UNCLASSIFIED

REPORT OF

THE SURGEON GENERAL'S CONFERENCE

with

CHIEFS, MEDICAL BRANCH OF SERVICE COMMANDS

Washington, D. C.

14-17 June 1943.

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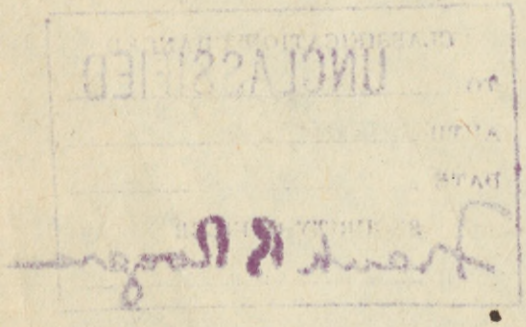

FOREWORD

The following pages contain the questions, answers, and general discussions occurring during the conference with chiefs, Medical Branch of Service Commands, held in the office of The Surgeon General, 14-17 June 1943. The various division directors and their assistants were called upon to reply to the matters presented for discussion.

Those present:

Colonel John J. Reddy,	M. C.	1st Service Command.
Colonel Charles M. Walson,	M. C.	2d Service Command.
Colonel Thomas W. Burnett,	M. C.	3d Service Command.
Colonel Sanford W. French,	M. C.	4th Service Command
Colonel Edgar C. Jones,	M. C.	5th Service Command
Colonel Don G. Hilldrup,	M. C.	6th Service Command
Colonel Herbert C. Bibner,	M. C.	7th Service Command
Colonel W. Lee Hart,	M. C.	8th Service Command
Colonel Harvard C. Moore,	M. C.	9th Service Command

The following representatives of other offices also attended and discussed matters related to their special endeavors:

Brig. General Clinton F. Robinson, Chief, Control Division, ASF.
Colonel Robert C. McDonald, M. C., Z of I Planning, Operations Division, ASF.
Colonel Francis N. Fitts, M. C., Army Specialized Training Program Division, ASF.
Colonel R. H. Eanes, M. C., Selective Service.

Brigadier General George F. Lull, Deputy Surgeon General, presided over the conference for The Surgeon General.

In many instances the questions, replies, and discussions are set forth as originally stated; in other instances considerable editing has been made necessary in order to consolidate and clarify the matters presented. Opportunity to edit remarks was given to all concerned.

Fiscal Division

Question: Civilian, medical, and dental attendance is being rendered and drugs purchased in emergency for military personnel on troop trains, and in almost every instance difficulty is experienced in obtaining the information required to submit a proper voucher. It is believed that if funds were allocated to train commanders for such contingencies, payment could be made when the services were procured and would alleviate the effort and correspondence required in tracing patients and responsible officers.

Answer: It is indicated that difficulty is being experienced in obtaining information required to present vouchers for civilian medical and dental attendance obtained for military personnel on troop trains. It is also indicated that if funds were allotted to train commanders, payment could be made when the services were procured and that this would solve the problem. It is the opinion of this Division that the difficulties encountered would not be solved by making allotments to troop train commanders because it would still be necessary, under the law, to assemble and furnish the same information now required. In order for a train commander to make immediate local disbursements, it would be necessary for him to be designated as a disbursing officer, and he would be required to support his payments with proper vouchers containing the same type of information as is required under the present system. In addition, he would be required to furnish a bond and would be personally liable for unsupported disbursements. It is the recommendation of this Division that the attention of train commanders be invited to section III, War Department Circular 387, dated 28 November 1942. If at the time that civilian medical attendance is requested, the information outlined in the circular cited is stated in a letter to the civilian physician or dentist, further correspondence in tracing patients and responsible officers would appear to be unnecessary. In such a case, the civilian physician or dentist would have available all the information needed for presenting his invoice for services. The physician or dentist could be instructed in the letter to forward his bill to the service command headquarters together with a copy of the letter.

Question: This headquarters is at present using the Revised Schedule of Fees, Veterans' Administration, dated 1 July 1939, as an official reference for fees to be authorized for civilian medical attendance. Information is requested as to whether the maximum fees listed in the above schedule are still to be considered the maximum which should be authorized in the absence of extenuating circumstances.

