient or his family is free to call on the worker for help.

Before a patient is discharged all home investigations are routed through the social worker. Although the actual investigation is usually done by the local health department, many problems are worked out in the hospital. For example:

> Mr. C., a young man in his 20's, the youngest of a family of 9, had been only 10 when his father died

and left the mother with her children and a farm. At 16, he had been caught stealing from a gas station with some other boys and sentenced to the state reformatory. He finished high school there and learned a trade in the office. Upon his release, he had gone back home and his mother had made him promise never to leave her, in order to pay for his "sin." Although an active 54 year old woman, she sat back and expected him to wait on her and treated him as a child.

This family situation had to be clarified before discharge could be effected although the physical set-up of the home was excellent. In this particular case, referral was made to other agencies as is often done, however, in order to keep the patient from going out against advice until his home could be approved, interpretation both of the situation and help in realizing his real obligations were part of the social workers daily routine.

At Ingham, we are limited to the hours we can see patients because of their strict schedule of rest. In trying to work with 135 in-patients on a limited amount of time, approximately 2 hours per day, it is not always possible to carry through a continuous casework process which might do more to alleviate walk-outs. The patient should undoubtedly be seen sooner and interpretation of tuberculosis and hospitalization made but it is not always possible.

For the patient who is interested in vocational education, in finding the kind of work he can do, help in preparing for a new job or bettering

himself on his old one, the Vocational Counselor is available to give psychological tests and counsel. Through Vocational Rehabilitation, correspondence courses may be purchased or even training after his discharge. Many will stay, secure that there is vocational help available when otherwise he would leave before he should.

Occupational Therapy is one of the most needed functions in a tuberculosis hospital. Time passes more quickly when one is busy and when one is making something for their family, they too are a part of that family even though separated. Each patient is encouraged to do the thing he likes the craft that will bring him the most satisfaction, either in the actual craftwork or in the pleasure some member of his family will receive.

> Mrs. J.J., a Mexican girl who could neither read nor write, was spending her time unhappily looking at the ceiling until the Occupational Therapist taught her how to sew. It would have been only a short time before she left had not something been given her that she could do.

The library, a branch of the county library, is also a part of the Rehabilitation Department. Often one is able to read when they can do nothing else and often a quieting activity must be substituted for a more active one. The weekly visit of the book-cart and helpful suggestions of the librarian do much to cut down walk-outs.

> Miss E.B. was very restless and talked often of "leaving immediately". When the librarian found that she had a collection of antique glass but actually knew little about the pieces she had or where they came from, she sent for several books

on the subject. Miss B. eventually found a satisfying hobby and did not leave against advice.

Bedside teaching does much to help the patient adjust to hospitalization. Under state law, the special education teacher, who is a part of the Lansing Public School System, may work with any pupil up to the age of 25, who has not completed his high school work. As this includes many in the older age group, who perhaps have finished only the 8th or 9th grade, attempt is made to give them practical studies; business arithmetic, English grammar, business law, etc. When they feel they are learning that which will be useful in their own life, adjustment is made easier. For the younger pupils, the knowledge that they can keep up with their class makes the future seem more secure.

Homemaking is another function which aids in adjustment. The Homemaking teacher works with all women patients in an effort to help make their housework easier and more pleasant on their return home, give a broader knowledge of nutrition and the necessity of realizing the part it plays in tuberculosis and when necessary, aids the individual patient in her own problem.

Mrs, C.G. was very worried about her family and how the new, inexperienced housekeeper was getting along with them. She knew from family and neighbor reports that she (housekeeper) was not able to cope with the situation. She was referred, by the social worker to the homemaking teacher, who helped her work out a series of menus and a schedule of work. The social worker helped the housekeeper

understand the importance of lack of worry to the mother and the situation adjusted so the mother talked no more of walking-out.

