Social service functions with patients discharged against medical advice in a neuropsychiatric veterans administration hospital.
SOCIAL SERVICE FUNCTIONS WITH PATIENTS DISCHARGED AGAINST MEDICAL ADVICE IN A NEUROPSYCHIATRIC VETERANS ADMINISTRATION HOSPITAL

A thesis

Submitted by
William Herbert Casey
(A.B., Boston University, 1953)
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ACKNOWLEDGMENT

The writer would like to express his sincerest gratitude to all the members of the Northampton Veterans Administration Hospital staff that have made this presentation possible. In particular, the writer would like to cite Mr. Francis K. Hayes and Mr. Nelson K. Woodfork for their cooperation and assistance in this project.
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CHAPTER I
INTRODUCTION

Purpose of the Study

The purpose of this study is to gain some understanding of the patient who leaves the neuropsychiatric hospital against medical advice and the ways in which social service has helped or failed to help these patients. The writer would like to examine some of the facets of this problem in the light of the following questions:

1. Is the patient's denial of his illness a factor in the discharge against medical advice?

2. Are there factors in the personality of either the wife or the concerned relative who signs out the patient against medical advice that make it impossible for them to accept his illness?

3. Are either the patient, his wife, or the concerned relative accessible to casework help?

4. Are the reasons for signing the patient out against medical advice reasonable in the light of the casework and psychiatric help offered?

Scope and Limitations

The writer has limited his material to all the cases discharged against medical advice from the Northampton Veterans Administration Hospital between June, 1954 and October, 1955, twenty in number. The writer felt it was
necessary to place this limitation on the study as the records of discharges against medical advice prior to June, 1954 were not always available and when interviewed the caseworker who had handled the case was not always sure in his memory of the exact circumstances which surrounded it. An additional consideration which mediated against the collection of data prior to the above date was that there had been a turnover in the staff and the caseworkers concerned were no longer on the staff. The writer felt that between the above-stated dates all the records were complete and available to him for examination.

The results of this thesis, because of the smallness of the sample, can only be applied to the Veterans Administration Hospital in Northampton in their handling of discharges against medical advice. However, it is hoped that these results will help towards an understanding of some of the factors surrounding the discharge against medical advice and the application of casework services in the neuropsychiatric hospital.

The social service and clinical records utilized by the writer for this study were designed primarily for treatment rather than research. The information was also in many instances in a highly summarized form and did not always deal with the specific topics that the writer was interested in. Individual interviews with the concerned caseworker were used to fill in this need.
Methods of Data Collection

The data were collected from the social histories, clinical histories, social service records, clinical records, and through interviews with the particular caseworker who was handling the case. The doctors' opinions were not obtained through personal interview for the following reasons: 1. The questions the writer is interested in are primarily social casework problems. 2. The doctors had recorded their ideas in the clinical records in most instances so that it seemed unnecessary to contact them personally. In two of the cases utilized in this thesis, the caseworker had left the agency. The worker by examining the above-named sources and in addition consulting with the casework supervisor was able to complete the schedules. 1/

Sample Selection

The 20 cases utilized in this thesis were obtained from examining the book of discharges from the Northampton Veterans Administration Hospital from June 1, 1954 to October 31, 1955. They were all of the cases discharged against medical advice within this period. There were 426 cases discharged during this period and only 20 of these or 4.7 percent were discharged against medical advice. It is the policy of the hospital for all relatives to be referred to Social Service if they wish to sign the patient out against medical advice.

1/ Schedule may be seen in the Appendix
This can be contrasted with the 1.06 percent of Shapiro's which was from a General Medical and Surgical Hospital and the 6.54 percent of Wertham in a psychopathic hospital. The author would like to speculate that the differences here could largely be due to the setting. That is to say the factor of chronicity of the illness was probably not as prevalent in the studies of Shapiro and Wertham as they were in this study.

Types of Discharges

When the writer uses the term discharged against medical advice in this context, he means that the patient, his wife, or relative has requested discharge from the hospital for any one of many reasons. The ward doctor has then presented the patient to the disposition staff. The staff has decided that the patient, though he was not dangerous to himself, others, or property, is in need of further hospitalization, and is not yet ready to resume his position in the community. The hospital makes their position known by rendering a decision of discharge against medical advice.

The Veterans Administration, in outlining further this procedure, explains the types of discharges:

General:
A. Classes of Discharges. Discharges from hospitalization are classified as regular or irregular.

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2/ Veterans Administration, Standard Administrative Procedures for Psychiatric Services in V.A. Hospitals, Manual 10-11, September 8, 1953, Section 138,
(1) **Regular Discharges** are to be given for and designated as:
(a) Maximum Hospital Benefits
(b) Terminal
(c) Under V. A. Regulations 6065(A) and (B) (for certain categories of tuberculosis patients)
(d) Observation (examination) completed
(e) No treatment required

(2) **Irregular Discharges** are to be given for and designated as:
(a) Against Medical Advice including refusal or obstruction of observation and examination or refusal of treatment.
(b) Absence Without Official Leave (for non-psychiatric patients).
(c) Disorderly conduct (for non-psychiatric patients).
(d) Not entitled to hospitalization.
(e) Other (specify).

Another bulletin 3 further defines the application of the discharge against medical advice.

This type of discharge will be given: (1) when a competent patient insists upon discharge before examination or observation is completed, or when without demanding discharge (the patient) refuses, neglects, or obstructs examination or observation; (2) when reasonable treatment is refused, neglected, or obstructed; (3) when, from a hospital to which (the patient) was admitted for treatment, it is necessary to transfer a competent patient to another hospital better adapted to the purposes, and (the patient) refuses the transfer, or, when a like transfer of an incompetent patient is refused by (the) guardian or, if there is no guardian, by the nearest relative; (4) when a guardian or nearest relative if there is no guardian, insists upon discharge of an incompetent patient who the hospital head has determined is in need of further hospitalization.

It is this fourth category that the burden of the cases will fall.

