AN EXPLORATORY STUDY OF TWENTY-SEVEN PATIENTS WHO REQUESTED DISCHARGE AGAINST MEDICAL ADVICE AND THE EFFECT OF SOCIAL SERVICE INTERVENTION UPON THE REQUESTS

by

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A PROJECT REPORT

Submitted to the School of Social Work
Michigan State University
in Partial Fulfillment of the
Requirements for the Degree
of
MASTER OF SOCIAL WORK

May 1958

Approved: Morris L. Bleckin
Chairman, Research Committee

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ACKNOWLEDGMENTS

The author wishes to express his sincere appreciation for the aid and encouragement given him by Mr. Morris Gluckin in the writing of this project. Appreciation is also due Mr. Manfred Lilliefors and Dr. Gordon Aldridge for their valuable assistance and suggestions.

Grateful acknowledgement is also extended to the entire staff of the Battle Creek Veterans Administration Hospital for their cooperation in the project. My most sincere thanks goes to Miss Jacquelyn Parker, Miss Barbara Hill, and Mrs. Doris Zinn for their assistance in gathering data, and to Mrs. Harriet Brigham and Mr. William Brewer for their assistance and guidance in formulating and completing the project.

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CHAPTER I

PROBLEM AND CONTEXT

This was an exploratory study of the effect that Social Service interviews had in assisting patients requesting discharge against medical advice (AMA) to remain at the Battle Creek Veterans Administration Hospital. The hospital is a 2,055 bed neuropsychiatric treatment center located at Fort Custer, approximately six miles west of Battle Creek, Michigan. The Social Service staff is composed of ten professionally trained social workers and five secretaries, as well as a varying number of graduate social work students from Atlanta University, Michigan State University and the University of Michigan. The team approach of psychiatrist, psychologist and social worker is utilized, although the relationships and functions of the team members are not formally defined and may vary from case to case. Social Service also has a working relationship with other treatment services such as: Special Services Division, Registrar Division, Physical Medicine and Rehabilitation Service, and Nursing Service.

The AMA discharge is a means whereby any patient who is not committed, may secure his release from the hospital

before the hospital staff would ordinarily consider him ready for discharge. The very term against medical advice, indicates that the dischargee is terminating his treatment contrary to the doctor's advice and is in need of further treatment. This is indeed the case as, if the patients mental and physical condition was judged by the hospital staff to be sufficiently improved to the extent that he should be able to function adequately in society, then he would be issued a maximum hospital benefits (MHB) discharge. The MHB discharge carries with it the condonation of the hospital staff and can be considered as that which the patient should work toward, rather than requesting an AMA discharge.

The veterans administration patient may also be discharged from absent without official leave status (AWOL) or from an elopement. The latter is equivalent to the patient's escaping from the hospital while the former is a situation where he fails to return from a pass or leave of absence from the hospital. These two discharges, along with the AMA, are defined by the Veterans Administration as being irregular discharges. However, this study was confined only to patients requesting AMA discharges, as there is no sure method of ascertaining when a patient is contemplating elopement or failure to return from a leave of absence.

The patient requesting an AMA discharge is not always granted such. When the request is made, it can be either

verbal or written at the Battle Creek Veterans Hospital, the patient's ward physician advises the Registrar and the Director of Professional Services as to whether or not he considers the patient dangerous to others or to himself. If the patient is judged dangerous the Registrar communicates with the Chief Attorney's Office, Veterans Administration Regional Office at Detroit, Michigan, advising that office of the situation. The Chief Attorney's Office then contacts the patient's family requesting that it sign a committment petition on the veteran in question. The patient's family is faced with a difficult decision to make in this situation. They usually realize that the patient should be committed because of his homicidal or suicidal tendencies and to insure his continued treatment, yet the relatives sometimes hesitate to sign a committment petition as they fear that the veteran's reaction will be that he is being 'put away' by the family. This is a realistic evaluation of the situation by the family as a psychotic patient is seldom able realistically to evaluate why he is being committed and often holds bitter feelings toward the relative who signed the papers. If the family refuses to sign committment papers the Chief Attorney may ask the Friend of the Court of the veteran's county to sign. However this is seldom done. Occasionally an AMA discharged veteran is given over to the custody of the police of his home area in the event that he has a crime outstanding against him.[1]

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[1]Interview with Director of Profession Services, A.H. Braverman, M.D., January 3, 1958.

The maximum amount of time that a patient can be held at Battle Creek Veterans Administration Hospital after requesting AMA is ten days, that being the estimated number of days that communications require to go from the hospital to the Chief Attorney's Office and back again.[1]

In the majority of cases, no committment proceedings are inaugurated. The doctor decides that the patient is not dangerous to others or himself and signs his release. At Battle Creek Veterans Hospital no formal board meeting is called to decide whether the AMA request should be allowed or the patient committed, except in very rare instances. The hospital routinely requests that the AMA dischargee be signed out by his family so that his family has full responsibility for him after he leaves the hospital. Often the relatives are unavailable or refuse to sign; so veterans leaving AMA are permitted to sign their own responsibility forms. This happens in approximately fifty percent of the cases.[2]

THE PROBLEM

The Registrar's Division sees the AMA situation as a problem in two areas. First, it costs the Veterans Administration approximately one hundred and fifty dollars to admit and process each new patient or readmittance. If a

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[1]Interview with Registrar, W.E. Foreman, October 15, 1957.

[2]Ibid

patient remains in the hospital only a few days this expenditure clearly seems to be a waste of money. Secondly, the patient who leaves the hospital AMA is often a recidivist and the amount of time and effort spent on his case is disproportionate to the amount of treatment he receives. A veteran is required to wait ninety days before he can be readmitted after an AMA discharge, but if he is service-connected for his illness he can be readmitted at any time in case of an emergency.

The Veterans Administration Regional Office believes that Social Service can play an active role in reducing the number of AMA discharges:

> Central Office Social Work Service relies on the March report describing accomplishments of Social Work Service for the past year for information to be included in the annual report of the Administrator of Veterans Affairs to Congress. These reports are studied for specific achievements which improved quality of service to veterans and promoted other administrative objectives, such as reduction of length of hospitalization, reduction in re-admissions, and reduction in AMA discharges.[1]

The situation is summed up by an out of state Veterans Administration Hospital Chief Social Worker:

> In the evaluation of a hospital social work section, it is practicable to determine to what extent this service enables the patients to make maximum use of hospital facilities. In terms of economy of hospital management, it is meaningful that through the services of their social workers many patients are helped to stay in this hospital until such time as the doctors have completed their work. When patients leave the hospital against medical advice or AWOL, their incomplete

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[1]VA Planning Letter No. 58-22, March 25, 1958, 2nd paragraph.