In all of these services, it is the close inter-relationship between the various workers, each adding their own bit of information to draw a total picture that completes the realization of why the patient is dissatisfied and what should be done about it, that has helped decrease the number of those leaving against advice.

SUMMARY AND CONCLUSIONS

It was found that more data had been accumulated than was feasible to use at this time. Information gathered which pertained to the disease,itself, did not seem to have bearing on the problem of discharges against medical advice in this particular study.

1. Distance from home appeared not to be significant because of individual differences and family relationships.
2. The occupations of patients leaving against advice were so varied that it was impossible to draw any correlations among them.
3. No pattern of walk-outs was built up. Of the 110 A.M.A. (8) patients:

   80% had never gone against advice before.

   10% had left once before.

   Only 1 patient had been A.M.A. more than twice.

(8) A.M.M - Against Medical Advice

4. The majority of patient walk-outs occurred early in their hospitalization.

   69 patients - approximately 63% left in the first 5 months of hospitalization.

   27 patients - approximately 25% left in the 6 - 11 month period.

   7 patients - approximately 6% left in the 12 - 17 month period.

   7 patients - approximately 6% left in the over 18 month period.

5. By statistical analysis: (9)

   1. Significant difference - of the ages of AMA group to all discharged in 3 year period.
   2. Significant difference - of female AMA patients to control group.
   3. No significant difference - of male AMA patients to control group.
   4. No significant difference - of marital status of AMA group to all discharged. (10)

6. More patients left against advice in July than in any other one month. There is a definite decrease in the sale of Occupational Therapy materials in July and August. Fewer library books are taken out. Staff members have commented on a general restlessness in hot summer months. (11)

(9) See chart #1. Appendix I
(10) This group misses being significant by only .2
(11) See chart #2. Appendix III

7. So few patients fell in the under 20 or over 60 age groups that it was not always possible to treat them as separate groups.

8. In both medical records and case records, the largest percentage of AMA's were because of family pressures. (12) This is particularly true in the female 20 - 29 age group.

