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A study of veterans readmitted to Nichols Veterans Administration Hospital, Louisville, Kentucky, after having been discharged "improved" and received "maximum hospital benefits" from April through December, 1946.

Jeanne LaCourse
University of Louisville

UNIVERSITY OF LOUISVILLE

A STUDY OF VETERANS READMITTED TO NICHOLS VETERANS ADMINISTRATION HOSPITAL, LOUISVILLE, KENTUCKY, AFTER HAVING BEEN DISCHARGED "IMPROVED" AND RECEIVED "MAXIMUM HOSPITAL BENEFITS" FROM APRIL THROUGH DECEMBER, 1946.

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APPROVED BY READING COMMITTEE COMPOSED OF FOLLOWING MEMBERS:

Grace B. Caswell

Robert I. Kutak

Mathilda Mathisen

ACTING DEAN: Mathilda Mathisen

DATE: MAY 15, 1947

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INTRODUCTION

INTRODUCTION

This is a study of patients readmitted to Nichols Veterans Administration Hospital in Louisville, Kentucky during the period of April through December of 1946. This particular project was undertaken because on general observation, there appeared to be an unusual number of patients being readmitted to the hospital after having received "maximum hospital benefits" at a previous hospital admission and having been discharged "improved". To bear out this observation, a sample study was made over a ten day period and it was found that 14 percent of all the patients being admitted were readmissions. Since this was true, the question arose as to why so many patients sought readmission.

Normally, there are many deterrents to hospitalization. Ruth Emerson in Doctor Bachmeyer's book, The Hospital in Modern Society, says, in speaking of the dilemma of being a hospital patient, "hospital organization robs him of his individuality and personality and makes him merely a 'case'".[1] This is one of the

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[1] Arthur Bachmeyer and Gerhard Hartman, The Hospital in Modern Society, (New York: The Commonwealth Fund, 1943), p.

reasons why one does not seek admission to a hospital without real cause. Another drawback to hospitalization is that one must separate himself from his loved ones and often becomes economically dependent upon them or some social agency. Probably the matter which disturbs most patients more than any other is that of employment. There is always the question of whether the employer will pay him any wages while hospitalized or whether he will be fired.

Most persons considering hospitalization have an additional worry with regard to cost. However, the veteran is relieved of this particular worry since his hospitalization is free. Another area in which hospitalization may be desirable to the veteran is in the matter of the reevaluation of his medical condition. This reevaluation often means the acquisition of or the increase in government benefits.

With these thoughts in mind, the writer was interested in studying the cases of patients who returned to the hospital two, three and even four times over the short period of nine months, after having been discharged "improved" and having received "maximum hospital benefits". The writer wondered if the reason for this could be based upon the patient's inability to adjust to civilian

life. Therefore, the study was made to determine if these patients had anything in common which might point to some of the causes for the readmission.

ADMISSION POLICY AT NICHOLS HOSPITAL

Since we are concerned with the admissions and readmissions of hospital patients, the admission policy at Nichols Veterans Administration Hospital will be summarized herein. The reason for condensing this material is that it is extremely lengthy as found in the Manual of Regulations and Procedures of the Veterans Administration.[1] If a veteran requires hospitalization, he must file an Application for Hospitalization or Domiciliary Care, known as Form P-10. This application must be notarized and is necessary in all cases except emergencies. Nevertheless, the form is filed at the time that the emergency case is being admitted.

> The Veterans Administration is authorized to furnish hospital treatment or domiciliary care (including medical care if indicated):
>
> (1) To veterans of all wars, including members of the Women's Army Corps and Women's Reserves.
> (2) To veterans of peacetime service who were honorably discharged for disability incurred in line of duty, or who are in receipt of pension for service-connected disability.
> (3) To certain veterans of nations allied with the United States during World War I when such treatment is authorized by their home governments.[2]

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[1] Veterans Administration Manual of Regulations and Procedures, "Medical and Hospital Service", Section 6017-6049.

[2] American Red Cross SAF Handbook, 8.2.17.

In addition to these groups, persons needing emergency treatment or veterans who do not fit into any of the above categories may be treated in Veterans Hospitals. However, the order of acceptance of patients is 1) emergencies, 2) veterans with service-connected disabilities and 3) other veterans.

At the present time, Nichols Veterans Administration Hospital is able to care for all applicants in the "service-connected" category and emergencies. The non-service-connected applicants who cannot immediately be accommodated are placed on a waiting list and their order of acceptance is on a medical basis determined by the Clinical Director or the Chief of Reception, both of whom are physicians.

The admission policy at a Veterans Hospital is quite liberal as compared to civilian hospitals, public or private. This is because financial eligibility and residence requirements need not be considered. Another factor influencing this liberalism is the general feeling especially so soon after the war, that the veteran is "deserving". In the matter of residence, veterans from the area known as Branch number six, including Michigan, Ohio, Southern Indiana and Kentucky are accepted for hospitalization. If beds are available, veterans from any other Branch will be admitted. An effort is made by the Veterans Administration to place the patients as close to their homes as possible,

and at any time patients may request a transfer.

Veterans Administration Hospitals are classed as Tuberculosis, Neuropsychiatric and General Medical and Surgical. Nichols Hospital is of the latter classification but as such it includes medical, surgical, tuberculosis and neuropsychiatric services. At Nichols Hospital, as most other Veterans Hospitals, there is bed space for white and Negro, male and female patients. There are not enough women patients at this hospital to warrant a separate ward so they are placed in private rooms. For Negro patients there are two medical and two surgical wards. Negroes requiring hospitalization for tuberculosis are placed in private rooms on the Tuberculosis Wards, but there is no racial segregation on the Neuropsychiatric Service. If long periods of hospitalization are necessary for the patients requiring Neuropsychiatric or Tuberculosis services, they will be transferred to Veterans Administration Hospitals established specifically for that type of case.

A HISTORY OF NICHOLS HOSPITAL

With the ending of hostilities and the speeding up of demobilization the Veterans Administration found itself with an overwhelming amount of work. Under Public Law 293 as passed by the Seventy-ninth Congress of the United States, the Department of Medicine and Surgery of the Veterans Administration inaugurated a new program of medical care. "Numerous temporary Army and Navy hospitals are being utilized to supplement capacity of existing Veterans Administration hospitals until construction of the new Veterans Administration hospitals can be completed."[1] Nichols Hospital at Louisville, Kentucky falls into this category since it had been a temporary Army hospital from April 15, 1946 until it was converted into a Veterans Administration hospital. And like all such hospitals housed in temporary structures, Nichols will move to a new location as soon as the building can be completed.

According to Veterans Administration standards, these "Hospitals yet to be built are being designed to conform to modern standards, and whenever possible are located close to medical centers."[2] There was much debate in Louisville as to whether the structure should be erected

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[1] Annual Report of the Administrator of Veteran's Affairs (Washington: United States Government Printing Office, 1947), p. 3.

[2] Ibid.

in the downtown area near the city hospital and the University of Louisville Medical School or in an outlying district which had been offered to the Veterans Administration for this purpose. The final decision which came from General Omar Bradley was in favor of the less centrally located area because it would mean less expense and more rapid construction.

Nichols Veterans Administration Hospital opened on April 15, 1946 and by the end of April, 128 patients had been admitted. The total patient load on December 31, 1946 was 542. During this time there were 4,208 patients including readmissions who had entered the hospital. The aim of the administration was to have eventually, a 1000 bed hospital. The services offered at this hospital other than Medical and Surgical are Neuropsychiatric, Tuberculosis, Dental. Probably the most unusual of all departments within the hospital is that of Physical Medicine. It is under the guidance of a physician and includes Medical Rehabilitation, Corrective Physical Rehabilitation, Educational Retraining, Physical Therapy, Shop Retraining and Occupational Therapy. Other services within the hospital and giving direct benefit to the patient are the Special Services and the Contact Office. The only services not functioning during this nine-month period were the Convalescent

Ward of the Neuropsychiatric Department and the office of Vocational Advisement.[1]

Since one area of this thesis deals with the Social Service Department, let us say a word about its development. According to a narrative report by the Chief Social Worker which covered the period of April 22, 1946 to January 1, 1947, during the first three months of its existence, the department carried on a program of interpretation to divisions within the hospital and to outside agencies with whom Social Service would be working. This department started with a staff consisting of the Chief Social Worker, two Medical Social Workers and one secretary but by December, two more workers and a secretary had been added. However, with the number of patients increasing, it was not possible for the Social Service Department to give complete coverage to all wards. Because of the pressure of work, a system was devised whereby briefer services (covering only one month's activity), not involving intensive social case work could be recorded on 5x8 cards. All other cases followed the prescribed outline in recording and were thus filed in folders.

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[1] Report from the Manager of Nichols Veterans Administration Hospital for December 31, 1946.