> treatment is often sheer waste for themselves, for the hospital, and the community from every point of view, including dollars and cents, time, and human values.[1]

From the viewpoint of the Social Service Section of the Battle Creek Hospital it is unfortunate that any patient leaves AMA.[2] This occurance is an indication that Social Service has not reached the patient and helped him to accept his illness, has not helped him to accept treatment and the hospital.

Inasmuch as the AMA discharge seems to pervade almost every section of the hospital in some manner, it seemed to the writer to be a valid area for investigation with the focus being upon the effect of Social Service intervention in the request for the AMA discharge.

HYPOTHESIS AND ASSUMPTIONS

The assumptions upon which this study was based are that the neuropsychiatric patient who leaves the hospital against medical advice is doing a disservice to himself, the hospital, his family and society; that the reduction of the number of patients receiving AMA discharges is a desirable goal; that the patient who requests an AMA discharge is generally emotionally upset and his thinking is not apt to be rational; and that social workers possess a special

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[1]Clair Lustman, "The Patient's More Effective Use of Medical Care Through Social Service", HOSPITALS, November, 1946.

[2]Interview with Acting Chief, Social Service Section, Mrs. Harriett Brigham, January 8, 1958.

skill in interviewing those who are in an emotional state.

The hypothesis upon which this study was based is that discharges of patients who are leaving the hospital against medical advice can be reduced by Social Service intervention.

CHAPTER II

REVIEW OF THE LITERATURE

Of the few studies which could be found in the area of AMA discharges, the majority were follow-up studies of the patients' adjustment after leaving the hospital.

In a Veterans Administration publication entitled "Irregular Discharge: The Problem of Hospitalization of the Tuberculous",[1] the writer reports on a study undertaken by the Veterans Administration in which every veteran who left any Veterans Administration Tuberculosis Hospital during the month of July, 1947, was interviewed three months after discharge by a Veterans Administration Social Worker. He was interested in what type of patient goes AMA or AWOL, why the patient leaves prematurely and what preventative measures can be undertaken.

He found that the divorced or separated patient was more likely to seek irregular discharge than any other; and that such factors as age, prior service work, and degree of pathology were not particularly indicative. The reasons for leaving were divided in three main divisions: "1) Those

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[1]William B. Tollen, "Irregular Discharge: The Problem of Hospitalization of the Tuberculous", VA Phamphlet 10-27, October, 1948.

originating outside the hospital and related to personal, social and economic status, 2) Those originating within the hospital, and 3) Those emanating from within the personality of the veteran."[1] Most of the factors which contributed to the veteran's terminating treatment were fairly equally distributed within these three divisions. However, an interesting finding was that in many instances the reason the veteran gave for leaving irregularly did not coincide with the social worker's evaluation of why he had left the hospital. As an example, the social workers felt that in fifty-one percent of the cases, one of the causes was the pressure of factors originating within the veteran's personality, while veterans recognized these factors as causes in only nineteen percent of the cases.[2]

Tollen in summing up the preventative measures he feels will serve to lower the irregular discharge rate, stresses the point that:

> Casework services must be made available to the tuberculous patient from the moment of hospital admission. To initiate them at the time the patient is already headed in the direction of an irregular discharge is to have wasted valuable time and to betray inadequate understanding of tuberculosis and the tuberculous.[3]

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[1]Ibid., p.24.

[2]Ibid., p.46.

[3]Ibid., p.47.

A student writer undertook a follow-up study of psychiatric patients entitled, "Patients Who Left The Hospital Against Advice."[1] Anders found that the majority of the patients who left the hospital against medical advice had been hospitalized only a short time and were severely ill at the time of discharge. More than fifty percent of the sample were later re-hospitalized. In addition, she speculated that perhaps it is because of failure on the part of the hospital staff to interpret the patients' illness to the family and to help it accept continued treatment that influences the patients' leaving against advice.[2]

Another student writer did a follow-up study of veterans who left a Veterans Administration Hospital via irregular discharges.[3] Boyer found that patients left the hospital because of one or more of four general classes of reasons: "1) fear of the hospital, 2) boredom and restlessness, 3) family problems, and 4) difficulty in establishing a meaningful relationship."[4]

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[1]Carolyn Z. Anders, "Patients Who Left the Hospital Against Advice", (Unpublished Master's Thesis, Smith College School for Social Work) 1952.

[2]Ibid., p.2.

[3]Robert A. Boyer, "A Follow-up Study of Patients Discharged AMA and AWOL from the Psychiatric Unit of the Minneapolis Veterans Administration Hospital from July 1, 1948, to June 30, 1949," (Unpublished Master's Thesis, University of Minnesota), 1950.

[4]Ibid., p.54.

Boyer also found that patients suffering from personality disorders were more likely to leave the hospital either AMA or AWOL than were patients in any other diagnostic catagory.

The last writer, student Janet LaPlante, undertook her study at another Veterans Administration Neuropsychiatric Hospital but with a somewhat different focus than the aforementioned studies.[1] She too was interested in the 'why' and the 'who' of AMA discharges and also the factors influencing the disposition of the requests for these discharges. She interviewed patients requesting AMA discharges before they left the hospital to explore the factors which influenced them to make the AMA request, rather than after they had returned to the community. This study is of primary concern to the writer as his own was based partially upon it.

Regarding the 'who' of Miss LaPlante's study, it appears that the average patient of her sample of thirteen AMA's is young, single, and upon admission was diagnosed as schizophrenic. This hypothetical patient has seldom established satisfactory interpersonal relationships with family, employers, and hospital personnel. He has had a history of secondary adjustment and instability dating back to his childhood. He tends to create situations through his anti-

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[1]Janet Dorothy LaPlante, "Factors Influencing the Request for and Disposition of AMA Discharges", (Published Master's Thesis, Smith College), SMITH COLLEGE STUDIES IN SOCIAL WORK, Worchester, Massachusetts; Vol. XXVIII, No. 1, October, 1957.

social acts that exert pressure upon him. When this pressure becomes unbearable, he escapes by entering the hospital.

The 'why' factors contributing to the majority of the patients' reasons for requesting AMA discharges were more varied, yet followed a discernable pattern. The average patient stated that he was leaving the hospital because he was dissatisfied with the hospital or treatment and that he planned on going to work upon his release. The latter struck Miss LaPlante as unrealistic as: "though as seen previously, few of these patients had ever been able to make a satisfactory job adjustment."[1] She found no evidence to indicate that factors external to the hospital were of any significance in precipitating the requests. In most cases a specific frustration encountered in the hospital could be identified as precipitating the decision to terminate treatment. The veterans' behavior pattern of fleeing from pressure continues. Their low tolerance for frustration seems to be one of the chief causes for them to enter the hospital, and also to leave it against medical advice.