9. In both medical records and case records, the lowest percentage of AMA's were because of discontent. (13)

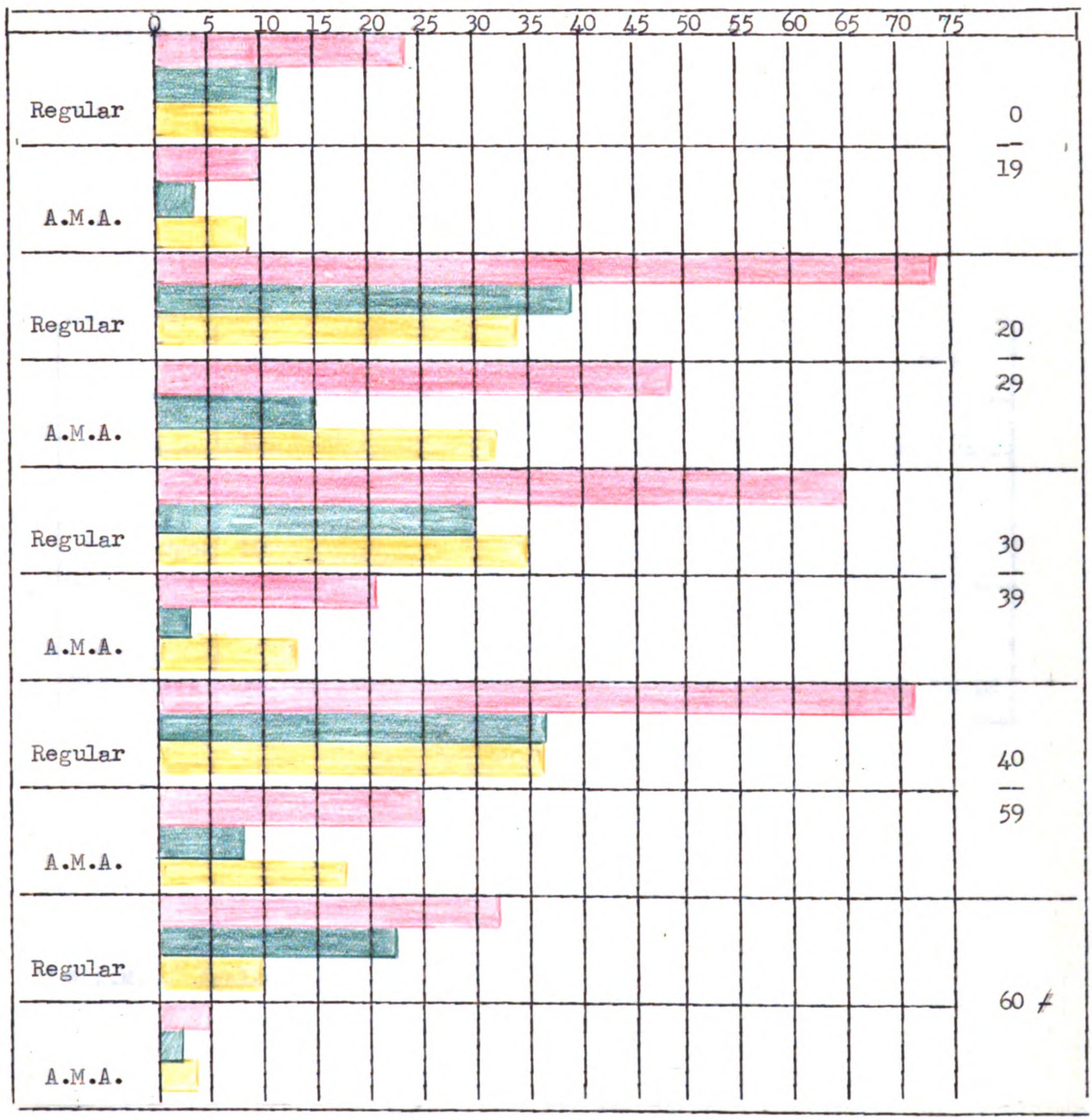
10. The percentage of cases on which the case record showed "No reason given" was too high and would indicate that more complete records should be kept. As the majority of such cases were patients who left in the first five month period, it would indicate also, seeing the patient earlier and to help see the program is better interpreted to him.

(11) See chart #2. Appendix III
(12) See chart #3. Appendix IV
(13) See chart #3. Appendix IV

APPENDIX

Ratio of Patients Regularly Discharged to those
Discharged against Medical Advice
According to Age Range