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As a further deterrent to this action, the hospital acts under a ruling of the Veterans Administration in which the patient is excluded from both hospital treatment and domiciliary care for a period of 90 days after the discharge against medical advice.

Except when requiring hospital treatment for a medical emergency, beneficiaries who had received an irregular discharge from a hospitalization—whether against medical advice, or for absence without official leave, or for disorderly conduct—will not be authorized hospital treatment or domiciliary care until the lapse of 3 months after the date of such discharge. Beneficiaries who have received 2 or more such discharges (that is, irregular discharges from an admission accomplished during a 3-months exclusion period for treatment of a medical emergency) will be excluded from re-hospitalization or redomiciliation for 6 months after the date of the most recent of such discharges.*

*Disciplinary provision is hard to maintain in neuropsychiatric cases. Most cases can be called medical emergencies for readmission, either by force of community pressures or by presence of patient in the custody of a relative proving to them that medical decision was really right.

Operational Definitions of Crucial Concepts

The writer also uses the term denial of illness, usually in connection with the patient although not always so. In this context, it is simply meant that the patient's distortion or lack of perception of reality is not recognized by him as

4/ Veterans Administration, Manual 10-6, Sect. 31, p. 106.01.
an illness, and this lack of recognition usually takes the form of a denial that he has this kind of illness.

The inaccessibility of the patient, or wife, or concerned relative would mean that the caseworker who was handling the situation found that there were conscious or unconscious needs involved that were so strong that these people found it necessary to avoid any reasonable consideration of the illness of the patient despite the worker's best efforts to call it to their attention.

The writer will attempt further to define these concepts in the main body of the thesis utilizing case histories for illustration.

Setting

The Northampton Veterans Administration Hospital is a neuropsychiatric hospital providing care and treatment for veterans suffering from psychiatric disorders. The hospital first opened for service on May 12, 1924, with a capacity of only 460 beds.

Since that time the hospital has experienced a period of steady growth until today it comprises a total capacity of 1105 beds, of which 150 are assigned for medical and surgical use. The remaining beds, with the exception of 74 distributed throughout the 12 wards for emergency purposes, are occupied by patients suffering from neuropsychi-

4/ Northampton Veterans Administration Hospital, Book of Historical Data, January, 1956.
The hospital services chiefly the entire states of Vermont and Connecticut (with the exception of Fairfield County), New York State from Poughkeepsie north to Plattsburg and Western Massachusetts. It was mainly because of the geographical distribution of patients discharged against medical advice that the writer felt that personal interviews with the patients would be inadvisable within the limited period of time at his disposal.

The organizational structure of the Northampton Veterans Administration Hospital is divided into two principle units: Administrative Services and Professional Services.

The Administrative Service Division carries out the operation of the hospital and has on its staff the following services: Finance, Supply, Engineering, Personnel, Registrar, Canteen, and Housekeeping Service.

The Professional Service Division, with which we will be chiefly concerned, has as its function the care and treatment (medical and psychiatric) of all patients admitted to the hospital. It is comprised of: the Acute and Intensive Treatment Service, the Continued Treatment Service, the General Medical and Surgical Neuropsychiatric Service, the Physical Medicine and Rehabilitation Service, the Clinical Psychology Service, Social Service, the Nursing Service, Dietetic Service, Laboratory Service, X-Ray Service, Dental Service, Pharmacy Service, EEG Service, Special Service,
and the Chaplaincy Service.

Both divisions are headed by the Manager, Dr. R. T. O'Neil, and the Assistant Manager, Mr. C. M. Blackwell. Dr. Lionel M. Ives is the Director of the Professional Services and Dr. Herman Rickless heads the Acute and Intensive Treatment Service.

The Acute and Intensive Treatment Service and the Continued Treatment Service

In practically all cases, the new admissions are directed towards the Acute and Intensive Treatment Service. There the patient is examined by either the head of the Acute Intensive Service or by the Officer of the Day and a tentative diagnosis is established. The patient is then seen by the Director of Professional Services and he, in turn, renders his clinical impression and also recommending the type of commitment paper or agreement under which the patient will remain in the hospital. Usually after a period of observation, the Chief of the Acute and Intensive Treatment Service makes the diagnosis after his examination with the aid of material obtained from Clinical Psychology and Social Service, and treatment plans are made. In those cases that do not respond to the intensive treatment and have not adjusted sufficiently to return to the community, they are assigned to the Continued Treatment Service.
The Social Service Department concerns itself in this setting chiefly with the personal and social difficulties of the patient as they affect him during his hospitalization and, upon release from the hospital, during his readjustment to the community setting. John H. Melville\(^5\) has earlier stated that a social worker in a neuropsychiatric hospital has "six major responsibilities". They are as follows:

1. Orientation of new patients. 2. Interviewing to obtain anamnestic data from family or other outside sources. 3. Continued service as an aid in the patient's hospital adjustment. 4. Interpretation to the relatives of the patient's progress and need for treatment. 5. Planning with the patient for his discharge. 6. Follow-up in form of Trial Visit or post-discharge supervision to facilitate patient's readjustment in the community.

The Social Service Department has, to discharge these responsibilities, a Chief Social Worker, a case supervisor, four psychiatric caseworkers, and two second year social work students, one from Boston University and one from Simmons College.

The case workers are assigned as follows:


2. Trial Visit and Post Discharge Continued Treatment - two workers. (One of these caseworkers carries in addition to his other duties, student supervision and the Family Care Program.)