METHOD OF RESEARCH AND SCOPE OF STUDY

It was quite evident to all of the workers in the Social Service Department that during the short period that the hospital was open, there were a great many readmissions. This was noted on the daily admission sheets which were reviewed by the workers each morning. When this matter was brought to the attention of the writer, a sample study was made of the readmissions over a ten day period in January 1947 since those admission sheets were readily available. The result of this showed that 14 percent of all patients being admitted were readmissions. In order to make a thorough study of readmissions, it would be necessary to read records of these patients. For this reason, permission was obtained from the proper Veterans Administration authorities.

The writer is interested in studying the records of patients being readmitted to Nichols Hospital after having been discharged "improved" and having received "maximum hospital benefits" to determine what elements may be found common to many of them. Therefore, those patients requested to return for further treatment or re-evaluation, or those who left the hospital "against medical advice", or who were "absent without leave" will not be included. Neither will the patients be included who are hospitalized while the survey is being conducted, because such records would not be available for study. Some of the periods of hospitalization extended into 1947

and may be mentioned in the write-up but will not be included in the tables.

The data secured consists of five types of information regarding the readmitted patient. The first area covered the identifying information about the patient and his family, including such items as age, race, sex and marital status. The second type of information covered the patient's service record such as branch of service, rank, discharge and pension data. The employment information as found in the third section showed the patient's pre-war and post-war occupations as well as his employment between hospital admissions. The fourth type of information related to the medical situation while the patient was hospitalized and included each readmission. The last and fifth type of information covered in this study was about the contacts which the hospital Social Service Department had with the patient and specifically whether or not post-discharge plans were made.

Since there was no statistical report of readmissions, the admission sheets over the period of April through December of 1946 were checked. This particular period was chosen because Nichols Hospital was converted from an Army to a Veterans Administration Hospital in April of 1946. (A brief account of this change will be

found in the chapter titled A History of Nichols Hospital). With the list of readmissions compiled, it was applied to the Master File of the Social Service Department so that the number and type of social service records on these readmissions would be known. Each readmission was then given a code number to be used on the schedule in place of the patient's name.

The schedule[1] was drawn up and tested against ten of the cases. Although many of the items were not found on all of the records, these items were kept in the event that from the entire group a significant number might be found. In reviewing the records for the purpose of filling in the schedule, a number of the cases were omitted for various reasons. For example, many of the patients had been requested to return for a further study, an operation or dentures and such facts could not have been determined from the admission sheets. Another cause for omissions was the fact that some patients had been discharged "unimproved". There were probably a few readmissions which were not reported on the admission sheets and therefore not included in this study.

After completing the schedules, the information found therein was tabulated on a master sheet. From this sheet, the tables

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[1] Appendix B.

as found in the thesis were taken. The tables were made out according to actual numbers and in many cases the percentages also were given. All percentages were rounded off to the nearest whole number. The only item of importance not tabulated on the master table was the actual diagnosis, but a table of the diagnosis for each case will be found in the study as will a table of occupations.

The many limitations found in gathering the material for this study should be mentioned here. First of all, the schedule was drawn up from the information which the writer knew could be found in the records. Because of this and the fact that the records were the only possible source of information for all patients, any information which might have been of interest but was not included in the records was not considered. It was also noticed from the outset that although the doctors and social workers who furnished the information on most of the records followed a definite outline, there was much variety in recording, which of course is to be expected. A great deal depended not only on individual differences, but also the patient's ability and willingness to express himself. Also, in a few of the cases, the complete Clinical Record was not available.

One cannot overlook the fact that this study was made during the first nine months of a newly established hospital. Policies were

being made and probably more pertinent, new personnel were learning the hospital set-up and their new jobs. The Social Service Department like many other departments within the hospital did not have sufficient personnel and was under great pressure. And we can assume that with an adequate staff, a much larger percentage of readmissions would have been covered by the Social Service Department.

This was a pioneer study in a new field and for that reason could not be compared to any similar studies. In searching for material on the subject, the writer surveyed the card catalogues of the University of Louisville Library and the library of the University of Louisville Medical School. The catalogues to current periodicals were also used. As a final source for bibliographic material, the writer requested any suggestions from the American Medical Association, the Association of Modern Hospitals and the American Hospital Association. The latter group was the only one to respond and did so through the Bacon Library, an organ of that association. The librarian forwarded the study, Medical Care of the Discharged Hospital Patient[1] by Jensen and others and she said that it was the only study known to her that was even related to the writer's topic. The Jensen study was made with

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[1] Frode Jensen, H. G. Weiskotten and Margaret Thomas, Medical Care of The Discharged Hospital Patient, (New York: The Commonwealth Fund, 1944).

regard to an experiment at a University Hospital to have an Extramural resident to give medical care to discharged hospital patients. The study was helpful for background material but could not be applied directly to this thesis.

CHAPTER I

IDENTIFYING INFORMATION

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IDENTIFYING INFORMATION

The scope and method of the study and the necessary background material has been presented in the preceding sections and we shall now analyze the data obtained. The original number of hospital readmissions as taken from the admission sheets was 208 but the final figure as used in the study was 135. This decrease is the result of many factors, as previously mentioned. That is, some of the readmissions had been requested, some had been discharged "against medical advice" or had been "absent without leave" and required rehospitalization. Still another group had been discharged with "maximum hospital benefits" but were "unimproved" and therefore not considered for this thesis. Taking 135 as the total number of veterans readmitted to Nichols Veterans Administration Hospital from April 15, 1946 through December 31, 1946, after having been discharged "improved" and received "maximum hospital benefits", the percentage of readmissions was three percent.

The statistical material regarding the race and marital status of this group of readmissions may be found in Table I. Of the 135 patients studied, 121 were white and 14 were Negro.

In other words, 12 percent were Negro. As a basis of comparison, the monthly Negro and white admissions were checked over the same nine month period. It was interesting to note that here, too the Negroes numbered 12 percent of all admissions.

TABLE 1

RACE AND MARITAL STATUS OF THE VETERANS READMITTED TO NICHOLS VETERANS ADMINISTRATION HOSPITAL, LOUISVILLE, KENTUCKY AFTER HAVING BEEN DISCHARGED "IMPROVED" AND RECEIVED "MAXIMUM HOSPITAL BENEFITS" FROM APRIL THROUGH DECEMBER, 1946.

	White	Negro	Total
Total	121	14	135
Married	58	8	66
Single	38	5	43
Divorced	18	0	18
Separated	6	0	6
Widowed	1	1	2

The marital status of the 135 readmitted hospital patients studied for this thesis is found in Table 1 according to race. The distribution in this table does not seem unusual, except that there

are so few Negroes, it is difficult to compare the two races with regard to marital status. In the Negro group, there was no one either divorced or separated, but this undoubtedly was due to the fact that there was such a small representation from that race. Because there were so few Negroes, it was not felt that the marital status percentages for that race would be valid.

Of the total number studied, 66 were married and 43 were single. 58 patients or 48 percent of the white race were married and 38 patients or 31 percent were single. Of the Negroes, eight were married and five were single. 18 of the white patients were divorced, six were separated and one widowed as was one Negro. In view of the fact that there were 30 patients 50 years of age or over, the figure of only two persons widowed is quite unusual.

Table 2 was set up as a basis of comparison between the white patients studied and the white males in Kentucky according to marital status.[1] In the Census Report, 63.4 percent was married and 30.9 percent was single while 48 percent of the studied group was married and 31 percent was single. The percentage of single males in Kentucky and in the group studied was approximately the

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[1] Sixteenth Census of the United States: 1940. Population: Kentucky, IV, 10. Washington: Government Printing Office, 1943.

same but the percentages of those married differed by about 15. In other words about 15 percent more of the group studied was in the category of divorced, separated or widowed. Knowing that only one was a widow, we assume that 15 percent more than the average in Kentucky had not adjusted to married life.

TABLE 2

COMPARATIVE PERCENTAGES OF THE MARITAL STATUS OF WHITE MALES IN KENTUCKY AND THE VETERANS READMITTED TO NICHOLS VETERANS ADMINISTRATION HOSPITAL, LOUISVILLE, KENTUCKY AFTER HAVING BEEN DISCHARGED "IMPROVED" AND RECEIVED "MAXIMUM HOSPITAL BENEFITS" FROM APRIL THROUGH DECEMBER, 1946.

Marital Status	Study	Census
Married	48%	63.4%
Single	31%	30.9%

The age distribution of the patients readmitted to Nichols Veterans Administration Hospital after having been discharged "improved" and received "maximum hospital benefits" is in Table 3. It was set up at intervals of ten years and ranged from an item labeled "less than 20" to one called "70 or over". Only three of the patients were less than 20 years of age and two of them were over

70 years old. The ages of five of the veterans were unknown. The largest group of patients was centered in the interval of 20 to 29 years and numbered 51. The average age was found to be 37 years while the median was 34.4 years. One also notices in the age distribution table that the number of veterans between the ages of 40 and 50 drops to 15 and then increases to 24 veterans between the 50 and 60 interval. This undoubtedly is due to the period of peace between 1918 and 1941. The persons "in their 40s" were often too young for World War I and too old for World War II. This is not true in every case, but does account for some of the decrease at that particular interval.