Chart # 1



Legend:
¼" = 5 patients

- Total
- Men
- Women

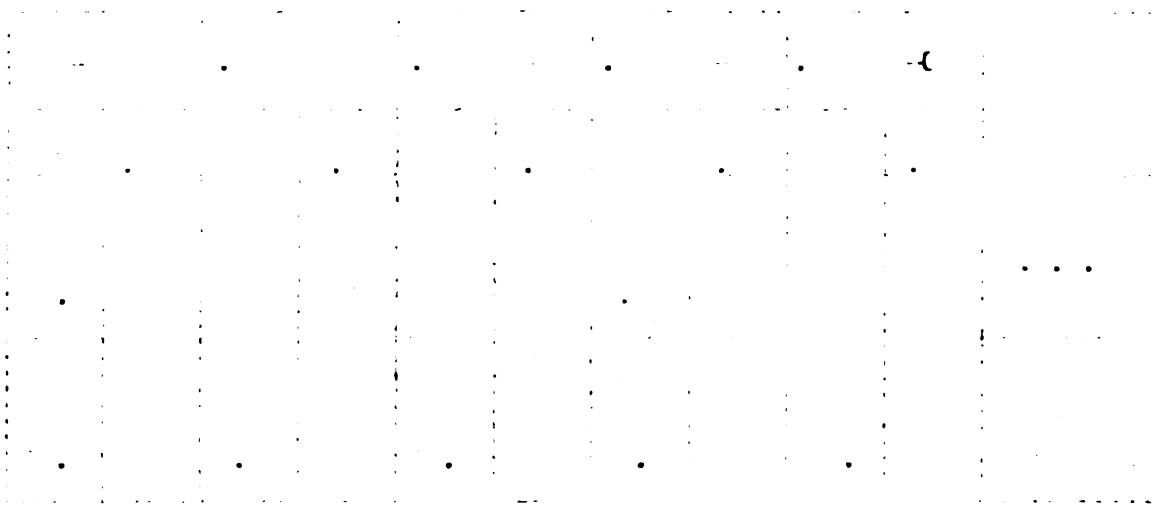
* A.M.A. Against Medical Advice

Statistical Analysis of Regular Discharges
and
Discharges Against Medical Advice
According to Age Range