In actual practice any of the members of the Professional Services may be the first to hear of the patient's intention to leave the hospital against medical advice. However, as soon as the medical staff hears of it, the patient's intention is communicated to the Social Service Department and the relatives' attitudes sounded towards the patient and his disease. However, it may be that the doctor will hear directly from the wife or the concerned relative who will notify him of their intention to take the patient home against medical advice. Here, the social service department will emerge more prominently inasmuch as they, more than any of the other professional services, have had more contact with the people that are closest to the patient. In many instances, incipient discharges against medical advice are "nipped in the bud" by timely casework intervention. Realistic problems are recognized and the worker is able to render valuable services in organizing the appropriate community forces to fill the need that the relatives are expressing. In some cases explanation of the treatment procedures go far to alleviate the anxieties of the relatives.
With the patient, however, the case is in many respects quite different. The worker shares his interest in the patient with many other professional disciplines. He may or may not be the vital person in the hospital setting whom the patient has formed a trusting relationship and whose direction he will be able to follow. In one of the current cases that the writer handled, it was only with the combined efforts of the ward psychiatrist, the Manager, and the Registrar, that the patient was able to reconsider his decision to leave the hospital against medical advice.

The reader has perhaps by now been able to see that the approach to this problem which is most effective is the team approach. The writer's intention is to examine more closely some of the aspects of this problem in the light of the case work service rendered so that the contribution of the Social Service Department can be even more effective.
CHAPTER II
PREVIOUS RESEARCH ON DISCHARGES AGAINST MEDICAL ADVICE

A Review of the Literature

Because of the scarcity of the literature dealing with this subject, the writer was forced to consider material dealing with the patient who leaves the hospital against medical advice from tubercular hospitals as well as psychiatric and general medical and surgical hospitals. He has also investigated unpublished theses of other students who were interested in other aspects of this problem within a psychiatric service.

An article by Fulcher and Beasley\(^1\) takes the point of view of a public health nurse who is referring patients to a tubercular hospital for treatment and receiving the patients who were discharged back into the community against medical advice and still in need of treatment. The writers examined the composition of a group selected from the Georgia State Hospital within a given period of time that had been discharged against medical advice. Aimed primarily at improving techniques of interviewing and referral of the public health nurse, the writers visiting the five regions

\(^1\) Fulcher, Elizabeth and Florence Beasley, "Consultant Nurses can Help the Staff Nurses", Nursing Outlook, 1:208-212, April, 1953.
within the State set up a review of interviews with these patients and the public health nurse. The conclusions and recommendations\(^2/\) reached by the writers were as follows:

A. Local Health Department
   1. More adequate preparation for hospitalization. This includes:
      a) Education about his disease
      b) Initiation of the basic treatment - bed rest
      c) Time and help in making satisfactory financial arrangements for his family before going to the hospital
      d) Helping patient to an emotional readiness in accepting separation from home and family for a long period of time
      e) Information regarding hospital routines

B. Tuberculosis Hospital:
   1. Sufficient medical and nursing personnel to make possible the continuation of complete bed rest and personalized service to patient.
      a) Supportive measures to sustain
   2. Psychiatric social workers in the state tuberculosis hospital to work with patients and staff.
      a) Available counseling at all times
   3. Individual interviews by skilled interviewers on admission to hospital.
      a) To help patient further understand his disease
      b) Clarify rules and regulations
      c) Interpret protective measures
   5. Consider a possible policy of holding beds of patients discharged against medical advice for a few days pending contact with local health department to ascertain if the patient has a desire to return. (Many patients report to health departments within a 24-hour period of arrival home, explain their regrets at leaving, and ask if they may be readmitted to hospital.)
   6. Separation of convalescent and bed patients.
   7. Referral plan which will include information on pending discharges so that local health departments can:

\(^2/\) ibid, p. 211
a) Make plans with family for patient's return
b) Clear treatment plans so that patients will know where and when to report for continuation of treatment

Another article by Joseph Tedesco, written from the point of view of the hospital towards the patient discharged Against Medical Advice brings out more clearly the role of the social service department. The findings were as follows:

(a) Twenty-two patients left because of difficulties which arose in the patient's home (financial problems; desired treatment closer to home);
(b) 29 discharges were attributed to difficulties resulting from the patient's personality (restlessness, impression that further rest was not needed, lack of insight into the seriousness of their disease, psychopathic personality);
(c) 20 patients left because of inability to follow hospital regulations. Thirteen of these 20 patients left before a board of discipline could be convened following breach of hospital rules; 3 others left because they objected to certain hospital regulations; 1 patient was discharged by the disciplinary board; 1 patient left after he was not discharged as having achieved maximum hospital benefits; 2 others left after only a few days of hospitalization, stating that they had expected only a brief period of observation. These figures parallel those reported by other observers, namely, that, in the overwhelming majority of irregular discharge cases, the departure from the hospital can be attributed to either factors arising within the patient or in the patient's home situation. Only a very small percentage can be attributed to factors originating in the hospital.


4/ Ibid, p. 396
More adequate preparation for a prolonged period of hospitalization with a correct orientation as to its necessity; attention to the various financial and personal problems of the family that the patient leaves behind him; a closer referral system of the hospital service for these patients that "cannot stand long periods of hospitalization" to the clinical psychology department as well as the ward physician; and a more liberal and flexible furlough policy were the chief recommendations made in this study.

It is significant, the writer feels, that in both hospitals the discharge against medical advice rate was 50 percent of the total discharge rate or higher.

In the area of psychiatric hospitals, a very early article by Wertham\(^5\) speaks of this in terms of social psychiatry. He found that within a 6 year period voluntary patients carefully screened by admitting psychiatrists and discharged against medical advice, comprised 6.54 percent of the total number discharged. As regards to the initiative taken per discharge Wertham\(^6\) found the following:


\(^6\) Ibid, p. 570
Initiative due to patient...............  26
Initiative due to family of patient....  99*
Family persuaded by patient to take him out.........................  47
Clinic advises transfer, but patient is taken home...................  17
Trial discharges...............................  4

*In 10 of these cases the patient was removed expressly against his own wishes.