TABLE 3

AGES OF THE VETERANS READMITTED TO NICHOLS VETERANS ADMINISTRATION HOSPITAL, LOUISVILLE, KENTUCKY AFTER HAVING BEEN DISCHARGED "IMPROVED" AND RECEIVED "MAXIMUM HOSPITAL BENEFITS" FROM APRIL THROUGH DECEMBER, 1946.

Years	Veterans
Total	135
Under 20	3
20-29	51
30-39	31
40-49	15
50-59	24
60-69	4
70 or over	2
Unknown	5

CHAPTER II

SERVICE INFORMATION

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SERVICE INFORMATION

Since this study deals with servicemen rehospitalized at a Veterans Hospital, it is imperative that we take into account some information regarding their service. Table 4 shows the distribution of veterans by branch of service and period of war, in order to present a clearer picture of the group studied.

TABLE 4

BRANCH OF SERVICE AND PERIOD OF WAR OF THE VETERANS READMITTED TO NICHOLS VETERANS ADMINISTRATION HOSPITAL, LOUISVILLE, KENTUCKY AFTER HAVING BEEN DISCHARGED "IMPROVED" AND RECEIVED "MAXIMUM HOSPITAL BENEFITS" FROM APRIL THROUGH DECEMBER, 1946.

	World War II	World War I	Span. Amer.	Total
Total	98	32	5	135
Army	72	32	5	111
Navy	20	0	0	20
Marine Corps	3	0	0	3
Army Air Corps	2	0	0	2
Navy Air Corps	1	0	0	1

Of the 135 veterans, 98 served in World War II, 32 in World War I and five were in the Spanish American War. Speaking in terms

of percentages, 73 percent were veterans of the Second World War, while 24 percent were veterans of the First World War and the remaining three percent were veterans of the Spanish American War.

By far the greatest number of the veterans readmitted to the hospital had served in the United States Army. The grand total of Army veterans was 111 or 82 percent of 135. It was also found that all of the veterans from World War I and the Spanish American War were in the Army. There were no other servicemen from those two periods of war in the group studied. Of the 135 veterans, 20 had served in the Navy, three in the Marine Corps and three in the Air Corps of the Army and Navy during World War II.

Table 5 is a presentation of the distribution of the length of time that each veteran spent in the service and is based on an interval of five months. The largest number of veterans served from nine to 43 months. The average number of months of service for each veteran among the readmissions studied was 27 and the median was 26.7 months. Because it was not possible to get an accurate estimate of the length of overseas service for all of the patients, this item was eliminated from the study.

TABLE 5

LENGTH OF SERVICE BY PERIOD OF WAR OF VETERANS READMITTED TO NICHOLS VETERANS ADMINISTRATION HOSPITAL, LOUISVILLE, KENTUCKY AFTER HAVING BEEN DISCHARGED "IMPROVED" AND RECEIVED "MAXIMUM HOSPITAL BENEFITS" FROM APRIL THROUGH DECEMBER, 1946.

Months of Service	World War I	World War II	Span. Amer.	Total
Total	31	98	4	133*
Under 5	2	4	1	7
5-9	5	9	1	15
10-14	10	5	1	16
15-19	3	7	0	10
20-24	5	9	0	14
25-29	4*	11*	0	15
30-34	1	13	0	14
35-39	1	13	0	14
40-44	0	14	0	14
45-49	0	3	0	3
50-54	0	2	0	2
55-59	0	5	0	5
60-64	0	2	0	2
65-69	0	0	0	0
70 or over	0	1	1	2

*Two of the veterans served during two different periods of war and the number of months served by each was totaled, thus making the total for all, 133 instead of the usual 135.

There were only four veterans who served less than three months. Two from the total number were in the service for more than 70 months, one being a veteran of the Spanish American War and the other World War II. There was a definite drop in the length of service above the period of 44 months. The total number in service between 45 and 70 or more months was 14. Because the average length of service was only 27 months, the writer did not feel that it was long enough a time to have a direct bearing on the veterans' adjustment to civilian life.

However, something which did appear to have more significance in the matter of the type of person being readmitted to the hospital was that of the veterans' ranks while in service. These data are tabulated in Table 6. Because of the variation of names between the Army and the Navy ranks, it was necessary to set up a chart of comparative ranks. This chart progresses from the lesser ranks (Private and Apprentice Seaman) to the highest ranks (Commissioned Officers) and has as the symbols to signify these ranks, the Arabic numerals one through nine. The greatest number of veterans in a single rank or 38 percent were in the lowest category. 86 percent of the entire group of 135 were in one of the first four ranks. Only three of them held the rank of a commissioned officer and in four of the cases the rank was unknown.

TABLE 6

RANK IN SERVICE OF THE VETERANS READMITTED TO NICHOLS VETERANS ADMINISTRATION HOSPITAL, LOUISVILLE, KENTUCKY AFTER HAVING BEEN DISCHARGED "IMPROVED" AND RECEIVED "MAXIMUM HOSPITAL BENEFITS" FROM APRIL THROUGH DECEMBER, 1946.

Rank*	Veterans
Total	135
1	51
2	27
3	25
4	13
5	8
6	2
7	2
8	0
9	3
Unknown	4

*COMPARATIVE RANKS OF THE ARMY AND NAVY AS USED IN THE ABOVE TABLE

Army		Navy
Private	1	Apprentice Seaman
Private First Class	2	Seaman or Fireman Second Class
Corporal or T/5 Grade	3	Seaman or Fireman First Class
Sergeant or T/4 Grade	4	any Third Class rank
Staff Sergeant or T/3 Grade	5	any other Second Class rank
Technical or First Sergeant	6	First Class Petty Officer
Master Sergeant	7	Chief Petty Officer
Warrant Officer	8	Warrant Officer
Commissioned Officer	9	Commissioned Officer

Table 7 gives the number and percentages of the service-connected status of the veterans readmitted to Nichols Hospital from April through December of 1946. 30 of the patients had service-connected disabilities, one was unknown and the remaining 104 were in the non-service-connected category. In terms of percentages, 77 percent were non-service-connected and 22 percent were service-connected. These percentages as compared to the total veteran group in the United States appear to be average.

TABLE 7

SERVICE-CONNECTED STATUS BY NUMBER AND PERCENTAGE OF THE VETERANS READMITTED TO NICHOLS VETERANS ADMINISTRATION HOSPITAL, LOUISVILLE, KENTUCKY AFTER HAVING BEEN DISCHARGED "IMPROVED" AND RECEIVED "MAXIMUM HOSPITAL BENEFITS" FROM APRIL THROUGH DECEMBER, 1946.

Status of Readmissions	Veterans	Percentage
Total	135	100
Service-Connected	30	22
Non-Service-Connected	104	77
Unknown	1	1

Table 8 deals with the disability pension status of the readmitted veterans. It might be said at the outset that all

benefits have been rounded off to the nearest 10 percent for purposes of this study. Approximately 50 percent of the total or 68 patients were receiving government benefits. The largest number of patients receiving any one type of benefit was 17 with a 10 percent disability. There were 14 patients in the group studied who were getting a 30 percent government benefit. Only six of the patients were receiving the 100 percent one and no one had either an 80 or a 90 percent disability. It was interesting to see that 78 percent of all the patients receiving government benefits were in the categories below 60 percent. In other words, of that 78 percent, no one was receiving any more than $69.00 a month from the government.

TABLE 8

DISABILITY PENSION STATUS OF VETERANS READMITTED TO NICHOLS VETERANS ADMINISTRATION HOSPITAL, LOUISVILLE, KENTUCKY AFTER HAVING BEEN DISCHARGED "IMPROVED" AND RECEIVED "MAXIMUM HOSPITAL BENEFITS" FROM APRIL THROUGH DECEMBER, 1946.

Pension		Veterans
Percentage of disability	Amount	
10	$ 13.80	17
20	27.60	7
30	41.40	14
40	55.20	7
50	69.00	8
60	82.80	2
70	96.60	2
80	110.40	0
90	124.20	0
100	138.00	6
No pension		67
Total		135

CHAPTER III

OCCUPATIONAL INFORMATION

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OCCUPATIONAL INFORMATION

Probably the most interesting and significant data gathered to this point about the readmitted patients studied were those relating to occupations. There were, of course, various types of employment ranging from a billiard room attendant to a deputy sheriff. However, because there were so many occupations covered by the entire group and they could not readily be tabulated, the complete list will be found in the Appendix. In order to show the different kinds of occupations, the data were classified under the eleven main divisions used by the United States Census Bureau. These categories plus the three additional ones of "student", "unemployed" and "unknown" make up the headings for the table regarding occupation. It is divided into the three main topics of before and after the war and between hospital admissions.