Miss LaPlante's final conclusion was that which lent most to the focus of the present study:

> It would appear that casework services could be utilized more fully in connection with the handling of an AMA request. Perhaps a substantial number of AMA discharges could be averted if the case worker were alerted to each request

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[1] Ibid., p.51.

> and played a more active role. Their low tolerance for frustration and tendency to act on impulse cause many of these patients to flee from the hospital on slight provocation. The opportunity for discussing their feelings with someone and the knowledge that someone wanted them to stay might serve to reduce the frustration which causes them to take flight.[1]

This study was fact-finding in nature and the interview was not intended to be a therapeutic one.

The present study appears then to be unique as no previous investigations could be found with the focus upon attempting to dissuade psychiatric patients from leaving the hospital against medical advice.

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[1] Ibid., p.58.

CHAPTER III

METHOD OF STUDY

In selecting patients for this study, the sample was limited to those male veterans who had been admitted voluntarily, who were currently hospitalized on psychiatric wards, and who were requesting an AMA discharge. Patients hospitalized on the general medical and surgical ward were not included in the study as the writer wished to select his sample from the same type of population as had Miss LaPlante.

To be included in the sample, the patient could not be committed to the hospital prior to his AMA request because, as stated above, a committed patient may not make a valid request for an AMA discharge.

In order to obtain his sample, the writer asked the hospital staff to cooperate in the study by notifying him at the earliest possible time when a patient made a request for an AMA discharge. The writer hoped to see every request he was given notification of during the four month period of the study, dating from December 1, 1957, through March 31, 1958. About the first week in January of 1958, it became evident that the writer was unable to interview

every patient that was being referred to him by the ward clerks, nurses, and in a few instances, the ward physicians. This can be attributed to the fact that the writer was on duty in the hospital only twenty hours per week.

Approximately, January 4, 1958, the writer presented this problem to the Social Service staff at a staff meeting and it was agreed that upon such occasion that the writer was not present when an AMA request was made, another worker would take the interview. This method provided more complete coverage of the AMA requests and was coordinated by Mr. William Brewer, the writer's supervisor. Twenty-seven patients who met the stated criteria were interviewed by the Social Service staff members during the period of the study. Of this number, twenty were seen by the writer and seven by other workers.

As soon as possible after an AMA request referral was received, an appointment was made with the patient. The interview was explained to the patient as part of the hospital procedure connected with an AMA discharge. In each interview a copy of the schedule that Miss LaPlante used in her study was employed.[1] However, inasmuch as her study was designed for fact-finding only, the writer added to the schedule an additional question designed to change the focus of the interview from that of an information

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[1]See appendix one.

seeking process, to a therapeutic and helping process.[1] Essentially, this question asked the patient if he saw anything that the interviewer could do to assist the interviewee to remain in the hospital and in treatment, rather than following his stated intention of leaving AMA.

The schedule consisted of eleven questions. The eleventh being the writer's addition to the original ten which dealt with such areas as exploration of why the veteran felt compelled to leave AMA, what his plans were for himself after discharge, and related material.

Data for the study were obtained from three sources: from the patients, via the schedule; from the Registrar Division's records; and from the patients' individual records, such as clinical, correspondence and Social Service. April 20, 1958 was arbitrarily established as the final evaluation date of the patients' status. On that date the writer ascertained whether each patient in the sample had left the hospital or remained. In the event the veteran had absented himself by April 20, special attention was paid to determining what procedure was employed in accomplishing this action. In the case of those who had requested AMA discharges and remained in the hospital, the writer attempted to evaluate: 1) the role that Social Service intervention played in assisting the patient

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[1]See appendix two.

to decide not to go AMA, and 2) to what extent Social Service played a continuing role in helping the patient to adjust to the hospital and treatment.

LIMITATIONS OF METHODS USED

The study's focus of exploring the factors which influence patients to request AMA discharges and to what extent Social Service can assist them to remain in the hospital, is limited due to the small size of the sample. Limitations of the writer's time made it impossible to see every patient requesting an AMA discharge. Even when the writer was present in the hospital when a referral was called in, a delay of two hours in contacting the patient might mean that he had already signed-out AMA. When the Social Service staff agreed to cooperate with the writer, the situation improved, especially on the writer's classroom days. However, five AMA requests were still missed due to the limitations of the time of the other workers. As these five patients were missed unselectively, it would appear that the sample was not effected by this omission.

Another limitation of the study is not every patient who requested an AMA discharge during the four month period of the study was referred to the writer or his supervisor. This situation can be explained by the fact that communication in so large an institution is sometimes faulty. The

writer also gained the impression that a few of the hospital staff members resisted the idea of referring AMA requests to Social Service, although this procedure was sanctioned by the hospital administration.

A limitation in connection with determining the causative factors for AMA requests was noted by Miss LaPlante which seems applicable to the present study also: "Although the interviews are of value in obtaining a subjective view of the patients' reasons for requesting discharge, one may also question their validity. This is especially true if one keeps in mind that no relationship existed between the patient and the interviewer prior to this interview."[1]

The validity of the methods used to ascertain to what extent Social Service helped the patients to remain in the hospital can also be questioned because no control group was utilized and the evaluative methods were thus somewhat subjective.

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[1]Op sit., LaPlante, p.41.

CHAPTER IV

PRESENTATION AND ANALYSIS OF DATA

Description of Patients

Eight of the twenty-seven patients were Negro and the remaining nineteen were white. They ranged in age from twenty-one to sixty years as shown in Table I.

TABLE I

DISTRIBUTION OF AGES

Age	Number of Patients
20-25	2
26-30	4
31-35	6
36-40	10
41-45	3
46-50	1
51-55	0
56-60	1
Total	27

From this table it can be seen that six patients were thirty or under, five were forty-one or over and the remaining sixteen were thirty-one through forty. The mean age was thirty-five and seven tenths, with seven of the patients being thirty-six years old. This does not support Miss LaPlante's findings that the percentage of AMA

discharges is higher among the younger patients.[1]

Eight patients were unmarried; eleven were married, with two of these being separated; and eight were divorced. Several of the patients who had failed to marry were among the eldest in the group. Of the nine married patients who were not separated at the time of the study, at least five of the marriages were characterized by frequent separations and threats of divorce. It would appear then that the patients who request AMA discharges establish poor interpersonal relationships as evidenced by their failure to marry and the marital discord which ensues when they do marry.

Previous AMA Discharges and AWOLS

Six patients in the group had signed out of the hospital against medical advice during a previous stay at the hospital. Three of these had a history of AWOLS, while six other patients in the study had a history of going AWOL but no AMA discharge in conjunction.