With the help of a psychiatric social worker, Wertham reports the following on a post discharge follow-up to taken within 18 months after discharge:

<table>
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<th>Cases</th>
<th>Cases</th>
</tr>
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<tbody>
<tr>
<td>1.</td>
<td>2.</td>
</tr>
</tbody>
</table>
| No information.................. | Returned to mental hospital...... | Admitted to jail................ | Unimproved at home............... | Suicides........................ | Suicidal attempts (with subsequent adjustment, 3 cases; with subsequent admission to mental hospital, 5 cases) | Sudden death, possible suicide... | Homicidal attempts (with subsequent admission to mental hospital) | Died........................... | Satisfactory adjustment outside hospital..........................
| 21    | 60    | 1      | 15    | 8     | 8      | 1      | 8      | 7      | 64     |

In summary Wertham stresses the importance of the familial attitude towards the patient and his illness. He also points out the psychiatric areas of responsibility to the community as well as to the patient. The doctor comments on the fallibility of the doctor's medical prognosis in the light of the rather high percentage (37.1 percent) that have

2/ Ibid, p. 574-575
improved at home. He indicated the need for a careful social prognosis, pointing the way for the consideration of the patient as a total human being rather than defining him as a psychiatric entity, a rather predictive point of view for these times.

Anders\(^8\) doing a similar study at a later date, found of the 49 patients studied, more than one half of the total group were later hospitalized. Only 16 of these in the community at the time of the follow-up allowed themselves to be interviewed. The discharges against medical advice were 7.4 percent of the total discharges. In this thesis, the writer specifies that the known re-hospitalizations were due to an examination of the files of the hospital that discharged them.

Shapiro\(^2\) found that in the Boston Veterans Administration Hospital 1.06 percent of the total discharges were against medical advice. This setting was again different being predominantly a general medical and surgical hospital with a psychiatric service. Her investigation centered more around the reason given for leaving. In this she found the

\[\begin{align*}
\text{\(^2\) Shapiro, Frances M., "A Study of Social Service Activity in Relation to Patients Discharged Against Medical Advice from the Boston Veterans Administration Hospital," Unpublished Master's thesis, Boston University, School of Social Work, 1955, p. 46.}
\end{align*}\]
underlying factors four-fold. 1. To obtain drugs and alcohol, 2. Fear of treatment. 3. Unable to accept their illness. 4. A function of their illness, i.e., a paranoid patient who felt that no one in his ward liked him.

Dangrove and Kutasch\(^\text{10}\) in a more recent study than Wertham's in yet another setting deals essentially with the same difficult problem...how to help the patient to accept his illness and, concurrently, treatment for it. The authors arrived, through an analysis of their own clinical experience and the records within the clinic, at the following as causes of discontinuing treatment.

I. Factors Attributable to the Patient
A. Poor Motivation - wherein the veteran feels that treatment and pension are vitally connected - or where the family is pressing for treatment rather than the veteran - when the veteran feels that his illness is of an organic nature - not correctly oriented, feel that they are going to a "nut clinic" - some are not yet ready to accept treatment, feeling that they would like to work it out for themselves.

B. Discussion By Others - where family or friends advise him to "fight it yourself" or that he's just "running away" - or where a wife may feel that her husband's "telling all" will cause her shame, or that the therapist is siding with the husband against her, or that it may interfere with his work.

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\(^{10}\) Dangrove, Edward, M.D. and Samuel Kutasch, Ph.D., "Why Patients Discontinue Treatment in a Mental Hygiene Clinic," *American Journal of Psychotherapy*, 4:459-472, July, 1950. The following quotation is paraphrased from the original by the present writer.
C. Cannot "Take" Treatment - where the veteran cannot tolerate the anxiety of treatment when therapy spontaneously turns to hostile and/or sexual material - or when the therapeutic situation is seen as seductive with stimulation of repressed "id" wishes - or a loss of secondary gain, that is a veteran may prefer the loss of treatment rather than the loss of the disease - or where the veteran feels a loss of self-esteem in speaking of the taboos of our culture, i.e., speaking of intimate sexual experiences with a strange psychiatrist.

D. Inadequate Personality - where the patients are either too limited in intelligence or are ambulant schizophrenics.

E. Antagonism to Doctors and/or V. A. Personnel - continuance of feelings around authority as in the service "hurry up and wait" or "red tape."

F. Does Not Pay for Treatment - more veterans break appointments and treatment in the clinic than in private practice.

II. Factors Attributable to the Therapist
This is due to a lack of self-understanding on the part of the therapist, or hostility which communicates itself to the patient.

III. Factors Attributable to Management
A. Errors in Therapeutic Technique - where unrealistic promises are made to the patient - there is a failure to clarify material and misunderstanding - failure to recognize dynamic trends and hostility - failure to recognize when to terminate treatment.

B. Passing Through Too Many Hands

C. Lack of Therapeutic Means - i.e., with ambulant schizophrenics.

D. Missed Appointments by Therapist

E. Short Duration of Interviews
F. Physical Setup of the Clinic - lack of privacy, sound-proof rooms, etc.

G. Lack of Trust that Confidence will be Kept

H. Oversold Psychotherapy not perfect

*Not to be confused with the diagnostic category of Inadequate Personality.

In summary then the writer would like to point out that the patient discharged against medical advice has been investigated in many different settings from his first referral to a hospital, to his stay within the hospital or clinic setting, to his subsequent return to the community and his fate while there.

During a careful review of the cases at the writer's disposal, the points mentioned in the introduction emerged as significant for this limited explanation. The writer will attempt to bring in the findings of direct pertinence to his study in the body of the thesis.