Of the pre-war occupations, the distribution was approximately 19 percent among the four most common categories; namely, farmers, craftsmen, operative workers and laborers. Three patients were of the professional group and one veteran was a proprietor.

TABLE 9

OCCUPATIONS BEFORE AND AFTER SERVICE AND BETWEEN HOSPITAL ADMISSIONS OF THE VETERANS READMITTED TO NICHOLS VETERANS ADMINISTRATION HOSPITAL, LOUISVILLE, KENTUCKY AFTER HAVING BEEN DISCHARGED "IMPROVED" AND RECEIVED "MAXIMUM HOSPITAL BENEFITS" FROM APRIL THROUGH DECEMBER 1946.

	Pre-War		Post-War		Between Hospital Admissions	
	No.	Percent	No.	Percent	No.	Percent
Total	135	100	135	100	135	100
Professional and Semi-Prof.Workers	3	2	4	3	2	2
Farmers and farm managers	26	19	15	11	6	5
Proprietors, managers, etc.	1	1	0	0	2	2
Clerical, sales and kindred workers	10	7	9	7	8	5
Craftsmen, foremen and kindred workers	25	19	26	19	13	9
Operative and kindred workers	26	19	24	18	18	13
Domestic and service workers	0	0	0	0	0	0
Protective workers	2	2	4	3	2	2
Service workers	5	4	9	7	4	3
Farm laborers and foremen	0	0	0	0	0	0
Laborers	25	19	13	9	7	5
Student	8	5	3	2	0	0
Unemployed	4	3	24	18	27	20
Unknown	0	0	4	3	46	34

There were no domestic workers or farm laborers but all of the 135 occupations were known. Ten of the veterans were clerical workers, two protective workers and five service workers. Before the war, eight of them were students and only four were unemployed.

The employment picture for this same group of patients after they had served in the war was somewhat different. Of the total number, the occupation for four of the group was unknown. The number of those unemployed was 24 or 18 percent of 135 and included in this group were a few veterans from World War I. The student group had dropped to three persons, all of whom were World War II veterans. The four principal occupations of the pre-war period carried over to the post-war period with some changes. The laborers had decreased to 13 as compared to the pre-war 25. The farmers also dropped a considerable number; from 19 to 11 percent. The operative workers went down by only two after the war and the craftsmen stayed at the same, 19 percent. The professionals had increased from three to four, and the clerical workers went from nine to 10 persons. The protective workers had increased by two and there were still no

veterans working as domestics or farm laborers. Although many of the patients listed farming as their occupation, there was some doubt in the writer's mind that they were all farm owners or managers, but there was no way of determining this from the patients' statements. Protective workers and service workers increased respectively from two to four and from five to nine workers.

The last section of Table 9 is in regard to the occupations of the readmitted patients between hospitalizations. One point which lessens the validity of this section is that 34 percent of the occupations were unknown. The reason that there were so many unknown was that on readmission the patient would often state his usual occupation but it would later be found in the hospital chart that the patient was unable to work between admissions or such an implication would be made. Therefore, more veterans were unemployed between admissions than the number who claimed to be. In view of the fact that the remaining 66 percent of known occupations showed some trends, they were used in this table.

Again for this period, there were no domestic workers

or farm laborers and added to this group with no representation was the item, "student". The laborers continued their downward trend from 13 to seven workers.

There were two protective and four service workers, and although this was a decrease from that of post-war employment, this might be accounted for by the large number of unknown occupations. The three largest categories, farmers, craftsmen and operative workers also showed a decrease which might in the same way be accounted for by the lack of information on 34 percent of the patients. The decrease in farmers had gone from 15 after the war to six between admissions; craftsmen from 26 to 13; and operative workers from 24 to 18 workers. The number of clerical workers had decreased only by one making eight of that type of worker. Two of the group were proprietors and two were professional workers. The only marked increase in any of the items was the unemployed which went to 27 patients or 20 percent of the total.

Looking at Table 9 as a whole, one sees that the occupations most frequently reported consisted of farmers, craftsmen,

operative workers and laborers. We might make the generalization that as a rule, one does not require a formal education to perform the duties of the four most common types of employment found in this table. It is also interesting to note that the craftsmen and operative workers who require more skill and who usually receive more adequate pay remained fairly static. The same was true of clerical workers. The only exception to this was in the period between admissions where there were so many unknown occupations, the real picture was not shown. On the other hand, the laborer and the average farmer may have, but does not necessarily need preparation for work and usually learns by experience.

The item on unemployment in Table 9 is the most significant because it shows a steady and marked increase. Before the war there were only four of the group studied that were unemployed. The number went up to 24 after the war and there were 27 veterans who stated that they were unemployed between hospital admissions. As noted in the many hospital records, some of the veterans gave their "usual" type of employment as their occupation, but actually did not work between hospital admissions. If these same patients were "improved" and had received "maximum hospital benefits", why were they unable to return to their former employment?

CHAPTER IV

HOSPITAL INFORMATION

CHAPTER IV

HOSPITAL INFORMATION

In this chapter, the information regarding the hospitalization and medical condition of the patients studied will be analyzed. Before studying the table that deals with the diagnoses, a word must be said about the length of time spent in the hospital and between hospital admissions. The averages were taken from the 135 cases studied. The average length of the first admission was 29 days and the average length of time between the first and second admission was 59 days. The length of the second hospital stay was of a somewhat shorter duration and averaged 25 days. Between the second and third admission, the average length of time was shorter than that between the first and second admission and equaled 56 days. The average of the length of the third admission was calculated from only 21 cases and was 20 days. There was a steady drop in the length of each period of hospitalization from 29 days at the first admission to 20 days at the third. However, there was also a decrease in the average length of time between admissions.

As a means of comparison for the averages of the length

of the period for hospitalization of the patients studied, the statistics for the total Veterans Administration were found. For patients with general medical and surgical ailments, the average length of stay had gone from 37 days in 1945 to 31.4 days in 1946.[1]

The information regarding the medical reasons for which the patients were admitted to Nichols Veterans Administration Hospital will be found in Table 10. Each diagnosis or type of illness is listed according to its frequency and for purposes of clarity, only the principal diagnosis is considered in this study. Because there were so many varieties of conditions which appeared for only one patient, these were grouped together in the item known as "miscellaneous". For a more detailed picture of the admission diagnoses, a chart of the diagnoses of each case will be found in the Appendix.

It is interesting that of the 135 patients studied, 101 had the same diagnosis on each readmission as on the first admission. The remaining 34 patients had a different diagnosis on a

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[1] Annual Report of Administrator of Veterans' Affairs (Washington: Government Printing Office, 1947), p. 8

TABLE 10

DIAGNOSES OF VETERANS READMITTED TO NICHOLS VETERANS ADMINISTRATION HOSPITAL, LOUISVILLE, KENTUCKY AFTER HAVING BEEN DISCHARGED "IMPROVED" AND RECEIVED "MAXIMUM HOSPITAL BENEFITS" FROM APRIL THROUGH DECEMBER, 1946.

Diagnosis	First Admission	Later Admission*	Total
Total	135	34	169
Malaria	17	0	17
Heart	14	0	14
Anxiety State	9	2	11
Ulcer	9	1	10
Arthritis	7	3	10
Hernia	6	3	9
Alcoholism	5	3	8
Dermatitis	6	1	7
Fractures	4	3	7
Abscess	4	2	6
Appendicitis	3	2	5
Gastro-Intestinal	5	0	5
Sinusitis	5	0	5
Nasopharyngitis and Otitis	4	0	4
Asthma	3	1	4
Other Neuro-psychiatric	3	1	4
Urethral Condition	4	0	4
Strain and Sprain	1	2	3
Bronchitis	2	0	2
Diabetes	2	0	2
Miscellaneous	21	10	31

*All readmissions diagnoses were for the same as at the first admission, but where the diagnosis differed at a later admission it was listed under the column labeled "Later Admissions".

later admission, either second or third. The information about these 34 diagnoses will be found in the second column of Table 11 and in the chart of Diagnoses. The greatest number of admissions for the same diagnosis was 17 for malaria. Of the 17 malarial fever patients, all subsequent admissions were for the same condition. The next highest number of admissions for a single diagnosis was 14 heart conditions and in these cases also, all later admissions were for the same condition. Nine of the patients were diagnosed as having an anxiety state on the first admission and two of the other patients were given that diagnosis on readmission. The next highest neuropsychiatric diagnosis with a total of eight cases was alcoholism. Of this group, five were alcoholic at the first admission and three others received that diagnosis at a later admission. There were only four other neuropsychiatric conditions listed, three of which were diagnosed when the patient was first admitted to the hospital. Therefore, the total number of all neuropsychiatric diagnoses in the group studied was 23.