These twelve patients, and the remaining fifteen, tended to have numerous previous hospitalizations, with the average being about four per patient. Inasmuch as the figures on previous AMA discharges pertain only to the Battle Creek Hospital, it would not be surprising to find that there were more discharges of this nature within the

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[1]Ibid., p.43.

group if more were known about their experiences in other Veterans Administration Hospitals.

In summary, twelve patients possessed a history of either AMA discharges, or AWOLS from the hospital, or both; with the majority of the entire group conforming to the behavior pattern of frequent flights from the pressures of society to the hospital and subsequent flights from the pressures of the hospital back to society. These findings agree with those of Miss LaPlante and also with her opinion that:

> For many of these patients, flight seems to represent an avenue of escape from situations which they perceive as intolerable. Others take flight to avoid punishment when they have failed to conform to the standards of society. Therefore flight appears to be a two way street for many of these patients who are constantly taking flight from society into the hospital, only to take flight from the hospital as soon as their wishes are frustrated.[1]

A case example follows of one of the patients in the group whose history is not necessarily typical of the groups', but rather is an example of the extremes to which a veteran may go in following the flight from society - flight from the hospital pattern.

CASE O

> Current diagnosis is: Chronic Brain Syndrome with convulsive disorder, psychomotor epilepsy with characterological behavior (psychopathic), chronic severe. Other Veterans Administration hospitals have given him both schizophrenic and

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[1] Ibid. p.45.

psychoneurotic diagnoses. The patient is thirty-five years old, white, divorced, a laborer, and was born in Missouri. He is a World War II Army veteran serving from August 5, 1942, to December 15, 1945, part of which was overseas. Presenting complaint at time of admission was blackout spells which date back to his overseas duty. The patient has been known to swallow open safety pins to gain immediate admittance to VA hospitals. His body is covered with scars resulting from falling when he has Grand Mal seizures and also due to knife fights. He has several times attempted suicide and his behavior has been described as vagabondage, in that he travels around the country without settling down anywhere except for brief stays in VA hospitals. A search of his records revealed that he had sixty-three prior VA hospitalizations and that he seldom stayed longer than two or three months in any one hospital. In almost every instance he left the hospital either AWOL or by means of an AMA discharge. His ward physician in the Battle Creek VA hospital saw him as an infantile, ingratiating, sort of patient who would use any method possible to gain his own way. He was also seen as a hospital problem in that he constantly pestered the staff to grant him favors and to allow him to have his own way. The patient was not allowed to enter the group therapies. His I.Q. is about ninety-six.

Current Diagnoses

Table II shows the formal diagnoses recorded in the clinical records for the twenty-seven patients at the time each was presented to the diagnostic staff meeting during their current hospitalization.

TABLE II

CURRENT DIAGNOSES

Diagnosis	Number of Patients
Schizophrenic Reaction, Unclassified Type	13
Schizophrenic Reaction, Paranoid Type	4
Schizophrenic Reaction, Catatonic Type	2
Schizophrenic Reaction, Hebephrenic Type	2
Schizophrenic Reaction, Simple Type	1
Chronic Brain Syndrome, Convulsive	3
Psychoneurotic, Anxiety Reaction	2
Total	27

It can be seen from this table that schizophrenia is the most prevalent diagnosis with twenty-two out of the twenty-seven having some type of it. Not every diagnosis was complete in respect to whether the patient's impairment was severe, moderate, or mild. Of the fifteen schizophrenics whose degree of illness was recorded, the writer noted that the majority were classified as 'severe'. This agrees with the writer's impression of most of the twenty-seven patients, gained during the interview situation.

Reasons Given By Patients For Requesting Discharge Against Advice

Table III shows that the reasons the twenty-seven patients gave as to why they wished to leave the hospital against medical advice tend to fall into three catagories. The reasons total more than twenty-seven as many patients

gave more than one reason. Most of the patients gave two reasons for leaving. The first reason was usually in the area of carrying out plans outside the hospital, while the second was an expression of dissatisfaction with the hospital and/or treatment. The first reason, although appearing valid on the surface, usually could be seen as a rationalization upon closer scrutiny. The second reason the patients gave concerning their complaints about the hospital seems to be closer to the reality of the situation than the first.

TABLE III

PATIENTS' REASONS FOR REQUESTING AMA DISCHARGE

Categories	Number of Patients
Carry Out Plans Outside Hospital	20
Dissatisfaction With Hospital and/or Treatment	19
Felt Improvement Warranted Discharge	3
Other	3
Total	45

Of those included in the "other" category in Table III, two patients stated that they had been 'framed' by their families and were being held in the hospital against their will. Another gave as his reason for requesting AMA discharge the fact that he had entered the hospital for a physical examination for compensation purposes and a mistake had been made in putting him in the admissions ward. This

last patient had a diagnosis of Chronic Brain Syndrome and the writer could find no evidence to contradict his statement. The two patients who stated they were being held against their will were both schizophrenic and quite obviously suffering from paranoid delusions.

Precipitating Factors Within The Hospital

Table III shows that nineteen of the twenty-seven patients claimed a definite grievence against the hospital although, as mentioned above, this was usually the second reason given and generally came out much later in the interview than did the first. Specifically, eleven patients expressed dissatisfaction with the treatment they were receiving; seven patients revealed that they were afraid of the sensation of being locked in; six were angry with their ward physician because they had been denied a pass, leave of absence, or a regular discharge; and two wished to leave in order to have operations they were unable to obtain in the hospital. These last two were not as realistic as they sound, as one of them wanted an operation to 'stop his hallucinations', and the other wanted his operation for a psycho-somatic stomach complaint.

Precipitating Factors Outside The Hospital

As seen in Table III, twenty patients stated that some happenstance outside the hospital was motivating them to

leave at the time they were making their request for an AMA discharge. Fourteen patients said they had to get out of the hospital so that they could either go back to their jobs or find work. Seven of the fourteen mentioned supporting their families in conjunction with going to work, while the others stated that going to work in itself was why they were leaving.

Three patients asserted that going back to school was the primary reason for their leaving. One wanted to get out in order to divorce his wife; another wanted to leave so that he could see his girlfriend; and the other wanted to visit his ill father in Georgia.

Of the twenty-seven, only ten reported that they had a job waiting for them and the figure may possibly be lower than that if the facts were known.

Where Did The Request Originate?

The request for discharge against medical advice was instigated by the family in only two cases out of the twenty-seven. In one case the patient's brother had written him and told him to leave the hospital and obtain a job. The brother was being separated from the service and would need some financial assistance for himself and his family from the patient, as he planned on returning to college to obtain his Master's degree. In the other case the patient's mother learned that he was beginning to 'come out' of a catatonic state and insisted that he return home to her.