Answer: The question is whether the revised schedule of fees, Veterans' Administration, dated 1 July 1939, is still the official guide in judging fees for civilian medical attendance. This schedule is still used by the Medical Department but the fees stated in the schedule are not necessarily the maximum that may be approved for payment. It is merely intended to be a guide as to reasonable fees in ordinary circumstances. In the judgment of approving officers, higher fees may be allowed if the circumstances indicate that higher fees are reasonable.

Question: Accounts for medical service. When fiscal offices pay accounts for civilian medical attendance (after 1 July), who will approve the accounts for payment?

Answer: Service commands will continue to approve civilian medical attendance vouchers after 1 July. The only change contemplated is that approved vouchers will not be forwarded to The Surgeon General's Office for payment but will be forwarded to Medical Department Fiscal Branch Offices for final administrative examination and approval for payment by the local finance officer. The function and authority of service commands will in no way be affected.

24-47405

Administrative Division
Hospital Fund Branch

Question: Does section IV, War Department Circular No. 118, 1943, in any way apply to general and station hospital funds?

Answer: The accepted interpretation of ration savings is contained in 8th Indorsement, dated 13 April 1932, from The Inspector General's Office to The Adjutant General, paragraph 2b of which is quoted as follows: "b. This office is of the opinion that ration savings in a hospital fund should consist of only the payments to the fund for the subsistence of enlisted men, not patients, at the hospital." From records presently available, the requirement for rendering a separate Ration Savings Account tabulation on monthly hospital fund statements was initiated in 1932. This requirement was first published in S.G.O. Circular Letter No. 23, 20 September 1932, and has been republished in yearly consolidated S.G.O. Circular Letter No. 1 (paragraph 20g (1) and (2) of S.G.O. Circular Letter No. 1, 1 January 1943). The object of this separate accounting is to insure legal use of funds appropriated for specific purposes. Based upon the Ration Savings Account tabulations received with hospital fund statements in this office from all Army hospitals, whereon expenditures for food supplies invariably exceed those funds received for the subsistence of enlisted men on duty, it is the opinion of this office that, in general, hospital funds are not affected by the provisions of sec. IV, W.D. Cir. No. 118, dated 10 May 1943. In the event there should be actual unexpended balances in a Ration Savings Account, it is believed that the provisions of sec. IV, W.D. Cir. No. 118, would be applicable to such balances. However, in view of the provisions of AR 210-50, paragraph 13b (1) and d, it is submitted that payments to enlisted men of authorized gratuities as mess attendants may be paid from funds accruing from such ration savings. It is considered that the privilege authorized in this regulation is a proper expenditure in connection with the operation of a duty detachment mess, and that should there be any unexpended balances carried in a Ration Savings Account, such balances could be properly applied for the payment of gratuities to enlisted personnel serving in detachment messes, which would considerably lower, if not eliminate such balance and thereby render the provisions of W.D. Cir. No. 118 inapplicable.

24-47405

Medical Statistics Division

GENERAL LULL: The next division to be discussed is the Medical Statistics Division. I introduce Colonel Williams, who will please take the stand. I will read these questions:

Question: Students assigned to civilian educational institutions are usually rendered medical service by the health authorities of the institution. What plan is suggested for obtaining the necessary statistical reports and records?

Answer: It is assumed that if medical care is to be rendered by the infirmaries or dispensaries maintained by the schools and colleges in question, the physicians operating such infirmaries will be made contract surgeons and obligated thereby to render medical reports. If a medical officer is on duty, this is, of course, his responsibility.

Question: What do you mean by contract surgeon?

GENERAL LULL: This matter will come up later under the Army Specialized Training Program. In these institutions it is our intention not to use medical officers. I believe it is more important to save the medical officer for other duties than it is to obtain these medical reports on the students. We must get the best reports we can, but we must save our personnel. If a physician in the institution can render some kind of simple report that will let this office know what is going on, I believe that is satisfactory, is it not, Colonel Williams?

COL. WILLIAMS: That is correct; that is all we require.

Question: What happens in the case of acute appendicitis of a boy in such an institution?