On first admission to the hospital, there were nine cases diagnosed as having an ulcer, most of which were duodenal. Only

one ulcer diagnosis was made at a later admission. The total number of patients with arthritis was 10, of which seven were diagnosed on the first admission and three later. Nine hernia cases were admitted to the hospital, six the first time and three at a later admission. Of the patients studied, there were seven cases each with the diagnosis of dermatitis and of fractures, while a total of six had abscesses. There were five admissions each of appendicitis, gastro-intestinal conditions and sinusitis. Nasopharyngitis and otitis was found as the diagnosis of four of the patients on first admission, as were urethal conditions. A total of four patients suffered asthma. Three of the cases had strains and sprains and two had bronchitis, while another two had diabetes. The remaining diagnoses are all listed as miscellaneous because they do not appear in a sufficient number to be tabulated.

On the whole, the diagnoses found among the studied group of readmissions were of a chronic nature, such as malaria, heart, ulcers, arthritis, asthma, sinusitis and neuropsychiatric conditions. Because of this, one would naturally expect exacerbations and recurrences of the illnesses but not so frequently and over such a brief period as was true of the studied group. Adequate

care, a healthy state of mind and emotional stability are all tied up with continued good health. We recognize the close correlation between the emotional phases of one's life and one's physical condition. This will be pointed out in discussing some of the specific diagnoses of the readmitted patients.

Malaria is of a recurrent nature and for that reason, one might expect that such patients would have to return to the hospital when they had an attack. There is some question as to how much a general run-down condition is related to an exacerbation of this disease. In a few of the cases it was known that the patient had ceased taking the prescribed Atabrine as a preventive measure.

Recognizing the seriousness of a heart condition, the writer would like also to point out the other factors which might have a definite effect on the readmissions of the heart cases over such a short period of time. Dr. Leonard G. Rountree in the introduction to Psychosomatic Diagnosis by Dr. Flanders Dunbar presents a good picture of illness.

> "We must avoid the concept that any disease is wholly physical or wholly mental. Rather all disease is both physical and mental and an efficient approach to its

> control must give correct weights to both factors. At various times the weight of different factors will vary. In this time of stress, mental factors may be of much greater significance than they are ordinarily."[1]

All patients with a heart condition who are discharged from a hospital are placed on a regime as a control and preventive measure. Some patients may follow such instructions religiously and still others may be unwilling or unable to do so because of a home situation. It is expected then that these patients as well as those with emotional difficulties which keep them upset will need rehospitalization.

Another common illness among the readmissions studied, was that of ulcer. This of course has long been considered a physical condition, treatable by surgery. But like all other conditions affecting a human being, ulcers also must be considered from a psychological standpoint. "The disturbances in secretion and the change in the motor activity and possibly even the alteration in the blood supply to the stomach"[2] can be laid to psychic factors. So with this in mind, if we think of the veterans returning to civilian life and finding a difficult time adjusting, it is understandable that being disturbed, they might keep their condition aggravated and thus require readmissions to the hospital.

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[1] Flanders Dunbar, Psychosomatic Diagnosis, (New York: Paul B. Hoeber, Inc., 1943), pp. vii-viii.

[2] Edward Weiss and O. Spurgeon English, Psychosomatic Medicine, (Philadelphia: W. B. Saunders Company, 1943), p. 251.

CHAPTER V

SOCIAL SERVICE INFORMATION

CHAPTER V

SOCIAL SERVICE INFORMATION

"Few if any serious students of hospital administration would at this time take issue with the statement that medical social service has attained the status of a major department in the hospital."[1] As a major unit of the hospital and as the department with one of the best opportunities of seeing the patient both in the hospital setting and as a functioning member of society, Social Service's part in the care of the patients studied will be considered. First, let us see how many of the readmitted patients were known to this department during any of the periods of hospitalization.

Table 11 shows that only 41 patients or 30 percent were known to the Social Service Department and of these, 16 were given extensive case work services. But here is an example of how statistics do not give the complete story. Because of the pressure of work on the social workers, they gave case work services to the patients in as many cases as they were able and for that reason, recording was at a minimum. In other words, these figures do not actually show all of the services given by the Social Service Department.

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[1] G. O. Whitecotton, "Medical Social Service The Secret is Liaison", from an address given at the annual convention of the American Hospital Association in Philadelphia, September 30 - October 3, 1946.

TABLE 11

CASES KNOWN TO THE SOCIAL SERVICE DEPARTMENT AND TYPE OF SERVICE GIVEN THE VETERANS READMITTED TO NICHOLS VETERANS ADMINISTRATION HOSPITAL, LOUISVILLE, KENTUCKY AFTER HAVING BEEN DISCHARGED "IMPROVED" AND RECEIVED "MAXIMUM HOSPITAL BENEFITS" FROM APRIL THROUGH DECEMBER, 1946.

	Patients	Type of Case	
		Brief	Extensive
Not Known to the Social Service Dept.	94		
Known to the Social Service Dept.	41	25	16
Total of Readmissions	135		

TABLE 12

SOURCES OF REFERRAL AND REASONS FOR REFERRAL TO THE SOCIAL SERVICE DEPARTMENT OF THE VETERANS READMITTED TO NICHOLS VETERANS ADMINISTRATION HOSPITAL, LOUISVILLE, KENTUCKY AFTER HAVING BEEN DISCHARGED "IMPROVED" AND RECEIVED "MAXIMUM HOSPITAL BENEFITS" FROM APRIL THROUGH DECEMBER, 1946.

Reason	Doctor	Other*	Patient	Outside	Routine	Total
Employment	2	0	0	0	0	2
Financial Assistance	0	2	2	1	0	5
Home Conditions Report	4	0	0	0	0	4
Marital Difficulties	4	1	0	0	0	5
Readmissions	0	0	0	0	3	3
Social History	4	0	0	1	0	5
Social Service**	8	4	3	2	0	17
Total	22	7	5	4	3	41

*"Other" means the other departments within the hospital.
**"Social Service" is used to include all services not found in other classifications.

By far the greatest number of cases was referred to the Social Service Department by the ward doctors. Of the group included in the study, 22 of all those known to that department had been referred by physicians. Eight of these referrals were made for social service, which term is used in a wide sense to include all services not mentioned in the other categories in Table 12. Four of the referrals were for home conditions reports and four were for social histories. Still another four of the patients were directed to Social Service for discussion of marital difficulties and two others for employment.

The types of referrals to the Social Service Department were indicative of the doctors understanding of its function. In this respect, it was interesting that financial assistance was not the basis of referral for any of the patients sent by the doctors. The writer found this unusual in that so many persons associate Social Service with the Federal Emergency Relief days and therefore think of social workers as dispensers of relief. Doctor Hinenburg in his article on the evaluation of a Social Service Department spoke in terms of the acceptance of the department and the use of it by the doctors as being a criterion for evaluation. He did not overlook the fact that some of the older doctors still frowned upon Social

Service because they did not have the opportunity to learn about it and its function while in medical school.[1] However, it would appear from the number of referrals from physicians, that the Social Service Department where this study was undertaken had been well accepted by the doctors in the hospital.

To go on with the other sources of referrals, seven of the patients were referred to the Social Service Department by other departments within the hospital such as the Contact Office and Special Services. These other departments referred seven of the total number of hospital admissions. The types of referrals made were for social service, financial assistance and in one case for marital difficulties. Five of the readmitted patients had come themselves to the Social Service Department for assistance. These patients in the readmitted group requested social services and financial assistance. Four of the readmissions were referred by outside social agencies. The reasons for referrals in these cases of readmitted patients were social service, one social history and in one case it was regarding financial assistance being given the patient's family.

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[1] M. Hinenburg, "Medical Social Service Criteria for Evaluation", from an address given at the annual convention of the American Hospital Association in Philadelphia, September 30 - October 3, 1946.

The term routine as used in Table 12 means that the individual social worker had taken the initial step in exploring a situation to determine if social service was needed. This may be done either by examining the information found on the daily admission sheets or by talking with the patients while making ward rounds. Of the readmissions studied, the Social Service Department had obtained only three in a routine manner.

Of the 41 patients known to the Social Service Department, 19 of them were helped with post-discharge planning. However, only 10 of these were known to the department during the first hospital admission and three were known during hospitalizations other than the first or the last. Since six of the cases were not carried by this department until the last admission, they should not be included in the number when analyzing the results of post-discharge planning. Looking at these 13 patients helped with discharge plans by the social worker, one sees that only 10 percent of the total number of patients readmitted were given this service.

CHAPTER VI

CASE ABSTRACTS

CHAPTER VI

CASE ABSTRACTS

The writer does not feel that these statistical explanations present the actual problems of the patients who were readmitted to the hospital after having been discharged "improved" and received "maximum hospital benefits." To illustrate some of the individual situations, a few cases from the files of the Social Service Department will be presented. This material will be disguised so that there will be no identifying information in any of it.

Case A

The ward physician requested the social worker to talk with this patient, Mister G, about his marital situation. The difficulty was centered around the fact that his wife was working and because she did not want to give her job up, she would not have a child. The patient was a chronic alcoholic and was admitted to the hospital for that condition.