Five patients stated that their wives desired them to leave the hospital and go to work because of financial difficulties. However, further investigation revealed that in each of these cases the wife actually felt that the patient should remain in treatment until the staff members felt he was well enough to go home. Also, that in each case the patient tended to exaggerate the extent of the financial problems.

In summary then, it would seem that in twenty-five cases out of twenty-seven, the request for discharge against medical advice was the patient's own idea. This agrees with Miss LaPlante's finding that only one out of thirteen requests originated with the family.[1] However, it is contrary to Ander's findings that the request originated with the family in forty-one out of forty-nine cases included in her follow-up study.[2]

Evaluation of Patients' Reasons For Requesting AMA Discharge

The writer attempted to evaluate in each case as to whether or not his opinion as to why the patient was requesting an AMA discharge coincided with the reasons the patient gave and, if not, what the actual reasons were.

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[1] Ibid. p.51.

[2] Op. cit., Anders, p.22.

The writer's opinions are based on his impressions gained from the interview situation and from investigation of the patients' records and other objective sources.

Out of the total sample of twenty-seven cases, perhaps three patients impressed the writer as attempting to conceal their real reason for wanting to leave by giving reasons which they hoped sounded more acceptable than the truth. Of all those who were frank in giving their reasons for leaving only three impressed the writer as possessing valid, realistic reasons for wishing to terminate treatment. The other twenty-one gave unrealistic reasons and tended to display schizophrenic thinking while doing so. A case example follows which illustrates a valid, realistic request for a discharge.

CASE B

> This is a World War II, white, service connected, thirty-six year old, divorced veteran with a diagnosis of Chronic Brain Syndrome, convulsive. He has three previous hospitalizations at this hospital with the latest being from October 5, 1955, to August 4, 1956. Since his last hospitalization the patient has worked steadily in California. About January 1, 1958, the patient was called home to Michigan due to his father's illness. He secured a job in his hometown and thought that possibly he could get his compensation raised if he underwent a physical examination at the hospital. As mentioned previously, his appearance at the hospital was misunderstood and he was placed in the admissions ward on January 12, 1958. The following day the patient realized he was being held for treatment and demanded his release. He was interviewed by the writer the same day, January 13, 1958, and displayed no delusional tendencies or other psychotic traits. He seemed to be in good contact and his only request of the writer was that he be allowed to return to his home and job.

An example of the type of patient who appears to be giving sincere reasons for wishing to leave, yet displays unrealistic thinking, follows. In this case the writer believes that the patient is more or less subconsciously fleeing from the hospital and treatment. He is afraid to face his illness and convinces himself that he does not need treatment.

CASE K

> This is a World War II, white, service connected, forty-four year old, divorced and re-married veteran. The patient was initially admitted to this hospital on July 15, 1957, and following a weekend pass went AWOL on November 21, 1957. He returned from AWOL on December 7, 1957, and requested an AMA discharge on the date of the interview, December 12, 1957. This patient was given an admission diagnosis of Anxiety Reaction. It appears that drinking was associated with his illness and initially his reason for coming to this hospital was a result of very heavy drinking coupled with anxiety. He explained that after returning home on leave he felt so good that he decided to stay AWOL. However, just prior to his readmission to this hospital, the patient was drinking heavily and had a 'reaction to the Thorazine he was taking'. As a result of this reaction he became scared and asked his sister to return him to the hospital. The patient had previously been hospitalized in Dearborn VA Hospital and one other general hospital. The patient explained that external circumstances were responsible for his deciding to take an AMA discharge. He stated that if he leaves his business, which is a milk route, too long the company will reclaim the route and set someone else up into business, thus losing a considerable investment the patient has in the business. Although his doctor recommended that he might benefit from further hospitalization, the patient insisted on leaving. Social Service was able to structure the possibility of his using out-patient treatment. This was somewhat easy as he previously has received out-patient treatment. Although the patient said he would not return, it was explained

> to him that he could return to the hospital if he wished to. This put him at ease because he was somewhat afraid that we would be 'angry at him for leaving'. Nothing offered to the patient would convince him that he was doing anything but the correct thing.

Nine patients in the group impressed the writer as being so far out of contact with reality that their reasons for wanting to leave the hospital tended to be products of their delusions. In some cases of this nature the unrealism of the patients' statements could be detected only after an investigation of their records. Others were less difficult to detect and the fantasy aspect of their reasons for leaving became fairly obvious during the course of the interview. A case example illustrating the later category follows.

CASE D

> This is a World War II, Negro, service connected, thirty-one year old, single veteran. The patient has a diagnosis of Schizophrenic Reaction; paranoid type, chronic severe. He is a tall, slim man who has allowed his hair to grow very long because it 'gives him strength'. The patient stated that he wished to leave the hospital against medical advice because he had been framed by his family and was being held against his will. He also wished to leave because a motion picture company had offered him a job in Hollywood, singing in the movies. He emphasized that he is the son of Jim Thorpe and the grandson of Red Grange. (Both former all-American, all time football greats.)

In the majority of the cases, twenty-four out of twenty-seven, the writer felt that he did not agree with the patients as to their reasons for requesting an AMA discharge. His impression was that the reasons they gave for desiring to

leave the hospital were secondary to the real reason which they left unspoken. A few hinted at it by mentioning their fear of the locked doors and being around mental patients. It appears that the primary cause for their wishing to leave was common to the whole group, with the exception of the three patients who seemed to have realistic reasons for leaving.

The precipitating, underlying factor seems to be that the patients requesting AMA are afraid to face their illness. They are afraid of treatment because treatment will force them to acknowledge that they are sick. They fear the hospital because it represents treatment and the facing of their mental condition. The patients are also frightened of locked doors because they cannot flee the immediate reality situation. They are forced to face the painful fact that they are mental patients, by being locked in, and the presence of the other patients serves as an added reminder. Almost every patient in the group transmitted a feeling of fear to the interviewer during the interview.

The writer is further supported in his belief that the underlying causative factors in the request for an AMA discharge are fear of the hospital, treatment, and facing one's illness, in that nineteen patients out of twenty-seven requested discharge against medical advice while on the admissions ward. Also, they had been there from one to five days on the average, since their admission to the hospital. The hospital per se then, does not appear to be

intolerable, but rather the adjustment to the hospital and the ramification of facing one's illness seem to be the crucial area. If a patient is going to request an AMA discharge during his hospitalization, it seems likely that it will be during the adjustment period on the admissions ward.

In summary, the writer's evaluation of why the patients wished to terminate their stay in the hospital by requesting discharges against medical advice did not correlate with the patients' explanations of why they wished to leave. The patients' statements of their reasons for leaving were either obviously delusional or hallucinatory, or else upon investigation, were found to be highly unrealistic. From most of the patients in the group the writer received a sense of fear, which one ordinarily does not encounter so strongly in the average patient. Also, many of the patients in the group had been in the hospital a very short time and were still on the admissions ward. These factors have caused the writer to speculate that the majority of the patients in the study were attempting to use the AMA discharge as a flight mechanism in order to escape the traumatic experience of facing their illness.