Chart # 1a

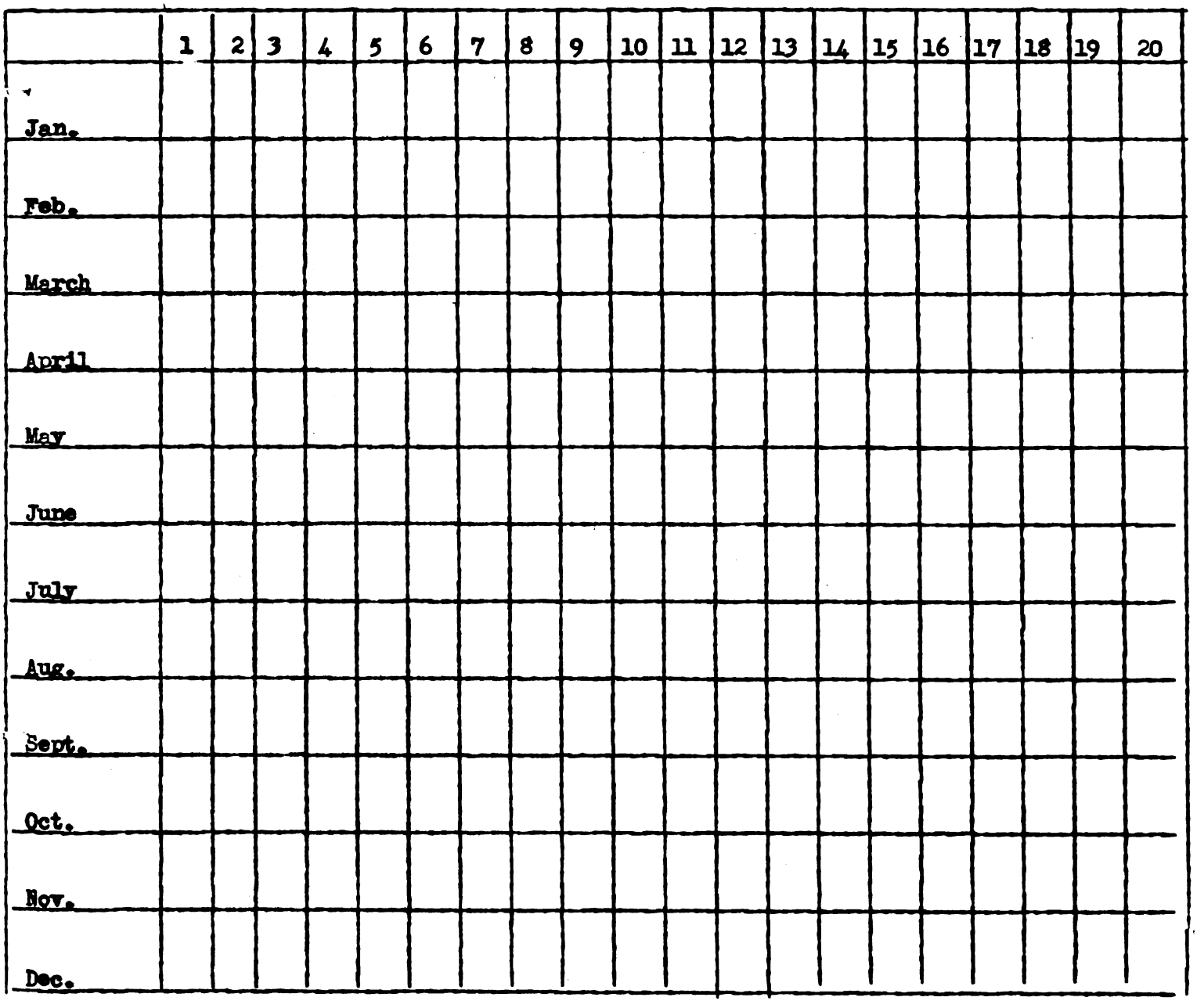
	0-19 yrs.		20-29 yrs.		30-39 yrs.		40-59 yrs.		60 +	
	No.	%	No.	%	No.	%	No.	%	No.	%
A.M.A. Discharges	10	9	49	44.5	21	19	25	23	5	4.5
Total Discharges	34	8.99	122	32.27	86	22.75	97	25.92	38	10.05