Mister G had graduated from a state university, where he had always received good grades but was in constant fear of failing. This anxiety carried over to his employment where he was always worried that

he would be laid off although he stated that he knew that he was doing satisfactory work for the newspaper. After ten years of newspaper work, Mister G took a position with a large manufacturing company in the personnel department and there he felt his anxiety was lessened. He did not start to drink excessively until about 1939 and he claimed that this was because he got no enjoyment out of his home-life. Mister G was inducted into the service where he felt no need to drink and he got along very well.

When the veteran returned from the service, it was necessary for him to live with his mother and father-in-law because of the housing shortage. Mister G was dissatisfied with this arrangement because the father-in-law had very rigid standards which he tried to enforce upon the veteran, his wife and child. He was also unhappy because when he returned to his old position, although he was given a pay increase, an "outsider" was made his superior and Mister G felt that he was entitled to this position. The additional post-war dissatisfaction was caused by his wife's refusing to have a child and continuing to work although she did not need to do so for financial reasons. The patient stated that when things did not turn out as he had dreamed they would in the army, he began to drink.

So, one can see that alcoholism is one of the clearest ways of demonstrating the close relationship between poor adjustment to civilian life and frequent readmissions to a hospital. The disease may have been present in the past but was precipitated by dissatisfaction and maladjustment. This is especially well illustrated in Case A in that the veteran had been able to refrain from alcohol while in service, where he was contented and sheltered.

Case B

The ward doctor referred Mister C to the Social Service Department because he had requested a transfer because of his asthma to a Veterans Administration facility in Arizona. At that time, the patient had been admitted twice for his asthmatic condition which he had developed three years previously.

The patient's mother had died when he was about eight years of age and he had been brought up by his father and maternal aunt, who also had asthma. The patient was drafted into the service, but after five days was hospitalized for asthma and eventually received a Certificate of Disability Discharge. He was employed as a factory laborer after discharge and went to live with his father when the latter remarried. Four months later Mister C was admitted to the hospital for the first time and was complaining of wheezing and

shortness of breath. Prior to hospital discharge, the patient was instructed in using adrenalin in the event of future attacks and told to follow the recommendations of the Allergy Clinic. Nevertheless, he reported back to the hospital because of frequent attacks. During the second period of hospitalization, Mister C requested the transfer to Arizona which was granted. However, from that hospital, he was transferred to a Domiciliary Home and after two weeks asked to be sent home because of illness in the family. Two days after his return to his father and step-mother, the patient returned to this hospital with typical asthmatic symptoms.

Doctors Weiss and English in their discussion of asthma and its psychosomatic implications point out the close relationship between the asthmatic patient and lack of mother love or fear of losing the mother person. These authors also discuss the fact that the psychic and allergic factors in asthma are complementary.[1] An attack may be precipitated by an emotional situation as well as an allergic factor and Case B illustrates the emotional factors related to that patient's attacks, and subsequent admissions to the hospital.

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[1] Edward Weiss and O. Spurgeon English, Psychosomatic Medicine, (Philadelphia: W. B. Saunders Company, 1943), pp. 419-427.

Case C

Mister W was seen routinely on the ward and requested financial assistance for his wife and two children. He also expressed concern over his ability to work after discharge from the hospital. The patient had been admitted to the hospital for a fungus infection of both feet.

Before service, Mister W worked as a store clerk and after his discharge he was a truck driver. In service, the patient served as a member of a gun crew on a freighter for 27 months. Since returning to civilian life, Mister W claims that people get on his nerves and he has had four different jobs. He used all of his savings to build a house but was troubled by the fungus infection just before the house was completed. For this reason, the patient was worried about his financial situation. Mister W obtained a position as a ward attendant after his discharge from the hospital although he knew that by doing so he would not be with his wife, because she would not move to Louisville.

About four months later, Mister W was readmitted to the hospital with a diagnosis of anxiety state. The patient had requested social service because of his marital difficulties. Since their marriage in 1936, the veteran and his wife had separated several times

but at the time of his second hospitalization, they were "definitely" separated and he wanted a divorce. The wife had tuberculosis for years but refused medical care for this condition. The patient's wife would not grant her husband a divorce and Mister W was afraid that he would be charged with desertion. There was an added pressure upon the patient because he had a "girl-friend" who was also anxious for the divorce but Mister W could not afford legal assistance.

In this case one sees a disturbed person whose conflict is obvious even to the patient. He turned to the protective environment of the hospital for employment but even this was not sufficient to quell his troubled mind and he developed an anxiety state.

Case D

This patient was referred to the social worker by the doctor for a home conditions report because Mister A was a cardiac patient and he was anxious to go home. The patient's condition was such that the doctor did not feel that he would ever improve so he was allowed to return home if he would observe complete bed rest.

Mister A was a veteran of World War I and had been a butcher since that time. He had been married for several years but he and his

wife had no children. He had been unable to work since about 1940 so he and his wife were recipients of public relief. His wife also received old age assistance. They lived in a small apartment on the third floor and were without any of the modern conveniences. It was necessary for patient's wife to carry the coal for the fire and the slop pail three flights of stairs every day. However, she insisted that she could manage and take care of her husband at home.

After several months the patient had to be rehospitalized because he had suffered heart attacks and his wife finally agreed that it was not possible for her to care for him at home. Mrs. A had the additional difficulty of having arthritis which was a great impediment to her, especially in the cold weather when she had to nurse her husband and do the housework.

This patient had a very severe heart condition but the adverse home conditions made it an undesirable place for such an ill person to receive care. Not only was the physical set-up in the home difficult, but the wife's unwillingness to care for the patient all precipitated the need for rehospitalization.

FINDINGS

FINDINGS

This study was undertaken to determine what factors were common to the 135 readmitted hospital patients who had been discharged "improved" after having received "maximum hospital benefits". The writer had the hypothesis that many of the patients were seeking the security of the hospital in their attempt to adjust to civilian life. Whether this was an escape or a step in adjusting was not known. Let us survey the results of the study to ascertain if the writer's assumption could be valid.

1. We shall not differentiate between the white and the Negro patients in the study because there was nothing significant in their numbers. The percentage of Negroes and whites, both among total admissions and the studied group was 12 percent.

2. The marital status of the readmitted patients was compared to the 1940 Census for population in Kentucky. 31 percent of the studied group was single while 30.9 percent of the males in Kentucky was single. The Census showed 63.4 percent as married and only 48 percent of the readmitted patients was married. This discrepancy of 15.4 percent covers the number in the study who were separated or divorced. The writer felt that this high percentage was an indication of maladjustment to married life or at least a marital difficulty in the way of total adjustment.

3. The median age of the patients readmitted to the hospital was 34.4 although the largest number of patients ranged between the interval of 20 to 29 years.

4. Knowing that the majority of the studied group was young, we can understand that most of them would also have served in World War II. Actually, 73 percent were veterans of the second World War which meant that they still were going through a period of transition to civilian life.

5. Veterans of the Army numbered 82 percent of the 135 patients and 86 percent of the entire group were in the four lowest ranks of service. Only three of the patients had held the rank of a commissioned officer.

6. The median for the number of months in service was 26.7 for the readmitted patients.

7. The percentages of service-connected disabilities among readmissions was 22 percent while 77 percent were non-service connected.

8. About 50 percent of the studied group was receiving government benefits of which 78 percent was for $69.00 or less a

month. 17 percent received only $13.80 per month.

9. The significant part of the study regarding occupations was the increase in unemployment. Before the war, only four of them were unemployed, after the war the number had risen to 24 and there were 27 unemployed between hospital admissions. Added to this number were many of the 46 patients whose occupations were unknown. The hospital might be a refuge for a veteran unable to obtain or keep a job.

10. In studying the occupations, it was also found that there were few professional workers but many farmers and laborers. However, the two latter groups showed a decrease after the war and between hospital admissions. On the other hand, the more skilled workers showed a more consistent record except for some decrease between hospital admissions.

11. The diagnoses as found in the studied patients were for the most part chronic or recurrent.

12. Classing anxiety state, alcoholism and other neuropsychiatric conditions together, the total number of such diagnoses given was 23. Anxiety state was the diagnosis in 11 of the cases

and alcoholism in eight. These diseases are so closely connected with emotional difficulties that the writer felt that this too showed maladjustment.

13. The majority of the other diagnoses, including ulcers, gastro-intestinal difficulties, arthritis, asthma and so forth were of a recognized psychosomatic nature. As such, they are closely related to the individual's emotional life.

14. Of the total number of readmissions to the hospital, 41 were known to the Social Service Department during one or more of the admissions. The lack of coverage by this department shows that there was a need for more social workers which was fulfilled shortly after this study was completed.

15. Of the cases known to the department, 25 were brief service cases and 16 were extensive cases. Post-discharge planning was done with 19 of the patients, 10 during the first admission, six during the last admission and three during admissions other than the first or the last. Of these 19 cases, only seven were known during two of the admissions. Post-discharge planning was done with 10 percent of the 135 patients thus showing a definite need for more workers.