Disposition of AMA Requests

As noted above, the writer ascertained what disposition had been made of each request for discharge against medical advice as of April 25, 1958. Table IV shows the results of the requests.

TABLE IV

DISPOSITION OF AMA REQUESTS

Disposition	Number of Patients
Continuing Treatment	13
Committed	2
MHB Discharge	5
AMA Discharge	6
AWOL	1
Total	27

It can be seen from this table that only six of the twenty-seven patients actually accepted an AMA discharge as compared to eight of the thirteen patients in Miss LaPlante's study.[1] Two others presumably would have accepted an AMA discharge but they were adjudged dangerous to themselves or others by their ward physicians and committed.

One patient went AWOL after making his request. He returned to the hospital after five or six days and then went AWOL again after a stay of a week.

Five patients received maximum hospital benefits discharges. Two of these received their discharges very soon after making the AMA request, one of whom was the patient previously described in a case example as Case B, the veteran who was hospitalized in error. The other three patients received their MHB discharges from a month to

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[1] Op sit., p.53.

three months after making the AMA request.

Thirteen other patients withdrew their AMA requests and continued in treatment. Two of these patients had begun ninety day trial visits at the time the writer determined each patient's current status on April 20, 1958.

In summary therefore, it could be said that twenty interviews given by the writer and other Social Service staff members, were successful and that seven were unsuccessful, the later being six AMA discharges and one AWOL.

Total AMA Discharges During Period of Study And Comparable Periods

The Registrar's records were examined to determine the total number of patients discharged against medical advice during the four month period of the study, December of 1957 and January, February, and March of 1958. These records were also traced back to determine the number of AMA discharges for the same four month period of a year prior to the study, and again for two years prior to the study. Table V shows the AMA discharges for these three periods.

TABLE V

AMA DISCHARGES FOR THE MONTHS DECEMBER THROUGH MARCH FROM 1955 THROUGH 1958

Month	Two Years Prior to Study 1955-56	One Year Prior to Study 1956-57	Period of Study 1957-58
Total	36	38	11
December	15	8	5
January	4	10	4
February	9	5	2
March	8	15	0

As can be seen in Table V the number of AMA discharges during the period of the study, eleven, were considerably lower than the thirty-eight and thirty-six of a year ago and two years ago, respectively. March of 1957 with fifteen AMA discharges contrasts markedly with the total absence of discharges of this nature during March of 1958, the last month of the study.

Social Service intervention appears to have a positive relationship to the reduction in AMA discharges. However, other factors which cannot be evaluated due to the limited nature of the study, may also bear a relationship. An example of this would be that economic conditions were not as favorable during the period of the study as they were during the same months a year before, and two years before. This criterion would not necessarily have a bearing in every

case as many patients in the study received fairly high rates of compensation from the government and, as mentioned previously, their thinking was not realistic.

Not every patient who received an AMA discharge during the period of the study was seen by the Social Service staff. As mentioned above, this was due to the fact that the writer was on duty an average of only twenty hours per week and the limitations of the other Social Service personnels' time. Table V shows that eleven patients left AMA during the period of the study and Table IV shows that six patients in the group left AMA during this period. This leaves five patients who were not given a Social Service interview before they received AMA discharges. Conceivably then, the total number of AMAs during the period of the study could have been appreciatively lower had all eleven patients been seen rather than only six out of the eleven. Table VI shows the distribution of the twenty-seven cases as seen per month.

TABLE VI

PATIENTS INTERVIEWED PER MONTH

Month	Number of Patients
December - 1957	5
January - 1958	10
February - 1958	6
March - 1958	6
Total	27

In summary, the number of AMA discharges during the four month period of the study dropped from the thirty-six of two years ago, and the thirty-eight of a year ago for the same months, to eleven. Five of the eleven were released before being seen by Social Service.

Patients' Requests of Social Service And Action Taken

Fifteen patients out of twenty-seven made specific requests of Social Service when asked if the interviewer could assist them in any way to remain in the hospital. Of the twelve patients who stated Social Service could not help them, four went through with their AMA discharges while eight withdrew their requests and remained in treatment or received MHB discharges. Of the other two patients who received AMA discharges, one told the writer that he would be glad to stay in the hospital if he could have a three day pass, while the other said he would stay if he could be transferred to an open ward. The writer took up these issues with the patients' ward physicians but was unsuccessful in both instances.

A case example follows where the patient had no request to make of Social Service and felt that nothing could help him to remain in the hospital, yet the interviewer did take action to further the patient's best interests.

CASE O

This is the case of a Korean War, Negro, service connected, twenty-nine year old, single veteran who is diagnosed as Schizophrenic Reaction, Unclassified type, Chronic Severe. His father died when he was two years old and he was raised by his mother and aunt. The mother has been described as an indulgent-punishing type of person and the patient appears to harbor a great deal of hostility toward her in particular and all women in general. The patient graduated from high school and subsequently entered the service where his adjustment was borderline. After separation he attended an art school in Detroit for four months and then applied for entrance into a University for art training under the GI Bill. This was refused him due to his mental condition and at this point he decided to enter the hospital. At the time of admission the patient complained of having 'telepathic visions' whereby those who were persecuting him forced him to see visions of a sexual nature via a combination of television and mental telepathy. The patient remained in the hospital a few days and then demanded an AMA discharge. The Social Service interviewer (not the writer) found that the patient wished to leave because his mother had told him to do so and also because his doctor would not operate on him to eliminate his hallucinations. The worker explained to him that medication, electric shock treatment or insulin shock treatment might very well have the desired effect. This did little to reduce the patient's desire to leave the hospital and he still insisted on being given an AMA discharge. The patient's mother arrived a few days following the interview to take the patient home. The interviewer saw her and explained to her the seriousness of her son's condition and the dangers involved in taking him from the hospital at the time. The mother seemingly could not accept this concept so the worker interpreted to her that the patient would probably have to be rehospitalized if he left at that time and that he would not be readmitted without committment papers being signed. This use of authority did have an effect on the mother and the request for discharge against medical advice was withdrawn.

Most of the fifteen patients who had a problem with which they thought Social Service could be of assistance tended to ask for help in such areas as transfers to a different ward, securing three-day passes, leaves of absences, and similar requests that could be attended to within the hospital. A few patients asked that they be assisted with a problem originating outside of the hospital. In each case this happened to be financial assistance for their families.