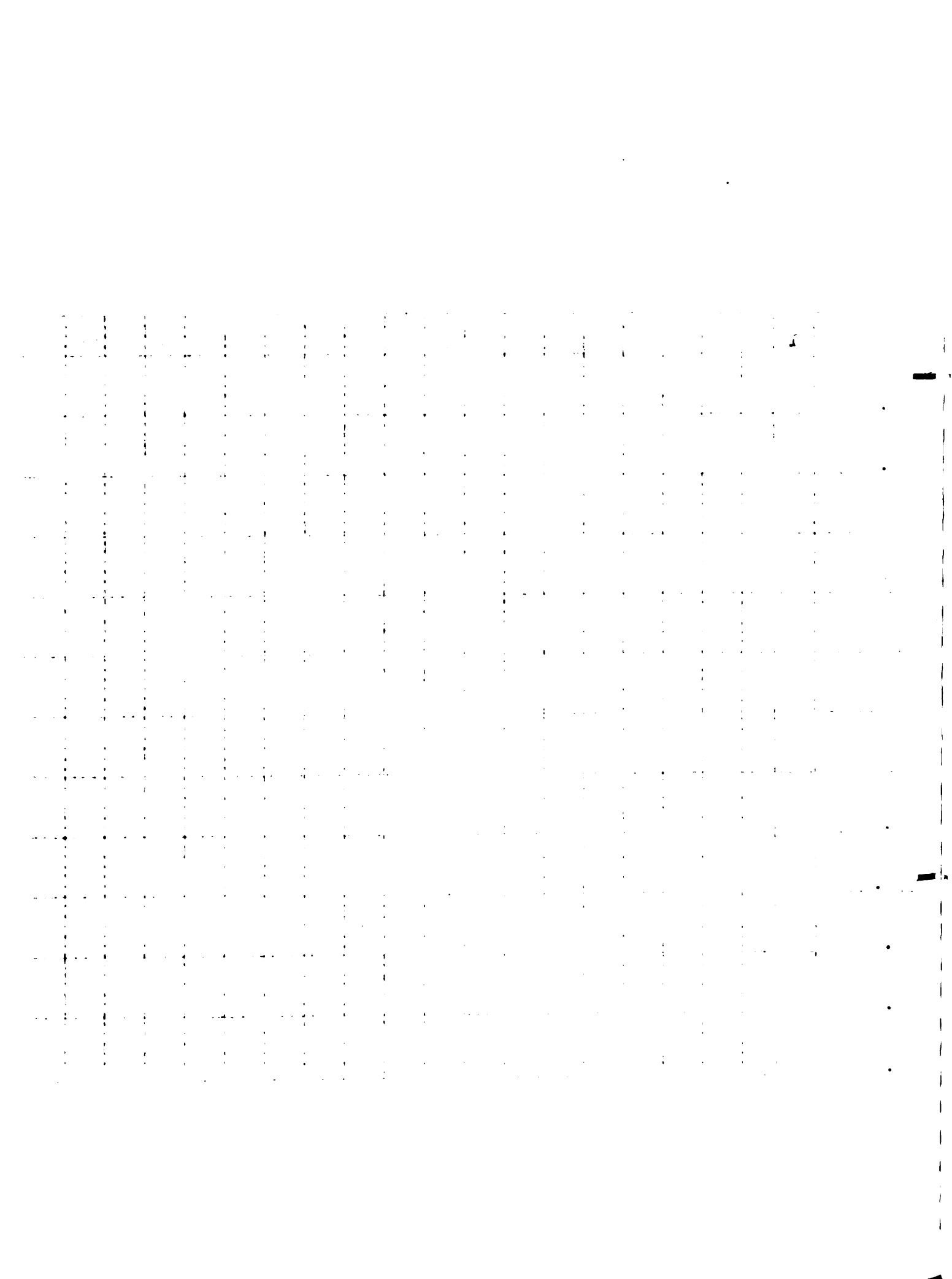
* A.M.A. Against Medical Advice



Number of Patient Walk-outs According to Month
1949 - 1951

Chart # 2





Reasons for Leaving Against Medical Advice

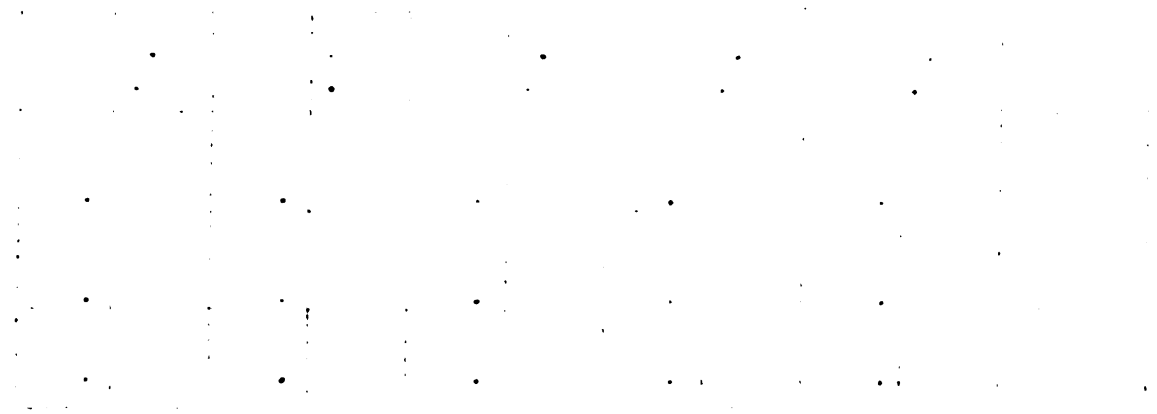
Charts #3

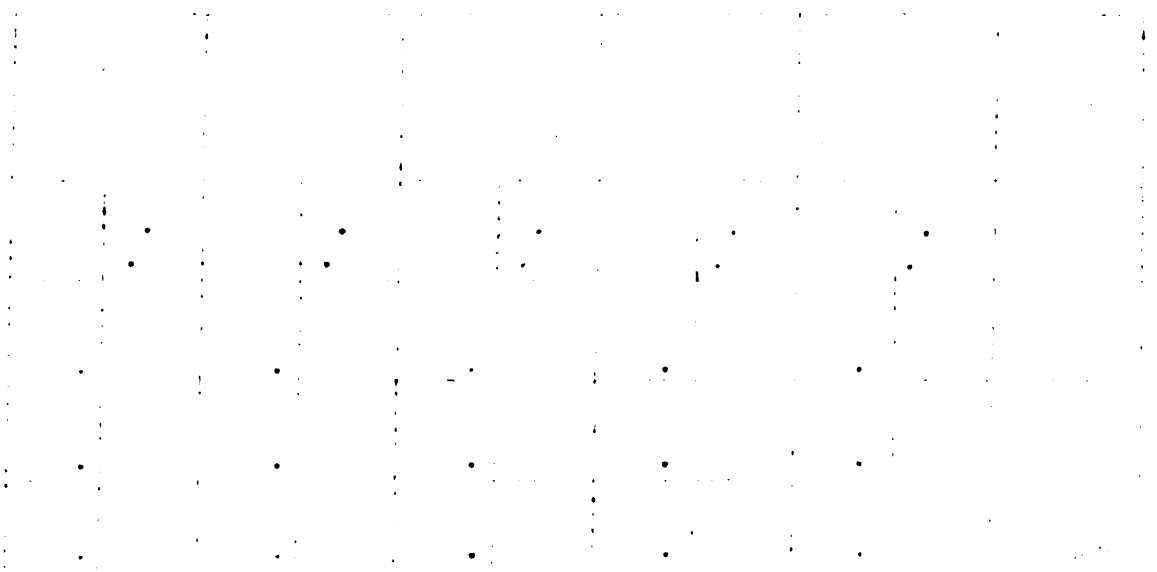
According to the Medical Records

	Emotional Instability		Family Pressures		Discontent		Other		No Reason Given	
	No. Pts.	%	No. Pts.	%	No. Pts.	%	No. Pts.	%	No. Pts.	%
Male	18	.163	12	.109	1	.009	16	.145	7	.063
Female	18	.163	26	.236	4	.036	5	.045	3	.027
Total	36	.326	38	.345	5	.045	21	.19	10	.09

According to Case Records

	Emotional Instability		Family Pressures		Discontent		Other		No Reason Given	
	No. Pts.	%	No. Pts.	%	No. Pts.	%	No. Pts.	%	No. Pts.	%
Male	16	.145	17	.154	4	.036	4	.036	13	.119
Female	9	.081	25	.227	2	.018	8	.072	12	.109
Total	25	.226	42	.381	6	.054	12	.108	25	.228





(Copy of material received from
Mich. Dept. of Health 7-24-51.)

COMPARISON OF DISCHARGES FROM TWO TUBERCULOSIS SANATORIA