One point, however, emerges from this discussion of the theoretical material. In only one study did the setting approximate that of the Northampton Veterans Administration Hospital, and this (Wertham's) was a psychopathic hospital that handled only acute voluntary admissions; as differentiated from the Northampton Veterans Administration Hospital where, in a sense, the more liberal limitations are the eligibility of the veteran, the fact of his having a psychiatric illness, and the hospital having a bed available for him.
All the studies concurred in the value of a proper orientation (and in Beasley and Fulcher of an adequate referral service) to the therapeutic program and the disease itself for both patient and family. All found that attention to the patient's financial resources and familial setting which they leave was a vital necessity for prolonged hospitalization. This would have particular meaning for the Northampton Veterans Administration Hospital as it has a large Continued Treatment Service.
CHAPTER III

THE COMPOSITION OF THE SAMPLE

The writer first wondered about the age of the patient discharged against medical advice and found the following:

Table 1. Age at Time of Discharge

<table>
<thead>
<tr>
<th>Age</th>
<th>No. of Patients</th>
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<tbody>
<tr>
<td>20-25 years</td>
<td>4</td>
</tr>
<tr>
<td>26-30 years</td>
<td>3</td>
</tr>
<tr>
<td>31-35 years</td>
<td>5</td>
</tr>
<tr>
<td>36-40 years</td>
<td>5</td>
</tr>
<tr>
<td>41-45 years</td>
<td>1</td>
</tr>
<tr>
<td>46-50 years</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
</tr>
</tbody>
</table>

The writer found the mean age to be 32.2 years.

The next consideration that the writer would feel to have significance was the marital status of the veteran. This, however, seemed inextricably bound up with the person who signed the veteran out against medical advice. Therefore the writer proposes the analysis in Table 2.

The case where the father was the person who signed the patient out against medical advice is of interest.

P.C. is a 22 year old, married, veteran with a diagnosis of having a schizophrenic reaction, schizo-affective type. Recently married the patient had, shortly after his wife conceived, many affairs with women. In an attempt to help the patient with this
difficulty, his wife had succeeded in getting him to move to a different locality. She was at the time of the veteran's hospitalization living at her parents' home, nursing an ailing mother, in addition to caring for her 8-month-old child. She was quite resentful of the father-in-law for not having been told of her husband's mental condition and had little hope for her marriage as her father-in-law insisted on interfering in their affairs. In interviewing the father, the worker found him to be a rather rigid controlling person who had been a former mental patient himself. After six months and two weeks of hospitalization the father insisted on taking his son from treatment as he could not see any further need for it. The worker found that both the patient and the father denied his (the son's) illness and were inaccessible to casework help.

Table 2 The Relationship between the Patient's Marital Status and the Person Who Signed the Veteran out Against Medical Advice

<table>
<thead>
<tr>
<th>Person Signing Patient Out</th>
<th>Single</th>
<th>Married</th>
<th>Divorced</th>
<th>Separated</th>
</tr>
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<tbody>
<tr>
<td>Wife</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self</td>
<td>1</td>
<td>1</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Brother</td>
<td>1</td>
<td></td>
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<tr>
<td>Relative</td>
<td>2</td>
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<tr>
<td>Totals</td>
<td>5</td>
<td>12</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>
In the above case the writer would like to speculate that the father's inability to accept his son's illness was based on a threat to his own security (health) and that he, therefore, needed to deny his son's illness.

Inasmuch as 60 percent of the veterans were married and 50 percent of these were signed out by their wives the worker felt that it would be wise to examine the income of this group while hospitalized. The writer feels that this is important inasmuch as several of the previous investigators found that there had been a social situation which, unattended, precipitated the discharge against medical advice. The loss of income for the patient, especially if he was a wage earner, could be such a situation.

Table 3  The Income of the Veteran During Hospitalization

<table>
<thead>
<tr>
<th>Type of Pension</th>
<th>No. of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Connected Disability</td>
<td>13</td>
</tr>
<tr>
<td>Non-Service Connected Pension</td>
<td>2</td>
</tr>
<tr>
<td>Non-Service Connected with Hospital Benefits Only*</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
</tr>
</tbody>
</table>

*PL 239

As can be seen 75 percent of the veterans were receiving some kind of compensation from the government. In only one case was a married veteran not receiving some kind of finan-
cial assistance each month. In the above chart, a Non-Service Connected Disability simply means that the patient is allowed hospital benefits for his illness but does not receive any financial benefits.

Therefore the writer concluded that financial consideration did not play as significant a part in most of the cases considered in this study, as they did in the cases studied by other writers.

The next consideration which emerged as being a significant one in this study was the factor of the gravity of the mental illness itself. To determine this, the writer made the following table listing the various diagnoses:

Table 4 Psychiatric Diagnosis at the Time of the Discharge Against Medical Advice

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>No. of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenic reaction, catatonic type</td>
<td>5</td>
</tr>
<tr>
<td>Schizophrenic reaction, paranoid type</td>
<td>2</td>
</tr>
<tr>
<td>Schizophrenic reaction, undifferentiated</td>
<td>2</td>
</tr>
<tr>
<td>Schizophrenic reaction, schizo-affective type</td>
<td>1</td>
</tr>
<tr>
<td>Psychosis, unclassified</td>
<td>1</td>
</tr>
<tr>
<td>Acute Brain Syndrome</td>
<td>1</td>
</tr>
<tr>
<td>____________-A/-</td>
<td></td>
</tr>
<tr>
<td>Anxiety Reaction</td>
<td>3</td>
</tr>
<tr>
<td>Emotionally Unstable Personality</td>
<td>2</td>
</tr>
<tr>
<td>Alcoholism</td>
<td>2</td>
</tr>
<tr>
<td>Obsessive Compulsive Personality</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>20</strong></td>
</tr>
</tbody>
</table>

\( a/ \) The writer in the above chart has drawn a dotted line in the middle of the chart to differentiate between the degrees of severity of the illnesses.
With the exception of the Acute Brain Syndrome (which is a severe neurological illness) the top six diagnoses are all psychotic forms of mental illness, that is to say, the most severe forms of mental illness. None of the patients were in remission (a state characterized by a lack of symptoms), and all needed hospitalization. Including the patient with the diagnosis of having an Acute Brain Syndrome, the psychotic patients amounted to 12 or 60 percent of the total sample.

The diagnoses listed below the dotted line were those patients having illness that would be more characteristically in the psychoneurotic group. The distinction between the psychoneurotic in the community and in the hospital is one of degree. The psychoneurotic in the hospital setting has this illness to such a degree of severity that it virtually incapacitates him in his adjustment within the community. The more protective environment of the hospital is then desirable.