16. The ward physicians referred 22 of the 41 cases thus demonstrating their acceptance of the Social Service Department.

This study of readmitted hospital patients was a preliminary one covering only 135 veterans so further studies would have to be made to draw any universal conclusions. However, on the basis of these few cases, there was enough evidence to support this writer's hypothesis. That is, many of the findings pointed out that these veterans who were discharged "improved" and received "maximum hospital benefits" were having a difficult time adjusting to civilian life. In the first place almost three-fourths of them were veterans of World War II and; therefore, had not long been out of the service. Moreover, the median age of this group was 34.4 years. It is usually recognized that the older veterans had a more difficult time adjusting to the service and by the same token find the change back to civilian life just as difficult. The veterans in the group studied had a comparatively high percentage of separations and divorces which would suggest in some cases an inability to adjust to married life. The employment record of the studied group was quite significant in that the number of unemployed increased, and there was a noticeable drop in the number of less skilled occupations. The majority

of the diagnoses were of a chronic or recurrent nature but on the whole not such that should require frequent hospitalization. The neuropsychiatric conditions were most common especially, anxiety state and alcoholism. Few of the other diagnoses were surgical or orthopedic but most were of an acknowledged psychosomatic nature. The value of post-discharge planning could not be determined since only 19 of the patients were given that service. The conclusions drawn cannot be final but do show definite trends among this particular group. Further study and follow-up interviews would be necessary to show more the the actual conditions in the case of each readmitted patient.

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APPENDIX

VETERANS ADMINISTRATION
Form P-10 Rev. May 1945

APPENDIX A

APPLICATION FOR HOSPITAL TREATMENT OR DOMICILIARY CARE

The applicant should forward this form, when fully executed, with the original or a certified copy of his discharge or release from last period of service, to the Veterans Administration facility nearest his home, which is located at _____
(Location of facility)

1. I, _____ C–No. _____ Social Security No. _____
(Print) (Last name) (First name) (Middle name)
hereby apply for admission to a Veterans Administration facility for *(hospital treatment) (domiciliary care) _____

_____
(Date of birth) (Color) (Sex) (Place of birth) (Present place of residence)

2. My entire service in the active military or naval service of the United States has been as follows:

Enlisted		Serial No.	Discharged		Rank and Organization	Character of Discharge
Date	Place		Date	Place		

Note.—If you served under a name other than the one used in this application, indicate the name under which you served and the period of service

_____

3. Have you filed claim for pension, compensation, or retirement pay? _____
(Yes or no)
What office has your case file? _____
(Location)

4. Give the name and address of your wife, or nearest relative, or guardian, or other person to notify in event of emergency.

_____
(Name) (Relationship) (Address)

Note.—Where application is for condition for which applicant was discharged for disability in line of duty, or held service-connected by Veterans Administration, questions 5, 6, and 7 need not be answered.

5. Are you entitled to hospital care by membership in a lodge, society, community group treatment plan, etc., or as a beneficiary of an insurance company, workmen's compensation commission, industrial accident board, etc.? _____ If "Yes," give
(Yes or no)
name of agency or organization _____

6. Are you financially able to pay the necessary expenses of hospital or domiciliary care? _____
(Yes or no)

7. Are you able to pay transportation to and from a Veterans Administration facility? _____
(Yes or no)

8. Have you received hospital care from the Veterans Administration? _____
(Yes or no)
If "Yes," state when _____ and where _____
(Give most recent dates) (Name of facility)

9. Have you received domiciliary care from the Veterans Administration? _____
(Yes or no)
If "Yes," state when _____ and where _____
(Give most recent dates) (Name of home, or hospital)

10. If discharged against medical advice, absence without official leave, for disciplinary reasons, or given an enforced furlough, underline applicable term.

I * {have read / have had read to me} and understand all questions and answers on this form, and the printed provisions on the reverse hereof.

The answers to all questions are true and complete to the best of my knowledge and belief. The foregoing questions and answers are made a part hereof with full knowledge of the penalty provided for making a false statement as to material fact in this application.

Witnesses to signature by mark (X)

1. _____
(Signature)
_____
(Address)

2. _____
(Signature)
_____
(Address)

_____
(Signature of applicant or representative)

Post office address _____
(Number) (Street)
_____
(City) (Zone) (State)

Subscribed and sworn to before me this _____ day of _____, 19_____, by _____
_____, claimant, to whom the statements herein were fully made known and explained. I certify that the questions and answers thereto have, in my presence, been *{read to / read by} the claimant.

[SEAL]

_____
Notary Public.

*Strike out inapplicable words or phrases.

16—9496-5

Penal Provisions Applicable to Title I, Public No. 2, 73d Congress

SECTION 15. Any person who shall knowingly make or cause to be made, or conspire, combine, aid or assist in, agree to, arrange for, or in any wise procure the making or presentation of a false or fraudulent affidavit, declaration certificate, statement, voucher, or paper, or writing purporting to be such, concerning any claim for benefits under this title, shall forfeit all rights, claims, and benefits under this title, and, in addition to any and all other penalties imposed by law, shall be guilty of a misdemeanor, and upon conviction thereof shall be punished by a fine of not more than $1,000 or imprisonment for not more than 1 year, or both.

REDUCTION OF PENSION, COMPENSATION, OR EMERGENCY OFFICERS' RETIREMENT PAY WHILE RECEIVING HOSPITAL OR DOMICILIARY CARE

Where any disabled veteran having neither wife, child, nor dependent parent is being furnished hospital treatment, institutional or domiciliary care by the United States or any political subdivision thereof, the pension, compensation, or emergency officers' retirement pay shall not exceed $20 per month, provided that the amount payable for such disabled veteran entitled to pension under Part III, Veterans Regulation No. 1 (a), as amended, for nonservice connected disability shall not exceed $8 per month, and provided further, that where any disabled veteran who is being furnished hospital treatment, institutional or domiciliary care by the United States or any political subdivision thereof, has a wife, child, or dependent parent the pension, compensation, or emergency officers' retirement pay may, in the discretion of the Administrator, be apportioned on behalf of such wife, child, or dependent parent, in accordance with instructions issued by the Administrator.

NOTE

This application is made with notice of Public Law No. 382 approved December 26, 1941 (38 U. S. Code 17–17j) which in effect provides that upon the death of any veteran receiving care or treatment by the Veterans Administration in any institution leaving no widow (widower), next of kin or heir entitled to inherit, all personal property, including money or balances in bank, and all claims and choses in action, owned by such veteran, and not disposed of by will or otherwise, will become the property of the United States as trustee for the Post Fund.

MEDICAL CERTIFICATE

A careful physical (including mental) examination of the applicant discloses these findings and diagnosis:

(1) Brief history:

(2) Symptoms:

(3) Physical findings:

(4) Diagnosis:

(5) Strike out the clauses not applicable: The applicant (is) (is not) ambulant. He (is) (is not) mentally competent. He (will) (will not) need an attendant during his travel. The proposed attendant's name is _____ address _____ The attendant (is) (is not) a relative of the patient. It is proposed that travel to the hospital will be made by (train), (bus), (automobile).

(Date)	(Signature of examining physician)	(Street)	(City)	(Zone)	(State)

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APPENDIX B

SCHEDULE

I. Identifying Information

Patient's code number_____Race: W__N__Other__
Address_____
Birth date_____ Marital status: M__W__S__D__Sep.__
Next of kin as noted on hospital admission:
Relationship_____
Address_____
Content of family:
Mother
Address_____
Living? yes__no__ Health: good__fair__poor ___
Father
Address_____
Living? yes__no__ Health: good__fair__poor ___
Siblings:
Number of brothers living: Health: good__fair__poor___
Number of sisters living: Health: good__ fair__ poor __
Patient's place in family_____
Wife
Address_____
Living? yes__no__ Health: good__fair__poor___
Children:

	Sex	Age	Health: good fair poor
1.			
2.			
3.			
4.			
5.			
6.			