GENERAL LULL: They have gotten along very well in years gone by. Such cases can be sent to a civilian hospital provided there is no Army hospital near that could perform the same service. One point we want to make here is that we do not want to put an Army surgeon at every school.

Comment: The suggestion has been made to put two or three enlisted men on duty at each of these schools to keep the medical records. We have no allotment that will cover that. We have resisted this move so far.

GENERAL LULL: Next question: The present AR 40-1060 is outdated; a revision is urgently needed. It is suggested that regulations be issued that have equal application to Army Service Forces and Army Air Forces installations. Current Army Air Forces instructions are oftimes at variance with AR 40-1060. This is

particularly true in connection with the distribution of the original and copies of the WD Form 86ab. The position of the service command surgeon should be more clearly defined with respect to the collection, review, consolidation, etc., of medical reports prepared by Army Air Force surgeons. It may be stated that AR 40-1080 is now in process of revision. It is anticipated that a meeting will be held with Army Air Force and Army Ground Force representatives to establish uniform methods of preparation and submission of the reports. The present AR 40-1080 was, of course, written before the reorganization of the Army was effected and for that reason many of the questions incident thereto are unanswered by the regulation in its present form. Is there any discussion about that? You heard what General Kirk said about trying to line up the Air Force hospitals so that they will all be under one head. If that takes place, we know this question will be answered.

GENERAL LULL: Now we will go on to the next question: Some Army Air Force stations are using Emergency Medical Tags. This is in conflict with AR 40-1025 and unduly complicates reporting procedures and results in an inaccurate consolidated station statistical report, WD Form 86ab, since patients sent to the station hospital with an EMT are formally transferred. It is believed that paragraph 36, AR 40-1025 (informal transfer), should apply in transferring patients to the station hospital from organizations at the station. Clarification of the responsibility of the service command surgeon in such matters is requested.

It is not understood why Air Force units not on maneuvers or operating under field conditions should use Emergency Medical Tags (W.D. Form 52b). An effort will be made to secure this information from Air Force Headquarters.

(Col. Williams informed General Lull later in the day that after a conference with Colonel Berkson, Vital Statistician of the Air Surgeon's Office, it is found that the 1st and 4th Air Forces operating on either coast, work under Defense Commanders. This is tantamount to being placed on war status. It is for this reason that the Emergency Medical Tag rather than the W.D., W.D. Form 52 is used by these units.)

24-47405

GENERAL KIRK: Sorry I couldn't be here to talk with you initially, but I had an appointment with the Assistant Secretary of War for that time. It's nice to see you here. If I may have a few minutes of your time I'd like to make a few remarks and then let you go ahead. I know you are all surprised at my appointment as Surgeon General. I was too. I hope it has met with the approval of service command surgeons and that I have your support.

Recently, I had a talk with General Somervell and from what I heard it struck me that we had more or less lost control in the service commands as far as the Medical Department was concerned and that the job there was being done on personalities and not on organization. I asked if he would entertain a proposal that we might bring to him as to where we thought the surgeon of the service command should be and his relation to the commanding general of the service command in order to carry out the responsibilities placed on The Surgeon General of the Army. I told him what I thought these responsibilities were and that everybody knows we couldn't carry on unless we had authority. He then suggested that you come here for a conference.

We have asked you to come here to help us set up something that would be acceptable both to General Somervell and to the service commands. There is some question as to whether the organization is what it should be. It is suggested that the problems of the service command surgeons be discussed as follows:

a. Status on staff of service commanders.
b. Organization of surgeon's office.
c. Operation of office; viz., relationship with other divisions of service command headquarters.
d. How to control Medical Department personnel in service commands.
e. Relationship of service command surgeon and Surgeon General.
f. Relationship of service command surgeons reference control over Air Forces, Ground Forces, and Defense Commands in reference to:

1. Hospitals
2. Personnel
3. Sanitation
4. Training
5. Inspections.

We will appoint a board to study this and submit a report so that we will have it in written form, brief and to the point, to submit to General Somervell. On that board from this group I want to appoint Colonels Hart, Jones, and Walson. This report will be presented to the Army Service Forces for acceptance or rejection. We are not going to get anywhere if we don't start carrying the ball. I think it is up to us to carry the ball and not leave it to somebody else.