Social Service action was taken in each of the fifteen cases where it was requested with the exception of one instance. In this case the patient wanted a drawing board placed on the admissions ward for patients who enjoyed drawing, (this patient enjoyed drawing). Social Service action was effective in eleven cases out of the fifteen and in six cases out of this group, it was especially so. Two case examples follow in which the writer feels maximum benefits were obtained for the patient through Social Service intervention in the request for an AMA discharge. The first case is a veteran who was seen by the writer and subsequently taken on by him as an intensive casework patient. The second is a case where the writer's supervisor saw the patient and was able to be of great assistance to him.

CASE Q

> This is the case of a World War II, white, thirty-nine year old, married veteran with three children. Diagnosis was Schizophrenic Reaction, Unclassified Type, Moderate. The patient's mother died when he

was very young and he was raised by a step-mother with whom he did not get along well. He completed high school and went on to night school drafting courses. He has had some degree of success in employment in this field and has had a few promotions. The patient saw combat duty in France and received the Purple Heart. After returning home from the Army, the veteran began to experience strange thoughts that all manner of physical ailments were wrong with him and that people didn't like him. He subsequently saw various Veterans Administration psychiatrists on an out patient basis for a period of several years prior to deciding to come to the hospital. A few months before hospitalization the patient grew so preoccupied with his symptoms that he consistantly stayed home from work and created poor relationships between himself and his wife and children. He was admitted on January 10, 1958, and his presenting complaints were vague fears; complaints about aches and pains in almost every part of his body; and weird ideas about his body, such as electricity is generated in the liver. On January 13, 1958, three days after admission, the patient requested an AMA discharge and the writer was notified by the admissions ward clerk. The patient stated that he had to leave because his sick-leave pay would expire soon, leaving his family without funds. The writer explained that possibly some financial arrangements could be made by Social Service through a referral to a social agency in his city. The patient agreed that this might help but that he still could not stay in the hospital as he would lose his job when his sickleave expired. The writer suggested that the patient's employer could be notified of his hospitalization through Social Service so that he could be granted a leave of absence. The patient was a little hesitant about agreeing to this but finally remarked that he would feel free to stay if these two referrals were accomplished. At the conclusion of this interview it was agreed that the writer would see the patient the following day. Throughout the course of this interview the patient displayed intense anxiety symptoms concerning the hospital and his own condition. The areas of his professed concern, his family and job, were discussed with a flattening of affect which led the writer to believe that he was much more afraid of facing his own illness than he was concerned over his family being inconvenienced by his absence. The patient was informed during the next interview that his employer

had been contacted and that the Michigan Veterans Trust Fund had also been contacted regarding financial assistance for the patient's family. These referrals later proved to be effective with the patient's wife receiving appreciable assistance from the trust fund. Realistically, the home situation was not nearly so acute as the patient implied. Upon receiving this information the veteran again thought he should leave the hospital AMA as the variety of physical symptoms he complained of had not been aleviated by the medication he was receiving. The writer then interpreted to him the nature and scope of the hospital's treatment services as related to his illness. He then decided he would be able to remain in the hospital on a tentative basis. He indicated that he felt a need to see the worker on a continuing basis. The patient was consequently taken on by the writer on an intensive casework basis. He was seen an average of an hour per week, contacts were made with the patient's wife, and his situation was interpreted to other members of the treatment team. He responded favorably to casework which was given in conjunction with electric shock treatment. On March 18, 1958, the patient was considered to be sufficiently improved to the extent that he was given a ninety-day trial visit to his home.

CASE U

This is the case of a World War II, white, divorced, veteran with a history of three previous, brief hospitalizations at the hospital. His diagnosis is Schizophrenic Reaction, Unclassified Type, Chronic Moderate; Diabetis; Severe Upper Respiratory Infection. Little is known about his early history except that he has seldom established satisfactory interpersonal relationships and tends to retreat to the hospital when outside pressures become too great. One previous AMA discharge. He was admitted to the hospital on January 7, 1958, and demanded an AMA discharge February 6, 1958, after his ward physician refused him an MHB discharge. The interviewer saw him on this date and found that he wished to leave because he felt better and 'wanted to make room for another sick veteran'. The patient planned to give up his rented house upon leaving the hospital so that he could live with his aged parents. He also wanted to make arrangements to rent a five acre tract of land to raise cucumbers on during the approaching season. The patient had telephoned his mother the evening preceeding the interview informing her of his decision. She had attempted to discourage him from

leaving AMA and advised him to wait until the doctor felt he was ready. The worker later found that the mother had written the hospital asking that they keep the patient until they believed his condition warrented an MHB discharge because he drank quite heavily and was not likely to follow medical recommendations regarding his diabetis. The patient's request was that the interviewer help him to obtain an MHB discharge. The worker agreed that he would look into the situation and subsequently reviewed the patient's clinical records and held conferences with his ward nurse and ward physician. The circumstances were that the patient was in the process of learning to administer his own insulin injections and to care for the equipment. Both the nurse and the doctor felt that the patient minimized his diabetic condition and doubted if he would carry through with medical recommendations if released at that time. The doctor stated he would be inclined to discharge him MHB if there were some assurance the patient would have supervision in continuing his insulin training and in staying on the medical regimen. Another interview was held with the patient to explain the staff's position. The patient tended to minimize his condition and expressed his fear that he would 'be here forever'. The worker re-emphasized the doctor's reasoning and assured the patient he would not be in the hospital forever. The worker referred the case to the County Health Department, asking that agency to appraise the family's attitude toward, and ability to keep the patient on medical regimen. Two or three interviews later the patient expressed interest in obtaining employment and a pass was arranged for him to visit the local Michigan Employment Service. The worker contacted that office in advance. On March 19, 1958, the veteran received a maximum hospital benefits discharge.

In summary, Social Service action was taken in almost every instance that it was requested and in a few cases where it was not requested. The writer believes that adequate assistance was rendered in the majority of the cases, but that much more service could have been given several of the patients requesting AMA discharges if it

were not for the limitations of the Social Service staff members' time.

Further Contacts With Patients After Initial Interview

A circumstance arose which was not anticipated at the beginning of the study, this being that the patients in the group displayed a marked tendency to continue their relationship with the interviewer over a period of time. The writer found that eight patients out of twenty-seven were not seen by himself or other workers after the initial interview given when the patients requested to leave the hospital AMA. Six of the eight patients received AMA discharges and two received immediate MHB discharges so that the chance of further contacts was negligable. The nineteen patients who did not leave immediately or at all, seemed to derive some degree of satisfaction from talking with the interviewer whenever he happened to see them.