October, 1949 through March, 1950 (Six Months)

	10/49	11/49	12/49	1/50	2/50	3/50	Average	AMA* and Absconded (6 Mo. Total)	Discharges (Excl. Deaths and Transfers (6 Mo. Total)
Hospital No. I									
Daily Average Census	230	277	223	230	239	241	232		
Medical Consent	2	1	3	5	2	6	3.2		
AMA*	3	5	5	3	3	6	4.2)		
Absconded	0	5	3	6	6	0	3.3)	45	64
% of AMA* and absconded of discharges, excluding deaths and transfers								70.3%	
% of average daily census (AMA* and absconded)									
Hospital No. II									
Daily Average Census	374	373	376	375	377	381	376		
Medical Consent	8	8	3	2	6	13	6.7		
AMA*	3	1	5	4	2	2	2.8)		
Absconded	5	7	0	2	2	4	3.3)	37	77
% of AMA* and absconded of discharged, excluding deaths and transfers								48.1%	
% of average daily census (AMA* and absconded)								1.0%	

*Against Medical Advice

C O P Y

NATIONAL TUBERCULOSIS ASSOCIATION
1790 Broadway New York 19, N.Y. Tel. Circle 5-8000

Mrs. Rachel F. Wood
Director, Rehabilitation Dept.
Ingham Sanatorium
Lansing 9, Michigan

Dear Mrs. Wood:

Other than a study by the Veterans Administration, entitled "Irregular Discharge: The Problem of Hospitalization of the Tuberculous", the great difficulty about inquiry into the subject of discharge a gainst medical advice is the absence of any uniform criteria among hospital administrators. Accordingly, when one looks into the problem, it is necessary to ascertain (often by field work) how the term was applied; for example in contiguous counties one administrator reports as AMA each discharge wherein the patient has not completed a full term of treatment recommended by the physician, while his colleague reports as irregular discharge cases in which the patient or his family forced the consent of the physician which was reluctantly given in view of the fact that sputum conversion had been obtained. There are also variations in the item of disciplinary discharge, - some administrators report it as AMA and others separately.

However, one of the most thorough inquiries into city and county institutions was done by the Department of Institutions and Hospitals for New Jersey. I think a line to Dr. Wm A. Doppler, Executive Officer, New Jersey Tuberculosis League, 15 East Kinney Street, Newark 2, N.J. might obtain a better citation than I can give you at the moment. This leads up to the suggestion that while reports from other areas may be interesting, comparisons are seldom statistically valid. Even when one compares AMAs in an institution for one year with the record of the preceding year, interpretation should be preceded by a consideration of differences or similarities in employment opportunities, welfare department policies, turnover in medical and nursing personnel and many other apparently ancillary factors which may influence the behavior of current patients.

As one rehabilitation worker to another, always represent the rehabilitation program as <u>one</u> of the means by which patients may be successful in adjusting to hospitalization.

Very sincerely yours,
Holland Hudson
Director
Rehabilitation Service

eh

Schedule used for analysis of records - AMA Patients

Name	sex	age at dischg.	home locale	Position in Family	Occupation (explain)	Diagnosis	Readmittance

adm. date	dischg. date	Mos. here	Prev. AMA's	Reasons for leaving. 1.Medical 2.Case record 3. Other

Schedule used for control group.

Name	dischg. date	sex	age	Position in Family	Diagnosis	Mos. in san

BIBLIOGRAPHY

Drolet, Godias J. & Porter, Don E., "Why do Patients in TB Hospitals Leave Against Advice," U.S. Public Health Service, 1949.

Frankel, Emil, "When Patient Leaves Tuberculosis Sanatorium Against Advice of Physician," Hospitals, (May 1942).

Frankel, Emil, "The Changing Scene in the State TB Sanatorium Field," The Welfare Reporter, New Jersey Dept. Institutions & Agencies, (December 1951 and January 1952).

Johnson, Robert D. "Unruly Patient Problem Reviewed," NTA Bulletin, (February 1951).

Mailander, Wilma, "Spotlighting the Patient and His Family - Unmet Needs in Patient Education," Transactions of the Forty-fifth Annual Meeting of the National Tuberculosis Association, 1949.

Medical Director's Annual Report, Ingham Sanatorium, Lansing, Michigan, 1949 and 1950.

Michigan Act 314 P.A. 1927, as amended.

New Jersey Dept. of Institutions and Hospitals, "Discharges with consent of Staff and Against Medical Advice from State and County Sanatoria in New Jersey - Five Year Period 1945 - 49," (September 1951).

Richardson, Henry B., Patients Have Families, New York, The Commonwealth Fund,(1945).

Saslow, George, M.D. "Help the TB Patient Cooperate," NTA Bulletin, (September 1950).

Sheen, Thomas, M.D., "How We can Reduce 'Signouts'," NTA Bulletin, (October 1950).

Tollen, William B., "Spotlighting the Patient and His Family - Decreasing Discharges Against Medical Advice," Transactions of the Forty-fifth Annual Meeting of the National Tuberculosis Association. 1949.

Tollen, William B., "Why do Patients go AWOL?" NTA Bulletin, (July 1950).

Upham, Frances, A Dynamic Approach to Illness, New York, Family Service of America. 1949.

Wilmer, Harry, M.D. "Patients are People," The Crusader, (1951).

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