The emergent facts then are that 60 percent of the sample had severe forms of psychiatric or neurological disorders, 40 percent had such a degree of psychoneurotic illness as to actually require hospitalization.

The next category that the writer was concerned about was the element of time. The following table will be illustrative of the findings.
<table>
<thead>
<tr>
<th>Length of Time Hospitalized</th>
<th>No. of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Week - 2 Months</td>
<td>12</td>
</tr>
<tr>
<td>3 - 4 Months</td>
<td>4</td>
</tr>
<tr>
<td>5 - 6 Months</td>
<td>1</td>
</tr>
<tr>
<td>7 - 8 Months</td>
<td>1</td>
</tr>
<tr>
<td>9 - 10 Months</td>
<td>1</td>
</tr>
<tr>
<td>Over 11 Months*</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>20</strong></td>
</tr>
</tbody>
</table>

*This patient was hospitalized 9 years and 2 months, and is considered by the writer to be a deviant and not characteristic of the sample.

Sixteen patients or 80 percent of the total sample left within the first 4 months of treatment; 12 or 60 percent within the first 2 months; 10 or 50 percent within the first month; and 4 or 20 percent left the hospital in the first week of treatment.

Typical of this is the following:

R. J. was a 32 year old, separated, white, male veteran diagnosed as having an Anxiety Reaction. On the hospital ward he was quiet, cooperative and apparently quite comfortable. On his admission, he had stated that he was nervous, jittery and quite apprehensive. He came to the hospital voluntarily. Before a week had passed, his mother came to his ward physician and demanded that he be released. The patient was signed out by his mother against medical advice.

This patient was removed before the social worker even had a chance to interview the mother for social history information (the only case in the sample that had not been
seen by the social service department). The above case illustrates well the precipitous manner of the against medical advice discharge which seems to be so characteristic of the cases within the sample.

The other striking factor to be seen in this table is the extreme shortness of time within which the discharge against medical advice takes place.

To further validate this conclusion the writer examined the type of service the patient was in at the time of his discharge.

Table 6 Type of Service from which Patient was Discharged

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>No. of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Intensive Treatment Service</td>
<td>17</td>
</tr>
<tr>
<td>General Medical and Surgical Service</td>
<td>2</td>
</tr>
<tr>
<td>Continued Treatment Service</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>20</strong></td>
</tr>
</tbody>
</table>

From the evidence presented it would seem that in the large majority of cases the patients in this sample were discharged from the Acute and Intensive Treatment Service, rather than the Continued Service.1/

To summarize the findings then, the writer has found that the patient discharged against medical advice has a mean age of 32.4 years. In 60 percent of the cases he is

married, in only 20 percent of the cases is he single. The remaining 20 percent being separated or divorced. His mental illness is generally quite severe. The length of time that he has spent in the hospital is quite short; in 60 percent of the cases less than 2 months, and the manner which was characteristic of the request for discharge seemed to be quite sudden and precipitous. The writer also discovered in a large majority of the cases (75 percent) the patients were receiving some kind of financial benefits from the government by reason of their disabilities.

The writer would like to point out that the findings would seem to indicate that financial problems which would seemingly be significant in the case of a married veteran were not always so, inasmuch as the veteran was not only not being charged for treatment but was actually receiving some kind of financial benefit because of his illness.

The writer would like to speculate that the chronicity of the illness was a factor in the discharge against medical advice.
CHAPTER IV

CIRCUMSTANCES SURROUNDING THE DISCHARGE AGAINST MEDICAL ADVICE

In this chapter the writer would like to consider some of the factors that surrounded the patients in this sample in the light of: first, their history of previous discharges against medical advice; secondly, the patient's acceptance or denial of their illness; and in the third instance, I would like to deal with the relatives, the caseworker's activity with them, and with the particular incident around which the discharge took place.

Table 7   The Discharge Against Medical Advice

<table>
<thead>
<tr>
<th>No. of A.M.A. Discharges</th>
<th>No. of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
<td>13</td>
</tr>
<tr>
<td>Second</td>
<td>6</td>
</tr>
<tr>
<td>Third</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>20</strong></td>
</tr>
</tbody>
</table>

In Table 7 we see that in 13 or 65 percent of the cases this was their first discharge against medical advice. There is apparently very little relationship between the number of discharges against medical advice and the severity of the disease. In 2 of the cases that had more than 1 discharge against medical advice the writer found that there
was also a history of discharge with maximum hospital benefits. A discharge with maximum hospital benefits at a Veterans Administration Hospital simply means the hospital feels that it has done all that it could to help the patient with his disease; they sometimes strongly recommend further care on an outpatient basis as they feel that the patient is still in need of further treatment.

A rather unusual case of a patient using the hospital as a support in his attempt to cope with the environment is the following:

W. D. is a 37 year old, white, married male who was a voluntary admission to the hospital. Diagnosed as having a schizophrenic reaction, paranoid type, this patient has a long history of hospitalization with a lobotomy several years before. Arriving at the hospital, he is usually footsore, hungry, and somewhat bedraggled after a long trip from another state. He last stayed at the hospital for 1 month. Married to a woman several years his senior, the history indicates some marital friction. When he proposed leaving the hospital on the last occasion he gave as his reason for leaving that he wanted to see the World Series. The worker in this case felt that inasmuch as he continued to come back to the hospital he did have some acceptance of his illness although when made aware of solutions other than discharge against medical advice, he remained inaccessible to casework help. He signed himself out against medical advice.