Further contacts with the veterans ranged from occasional short conversations, to brief casework services, to intensive casework. A typical happening would be that the writer would enter a ward to see one of his regular patients and be greeted with a remark equivalent to, "Well, there's the man who talked me out of going AMA, you are just the person I want to see". Then the patient would tell the writer about some problem he needed help with or perhaps

just relate how he was getting along. Many of these contacts developed into a regular pattern of the writer stopping to see the patient whenever he happened to be on his particular ward.

The reasons for this tendency to continue the relationships can be partially explained by the fact that most of the patients in the group appeared to derive some relief and satisfaction from the AMA discharge request interview. The patients seemed to feel gratified that someone was interested in having them remain in the hospital and was willing to assist them to remain if at all possible. Consequently, they impressed the writer as having developed positive feelings toward Social Service and being interested in maintaining contacts with that section of the hospital.

Miss LaPlante suspected that patients requesting AMA discharges would derive a therapeutic value from being interviewed with the focus on assisting them to stay in the hospital. This led her to recommend that a study such as the present one be undertaken.[1]

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[1]Ibid. pp.55-56.

CHAPTER V

CONCLUSIONS

In the cases which were used as a sample, the study brought out the fact that the neuropsychiatric patient in the Battle Creek Veterans Administration Hospital who requests an against medical advice discharge is likely to be in his middle thirties, more apt to be single or divorced than married, probably has previously left the hospital AMA or AWOL, is a recent admittance, and has been diagnosed as schizophrenic. He has a background of poor interpersonal adjustment and a pattern of fleeing from the pressures of society to the hospital, and fleeing from the hospital in turn, back to society. He tends to give two or three reasons as to why he is leaving. The first is usually concerned with plans outside the hospital and the second is an expression of dissatisfaction with treatment and/or the hospital.

The writer observed that the majority of the patients in the sample appeared to be in poor reality contact, and their reasons for leaving and their future plans were highly unrealistic. The general conclusions as to why patients request to sign-out of the hospital AMA are,

in the writer's opinion, the fact that they are afraid of treatment, the hospital, and the other patients because these things are both symbolic and concrete reminders that they must face their own illness if they are to stay in the hospital. These findings are for the large part in harmony with previous investigations in this area.

The second part of the study, the effect of the Social Service interview upon the request for discharge AMA, resulted in only six patients out of the twenty-seven interviewed actually following their stated intentions of leaving the hospital before the staff would recommend their doing so. Also, during the four month period of the study, the number of AMA discharges was only thirty percent of the average for this type of discharge during two comparable periods a year prior to the study and two years prior.

These data support the hypothesis of the study stated in Chapter I, that Social Service intervention will reduce the number of patients leaving the hospital against medical advice.[1] Although the evidence is not conclusive that Social Service intervention is entirely responsible for the reduction in AMA discharges, it seems likely that this approach can do much toward alleviating the problem stated in Chapter I.[2] The factors involved in the problem are many. The principal factors can be summarized that the AMA discharge:

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[1]Chapter I, p.7.

[2]Chapter I, pp.5-6.

1) costs the hospital wasted time and money, 2) creates problems for the patient's family and society, 3) deprives the patient of needed treatment.

Implications For General Practice

The conclusions reached in this study imply that perhaps any hospital setting could utilize the Social Service staff in reducing the number of patients leaving the hospital before the staff would advise termination of treatment. There appears to be no reason why this recommendation should be limited to the psychiatric setting as the patients who tend to leave AMA, basically seem to be afraid of facing and accepting their own illness. This manifestation could well be found in any hospital setting, regardless of its' particular nature.

One of the significant points brought out in the study, that the patient who requests an AMA discharge and is seen by a social worker tends to continue to use Social Services, suggests that perhaps this type of patient is he who most needs and can utilize the services of the social worker.

Because of the paucity of investigations into this area and the seemingly favorable results of the present study, the writer believes that further research in this area is indicated. The writer would recommend that future projects emcompass a larger scale and possibly utilize a control group.

Implications for Veterans Administration Hospitals

The general implications of the conclusions mentioned above also apply to the specific setting of the study - the Veterans Administration Hospital. However, because a few patients are going to leave AMA regardless of what assistance is offered them, the writer would also recommend that in the Veterans Administration Hospital setting a minimum period of hospitalization be established. This period might be set at thirty to forty days and the patient would not be allowed to leave prior to the expiration date of this minimum period. This would give the veteran an opportunity to become adjusted to the hospital and the fact that he is a mental patient. Also, the staff would have sufficient time to inaugurate his treatment plan.

Another implication of the conclusions is that because the majority of the patients in the group had been hospitalized only a short time, Social Service could focus more of their attention upon the admissions ward to improve the effectiveness of the Social Service section.

APPENDIX 1

SCHEDULE

I. Tell me about the reasons why you are requesting an AMA discharge.
   a. At what precise time did you decide to leave?
   b. How long did you wait and think it over?

II. Has anything happened in the hospital to make you decide to leave at this particular time instead of last week or several weeks ago?
   a. Were you angry, upset, or discouraged about something when you wrote the letter? - Or asked about AMA?

III. Is something happening outside the hospital to influence your decision about leaving?

IV. What are your plans after you leave? Do you have a job? With whom will you be living?

V. How does your family feel about having you sign out against medical advice?

VI. What do you understand about the doctor's reasons for recommending that you stay?

VII. Have you ever been discharged AMA from this or any other hospital previously? Did you ever make a request? What were the circumstances then?

VIII. How did you first learn that you could sign out AMA? Have you heard it discussed by other patients?

IX. Have any of your friends left AMA recently?

X. If you leave AMA, do you believe that you can return to the hospital? Under what circumstances?

APPENDIX 2

This schedule is for use in interviewing patients who are requesting to sign out AMA. The resulting data will be used in my MSW study on AMA patients. The focus of the study is two-fold:

1. To gather information on AMA patients.
2. To ascertain if Social Service can offer services to prospective AMA patients which will persuade them to stay.

SCHEDULE

I. Tell me about the reasons why you are requesting an AMA discharge.
   a. At what precise time did you decide to leave?
   b. How long did you wait and think it over?

II. Has anything happened in the hospital to make you decide to leave at this particular time instead of last week or several weeks ago?
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V. How does your family feel about having you sign out against medical advice?

VI. What do you understand about the doctor's reasons for recommending that you stay?

VII. Have you ever been discharged AMA from this or any other hospital previously? Did you ever make a request? What were the circumstances then?

VIII. How did you first learn that you could sign out AMA? Have you heard it discussed by other patients?

IX. Have any of your friends left AMA recently?

X. If you leave AMA, do you believe that you can return to the hospital? Under what circumstances?

XI. Can I do anything which would help you to stay?

SOCIAL SERVICE ACTION

I. What were patient's requests? (Brief description)

II. What action did worker take on requests?

III. Brief description of patient.

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