II. Service Information
World War I____World War II__Other_____
Branch of service_____
Period of service_____to_____Length of service in months__
Highest rank in service_____Rank at discharge_____
Disabled: yes__no__Service-connected__Non-service-connected_____
Pension: Yes__no__Amount_____
Discharge: Honorable__Without Honor__
Type of discharge_____

III. Employment information:
Occupation or trade_____
Pre-war employment: yes__no__Type_____
Type of work in service_____
Post-war employment: yes__no__Type_____
Work between hospital admissions: yes__no__Type_____
Work record: good fair poor
Pre-war:
Post-war:

IV. Hospital Information:

First admission:

Date_____ Onset of illness_____

Principal diagnoses_____

Type: Medical__Surgical__Orthopedic__Neuropsychiatric_____

Chief complaint_____

Consultations:

Type	Date	Recommendations

Condition at time of discharge_____

Date of discharge_____Length of hospitalization by days__

Second admission:

Date_____ Onset of illness_____

Principal diagnoses_____

Type: Medical__Surgical__Orthopedic__Neuropsychiatric____

Chief complaint_____

Consultations:

Type	Date	Recommendations

Condition at time of discharge_____

Date of discharge_____Length of hospitalization by days___

Type of discharge_____

***

V. Social Service Information:

Social Service Exchange Listings:

Agency	Date	Agency	Date

Social Service Department Record? yes__no__

Source of referral:

Doctor__Nurse__Gray Lady__Patient__Routine__Other_____

Reason for referral_____

Statement of problem:

Medical

Social

Emotional

Occupational

Mental

Brief statement of social worker's role in the case:

_____

Did Social Service help with post-discharge planning? yes__no____

If so how? with patient__with family__with agency__other_____

Time active with Social Service_____to_____; _____to_____

Reason for closing_____

***If more than two admissions, repeat this section on the additional page.

Hospital Information (continued)

Third admission:

Date_____ Onset of illness_____

Principal diagnoses_____

Type: Medical__Surgical__Orthopedic__Neuropsychiatric_____

Chief complaint_____

Consultations:

Type	Date	Recommendations

Condition at time of discharge_____

Date of discharge_____Length of hospitalization by days____

Type of discharge_____

Fourth admission:

Date_____ Onset of illness_____

Principal diagnoses_____

Type: Medical__Surgical__Orthopedic__Neuropsychiatric_____

Chief complaint_____

Consultations:

Type	Date	Recommendations

Social Service Exchange Information:

Name_____Wife's name_____

Address_____Parent's name_____

Children's names

APPENDIX C

CLASSIFICATION OF OCCUPATIONS OF THE STUDIED GROUP OF HOSPITAL ADMISSIONS

I. Professional and semiprofessional workers

1. Draftsman
2. Laboratory Assistant
3. Mechanical Engineer
4. Personnel Interviewer
5. Showman
6. Union representative

II. Farmers and farm managers

III. Proprietors, managers, etc.

1. Manager, Optical Company
2. Restaurant Owner
3. Tavern Owner

IV. Clerical, sales and kindred workers

1. Accountant and Auditor
2. Bookkeeper
3. Clerk
4. Insurance
5. Mail Carrier
6. Peddler
7. Solicitor
8. Stenographer

V. Craftsmen, foremen and kindred workers

1. Blacksmith
2. Butcher
3. Carpenter
4. Chemical mixer
5. Cobbler
6. Cook or Baker
7. Electrician

8. Inspector
9. Machinist
10. Marker and cutter, men's clothes
11. Mechanic
12. Molder
13. Painter
14. Plasterer
15. Radioman
16. Steam fitter
17. Tinner

VI. Operative and kindred workers

1. Ambulance driver
2. Assembler
3. Boring Mill Operator
4. Bus driver
5. Cab driver
6. Cement worker
7. Chauffeur
8. Coal Miner
9. Crane and shovel operator
10. Deck hand
11. Finisher
12. Metal worker
13. Meter reader
14. Mover
15. Paint manufacturer
16. Presser
17. Punch Press Operator
18. Radar operator
19. Saw operator
20. Service Station Attendant
21. Stoker
22. Telephone operator
23. Tractor operator
24. Transportation worker
25. Truck driver
26. Welder
27. Wood worker

VII. Domestic and service workers

VIII. Protective workers

1. Deputy sheriff
2. Fireman
3. Guard

IX. Service workers

1. Barber
2. Bartender
3. Billiard Room Attendant
4. Maintenance and Caretaker
5. Medic
6. Mess Attendant
7. Porter
8. Ward Attendant

X. Farm laborers and foremen

XI. Laborers

1. Ammunition handler
2. Boilermaker helper
3. Crater and Packer
4. Distillery worker
5. Factory worker
6. Laborer
7. Race horse groom
8. Stockman
9. Tannery worker
10. Tub cleaner

XII. Student

APPENDIX D

LIST OF THE DIAGNOSIS OF EACH READMITTED PATIENT AND DIAGNOSIS AT LATER ADMISSION IF DIFFERENT

	First Admission	Later Admission (differing from first)
1.	Abscess, stump	Same
2.	Pneumonia	Same
3.	Diabetes	Same
4.	Arthritis	Same
5.	Loose body in knee joint	Same
6.	Effusion	Same
7.	Trichophytosis	Same
8.	Fracture, ulna	Same
9.	Malaria	Same
10.	Psychogenic dyspepsia	Same
11.	Heart	Same
12.	Scabies	Same
13.	Malaria	Same
14.	Impotence	Same
15.	Gastritis and Asthma	Same
16.	Osteomyelitis, arm	Same
17.	Sinusitis	Same
18.	Ulcer	Same
19.	Ulcer	Same
20.	Hernia	Appendicitis
21.	Anxiety	Fracture
22.	Hernia	Same
23.	Laceration, knee	Same
24.	Sinusitis	Hemorrhoids
25.	Abscess, Periproctic	Strain
26.	Cellulitis	Abscess, lung
27.	Hemorrhoids	Ulcer
28.	Nasopharyngitis	Same
29.	Otitis and Ulcer	Same
30.	Malaria	Same
31.	Malaria	Same
32.	Paratyphoid	Sprain, ankle
33.	Dermatitis	Same
34.	Anxiety	Same
35.	Gout	Same
36.	No disease	Cellulitis, left index
37.	Otitis	Asthma
38.	Foreign body in legs	Same

	First Admission	Later Admission (differing from first)
39.	Strain, gluteal muscles	Marie Strumpell Arthritis
40.	Malaria	Same
41.	Fracture, clavicle	Hernia
42.	Heart	Same
43.	Malaria	Same
44.	Anxiety	Same
45.	Malaria	Same
46.	Dermatitis	Same
47.	Heart	Same
48.	Urinary retention	Same
49.	Psychoneurosis	Same
50.	Appendicitis	Fracture, mandible
51.	Heart	Same
52.	Heart	Same
53.	Fistula, ano	Same
54.	Hernia	Anxiety
55.	Arthritis	Hernia
56.	Bronchitis, Asthma, and Arthritis	Same
57.	Alcoholism	Hysteria
58.	Arthritis	Cholecystitis and Hemorrhoids
59.	Arthritis	Same
60.	Dermatitis	Same
61.	Malaria	Same
62.	Endarteritis and Psychoneurosis	Alcoholism
63.	Malaria	Same
64.	Appendicitis	Psychoneurosis
65.	Fracture, vertebrae	Same
66.	Heart and Carcinoma	Same
67.	Colic	Appendicitis
68.	Heart	Same
69.	Abscess, perictonsillar	Same
70.	Malaria	Same
71.	Bronchitis	Arthritis
72.	Foreign body in arm	Same
73.	Anxiety	Same
74.	Otomycosis	Fracture, foot
75.	Heart	Same
76.	Malaria	Same
77.	Ulcer	Same
78.	Anxiety	Same
79.	Heart	Same
80.	Anxiety	Same

	First Admission	Later Admission (differing from first)
81.	Cirrhosis, liver	Same
82.	Ulcer	Same
83.	Contusion, spine	Alcoholism
84.	Malaria	Same
85.	Anomaly, blood vessels	Same
86.	Hemiplegia	Multiple sclerosis
87.	Hernia	Neuritis
88.	Dermatitis	Same
89.	Diverticulum	Same
90.	Hypertension and Arthritis	Same
91.	Eurethritis	Prostatitis
92.	Alcoholism	Same
93.	Anxiety	Same
94.	Abscess, frontal area	Same
95.	Sinusitis and Post-traumatic personality disorder	Same
96.	Malaria	Same
97.	Fracture, mandible	Same
98.	Tonsillitis	Arthralgia
99.	Pneumonia	Same
100.	Lymphangitis	Same
101.	Alcoholism	Same
102.	Ulcer	Same
103.	Stricture of rectum	Same
104.	Sinusitis	Alcoholism
105.	Heart	Same
106.	Ulcer	Same
107.	Malaria	Same
108.	Arthritis	Same
109.	Malaria	Same
110.	Malaria	Same
111.	Nasopharyngitis and Enuresis	Same
112.	Appendicitis	Same
113.	Raynaud's Disease	Gangrene, hands
114.	Contusion	Astigmatism
115.	Hernia	Same
116.	Prostatitis	Same

	First Admission	Later Admission (differing from first)
117.	Alcoholism	Same
118.	Tonsillitis	Same
119.	Alcoholism	Same
120.	Gastritis	Same
121.	Thrombophlebitis	Dermatitis
122.	Heart	Same
123.	Anxiety	Same
124.	Malaria	Same
125.	Diabetes	Abscess, thigh
126.	Malaria	Same
127.	Anxiety	Same
128.	Ulcer	Same
129.	Ulcer	Same
130.	Heart	Same
131.	Asthma	Same
132.	Stricture, urethra	Alcoholism
133.	Heart	Same
134.	Arthritis	Arteriosclerosis
135.	Urethritis	Fracture, clavicle wound of cheek