The worker found that in all but one other case, a total of 18 patients denied their illness and were unable to accept its implications. The case of G. A. is illustrative of this.
G. A. was a 28 year old, married veteran with a diagnosis of Obsessive-Compulsive Personality. On admission to the hospital, he told of spending hours in the bathroom combing his hair and masturbating. Having a history of a previous hospitalization in Philadelphia, he spoke of feeling very guilty and disturbed about his masturbation and quite uneasy and perturbed in his community adjustment. He was apparently doing quite well on the ward and was able to accept the fact that he was ill and needed help. When the caseworker interviewed the wife with the intention of obtaining a social history, he found her to be quite resistive to the idea of her husband needing hospitalization. She said she realized that he spent a great deal of time in the bathroom but dismissed this as a mannerism. She denied having any knowledge of his constant combing of his hair and attacked the social worker in the previous hospital for asking for information as to their sexual adjustment, saying that she did not see how that would aid treatment. Shortly afterwards (the length of the patient's hospitalization was 1 week) she demanded that he be discharged. She signed the patient out against medical advice. The wife was inaccessible to the worker and although an alternate solution was proposed she was unable to accept it.

In the above case we see where a patient actually was willing to accept his illness and to stay in the hospital setting; his wife's inability to accept it was the vital factor in the discharge. More usual is to find the following:

W. W. is a 32 year old, married veteran with a diagnosis of Alcoholism. He has a history of 2 previous discharges against medical advice and 1 discharge maximum hospital benefits. He has also had bleeding ulcers and during previous hospitalization has been suicidal. He had built up his own business and was buying his own home. When hospitalized on this occasion he reported to the hospital
intoxicated. After a short time in the hospital setting he was feeling better and began to speak about going home. His wife when interviewed by the caseworker, said that her husband was "all right except when he was drunk". She said that she felt that he was all right now and that she wanted him released. When the caseworker explored this a little with her, he found that the patient had made some business commitments that she did not feel could be kept while he was in the hospital. She also said the house was not paid for. The worker offered some solutions to this problem other than discharge against medical advice, but Mrs. W. remained adamant and demanded her husband's immediate release. The wife signed the patient out against medical advice. His length of hospitalization was 1 week.

In the above case, it is apparent that the wife's denial of her husband's illness was a factor in the discharge against medical advice. The particular incident was amenable to casework help, but the wife remained inaccessible to the worker even after the worker had offered a solution other than a discharge against medical advice.

Another case that would bring this out even more clearly is the following:

M. F. is a 49 year old, married veteran with a diagnosis of Alcoholism. The worker when interviewing him found him to be glib, demanding, narcissistic and somewhat psychopathic. After a short time in the hospital he began to demand his release. The worker was called by his wife and she discussed with him the financial problem that she was suffering due to her husband's not working. The worker referred her to Veterans Services for assistance. However, later on the same day, she called the Manager of the hospital and demanded her husband's release. She signed the patient out against medical advice after his being in the hospital for 2 weeks.
In the above case, both the husband and wife were inaccessible to the caseworker. Although the situation was amenable to casework help (her husband did have a service-connected disability and she was referred to Veterans Services for financial help), her denial of her husband's illness did seem to be the factor that brought about the discharge against medical advice.

The writer found that in all but one case in the sample the caseworker had suggested solutions other than discharge against medical advice. In 12 of the cases, the wife or the relative denied the patient's illness. In 4 cases the veteran was a voluntary admission and signed himself out against medical advice as in the case of Mr. W. D. Representative of the 4 cases in which the wife or concerned person does accept a patient's illness and does not seem to be inaccessible to the worker, is the following:

J. G. is a 31 year old, married veteran with a diagnosis of Schizophrenic reaction, undifferentiated type. When first seen by the caseworker Mrs. G proved to be an intelligent, cooperative person who had some acceptance of her husband's illness. Financial problems were raised during the interview and Mrs. G. was able to accept referral to the Soldiers Home and the Public Welfare Department. In speaking with the worker she agreed to sign the necessary papers for electric convulsive therapy and seemed to see the need for further treatment for her husband's illness. Shortly afterwards, she signed the patient out against medical advice. The patient's length of hospitalization was 1 week.
In the above case it was the worker's impression that Mrs. G. was frightened of her husband and intimidated into complying with his wish for release from the hospital.

The worker would like to speculate that it seems as if the relatives in this sample were not properly prepared for the prolonged period of hospitalization that the patient's disease in many cases seemed to require. It would seem almost that when confronted with the fact that the person about whom they were most concerned was a patient in a neuropsychiatric hospital they handled this by attempting to deny the patient's illness in many cases and taking them out of the hospital setting. There did seem to be a lack of understanding about mental illness. In this light the recommendations by Beasley and Fulcher about careful preparation for prolonged hospitalization and a more complete orientation and education about mental illness at the very outset would have particular meaning here. This would seem to have some meaning when we notice that there was only one patient in the total sample who had a longer period of hospitalization than 9 months and only 3 patients were discharged from the Continued Treatment Service. The writer would like to speculate further that it would seem that with some of these relatives it is necessary for them to work through their own feelings about mental illness before they can accept the patient.
In the Continued Treatment Service this seems to have been largely accomplished and the loss of the patient from the familial setting has been adjusted to by the remaining members of the family.

In summary, the writer has found that in the majority of the cases in this sample (65 percent) it was the patient's first discharge against medical advice; in almost all of the cases (90 percent) the patient denied their illness; in 90 percent of the cases the relatives and patients were made aware of solutions other than a discharge against medical advice; in 50 percent of the cases the situation around the discharge was amenable to casework help (in the 50 percent that were not, this was due either to the relatives or the patient's denial of his illness); in 60 percent of the cases in the sample the relatives were not accessible to the caseworker for help.

Therefore, once again we find that even though the workers in almost every case had offered realistic solutions to the problems that were attendant to the veteran's hospitalization, the wife or the concerned relative was unable to accept this. This would seem to indicate that although Social Service is able to help and provide resources to many of the hospitalized patients, the relatives of the patients utilized in this sample were unable to accept this help. Previous investigators (Wertham and Tedesco)
have posed this as a reality problem in the discharge against medical advice. These findings would not substantiate such a claim. However, the lower percentage in discharges from the Northampton Veterans Administration Hospital may be an indication of how Social Service has helped with this problem.
CHAPTER V

SUMMARY AND CONCLUSION

The purpose of this paper was four-fold. The writer wished to examine the following questions:

1. Is the patient's denial of his illness a factor in the discharge against medical advice?

2. Are there factors in the personality of either the wife or the concerned relative who signs the patient out against medical advice that make it impossible for them to accept his illness?

3. Are either the patient, his wife, or the concerned relative accessible to casework help?

4. Are the reasons for signing the patient out against medical advice reasonable in the light of the casework and psychiatric help offered?

The writer selected all the cases discharged from the Northampton Veterans Administration Hospital, 20 in number, from between June, 1954 and October, 1955 for a sample selection.

The methods used were data collected from the social histories, clinical histories, social service records, clinical records and through interviews with the particular caseworker who was handling the case.

The conclusions are as follows:
The writer has attempted in this thesis to find out if the patient's denial of his illness was a factor in the discharge against medical advice. He found that in almost all the cases, the patients denied their illness, but that in only 4 was this denial an outstanding factor in the discharge, inasmuch as the patients in these cases were voluntary admissions. The writer also wondered about the personalities of the relatives of the patients, and if this too, could possibly be a contributing factor toward the discharge. In 60 percent of the cases the relatives denied the patient's illness, and was found by the caseworker to be inaccessible to casework help. In some cases, it seemed to be very clear that the father and the wife were responding more to their own needs than to the patient's situation. In other cases this was much more difficult to determine.

However, in almost every case examined, the caseworker had suggested ways of solving the problems that the patient's hospitalization presented other than his leaving the hospital against medical advice. In the large majority of these cases, patients hospitalized were receiving some kind of financial remuneration from the government in addition to the care and treatment of the hospital itself. On the basis of these cases, the writer was forced to the conclusion that the demands for discharge against medical advice were unreasonable in the light of the help offered.
The writer also found a group of 4 relatives who were accessible to worker's help, but who, for a variety of reasons (among them fear of the patient), signed the patient out against medical advice. The writer also found that in one case it was quite clear that the patient accepted his illness, and yet the wife, because of her own needs, insisted on taking the patient out against medical advice. This would seem to concur with the findings of Wertham and Kutasch and Dangrove. The writer also found that in the majority of the patients in the sample, a diagnosis of having some kind of psychosis or severe neurological disturbance had been established.

An interesting finding is the element of time. The large majority of cases were discharged after a relatively short period of hospitalization. The writer also found that the manner characteristic of this kind of a discharge was an abrupt and precipitous one.

In the main, however, the writer is forced to conclude that in this sample, factors outside of the hospital setting were responsible for the discharge against medical advice. These factors have been found to be within the patient, or the relative, or in a combination of both, rather than because of a pressing social situation as contrasted to the findings of Wertham and Tedesco.

In these cases it seemed in many instances that the
patient and the relatives are not properly prepared for the care, treatment and, in some cases, prolonged hospitalization the hospital provides for the patient. The writer would like to recommend a more proper orientation of the agencies that refer the veteran to the hospital, with reference to this specific problem, so that they may thereby make more adequate referrals on the basis of their preparation of both the patient and the relative. The writer has in mind a similar recommendation on referrals that was suggested by Fulcher and Beaseley. He would also recommend a more liberal system of leaves of absence for those cases that seemed to have a particularly difficult time of accepting the need for prolonged hospitalization. The writer feels that financial considerations and the ensuing care of the family have been given consideration by the Social Service Department, but that in these cases, the patients and relatives have been unable to use them. The writer would suggest a more complete orientation to the hospital activities for those relatives that seem to the worker to need it, with special sensitivity to the relatives who have a tendency to deny the patient's illness. A referral to the psychiatrist of those relatives whose own needs seem to overshadow the patient's needs would seem to be in order.

The outstanding difference between this study and similar studies carried out in different settings is that financial problems were not as significant here as they were
elsewhere. The relatives' attitude seemed to be the vital factor in all but the cases of voluntary admissions. The length of time hospitalized seemed to be significantly short.

This can be accounted for in part by the fact that social service is available to the relatives and financial remuneration is available in the Veterans Administration Hospital system whereas it was not in other hospitals investigated.

The fact that the writer was dealing with a predominantly psychiatric disease in a neuropsychiatric setting would also account for further differences.

The fact that in many cases prolonged hospitalization seemed indicated and the hospital facilities were available for this treatment would further tend to differentiate these findings from others.

To substantiate these findings the writer would like to suggest that another group be taken from the same hospital, who had been hospitalized during the same period of time, who went to the Continued Treatment Service. The relatives' and wives' attitudes and subsequent adjustment to the veteran's absence can then be comparatively evaluated.

Accepted:
David Landy
Research Advisor
SCHEDULE

Caseworker: ______

I. Identifying Information.

1. Name: ______________________________________

2. Registration Number: ______

3. Age: ________________________________

4. Marital Status:
   Single ( )
   Married ( )
   Divorced ( )
   Separated ( )
   Widower ( )

5. Concerned person who signed patient out A.M.A.
   Wife ( )
   Relative ( )
   Self ( )

6. Service Connected ( ) Or Not Service Connected ( )

7. Psychiatric Diagnosis: _________________________________

8. How long was patient hospitalized?
   Years ______
   Months ______
   Weeks ______
9. From what hospital service was he discharged?
   a) Acute and Intensive ( )
   b) Continued ( )
   c) Medical or Surgical ( )

    Yes ( )
    No ( )
    If Yes, how many ( )

11. Does patient accept his illness?
    Yes ( )
    No ( )

12. Worker's evaluation of concerned person.
    a) Accessible to casework help ( )
    b) Inaccessible to casework help ( )

13. Is the inaccessibility of the patient or concerned relative a factor in A.M.A. Discharges?
    Yes ( )
    No ( )

14. Is the precipitating incident amenable to casework help? ( )
    Unamenable to casework help? ( )

15. Has either patient or concerned person been made aware of solutions other than A.M.A. Discharge?
    Yes ( )
    No ( )
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