Tuesday afternoon, General Robinson, who is the Control Officer, A.S.F., will be over here to sit with you all afternoon and help formulate this and give you information as to how it is proposed to set up the service commands.

There are some other plans we have for what we hope to do. First, at each general hospital I feel there should be a convalescent center where we could house, in barracks, say, 20 percent of the bed capacity, put them in uniform, recondition them, and get these men physically fit to go to replacement centers for assignment to line organizations rather than send them direct from the hospital to replacement centers. A man who has been in a general hospital, say with a hernia or other condition, needs reconditioning before he is physically fit for assignment as a soldier to a combat unit. (In peace time we could send such a patient back to garrison duty where he had little to do.) W.A.C. officers could act as company commanders and we could obtain physical directors who had had similar experience in civil life -- perhaps one for each 50 men -- to give them the necessary exercise and physical training to put them in condition to go to replacement centers. We want them to be able to do a 14-mile hike before we turn them over. We'll want to send similar units overseas. The British are doing an excellent job on it there now, and in their convalescent camps in North Africa.

This will save us money on hospital beds and also save building a certain number of general hospitals. We are working on a scheme to inaugurate this to supplement the equipment of a 1500-bed general hospital. The construction cost will be only a third of that for a general hospital and we won't need a million dollars worth of equipment to run it. It will also save a lot on medical and nursing personnel. In such a setup, patients who were sick would be seen by doctors from the hospital. The orthopedist, for instance, could go over once a week and see the cases undergoing reconditioning.

Air Corps. The Air Corps operates some 250 hospitals in the zone of the interior. We have a different thought on that. We think that all Army hospitalization should be under one control. It all belongs under the service command and we hope to take all that over. The flight surgeon has a very definite place as a specialist and he'll write the prescription

on all flying personnel training and flying. We will treat the fractured leg, hernia or what not, and when we finish with them, they will be turned over to the flight surgeon for reconditioning and to be kept in flying condition. We'll see that he has the necessary facilities -- swimming pools, golf courses, bands, or anything else he wants -- and give him anything we can. If necessary we will give him some of the facilities that we have, such as at White Sulphur, and have flight surgeon there to write the prescriptions for flying personnel. We want you to set this up so that you, as service command surgeons, can act for The Surgeon General and represent him in that service command, see that orders are carried out and proper medical care is being given to patients, act as inspectors for our hospitals, whether we have these Air Corps hospitals or not, and see whether or not proper training is being given in combat units (which I know is not from what I saw overseas). I want all that to operate under you, and I want you to set yourself up under the commanding general so that you can so function. We'll have to get authority from the Ground Forces, but we have the responsibility, and we must have authority.

There's a directive out that patients requiring hospitalization for over ninety days will be sent to general hospitals and now the amputation centers are set up, all amputation cases are to go there immediately. Patients requiring hospitalization for ninety days or more will be sent to general hospitals. I don't care whether there is just as good a surgeon at the station hospital. We have a policy, a plan, and it will be carried out or else be rescinded. I don't believe in putting out orders that can't be carried out. They shouldn't be written. Now I must attend a meeting of the Central Committee at the Red Cross; so I'll leave right here.

Veterinary Division

GENERAL LULL: Next, the Veterinary Division. I'd like to introduce General Kelser, the Chief of the Veterinary Division.

Question: A question submitted by the Sixth Service Command: Point of origin inspection required by the service command veterinary personnel is exceedingly heavy. Is it not possible to have War Department personnel, not chargeable to service command, assigned to heavy centers to help care for this work?

Answer: To set up a separate allotment of personnel, as suggested, is considered inadvisable.

In order to insure compliance with Federal Specification and contract requirements and obviate rejections of huge quantities of foodstuffs at point of receipt, with immediate satisfactory replacement often impossible, point of origin inspections on a large scale are considered highly essential by the War Department. With few exceptions, these purchases are made by the Quartermaster market centers and depots which are not under the jurisdiction of service commands. They do, however, purchase the bulk of perishable and nonperishable foodstuffs for installations of the service commands. In order to conserve veterinary inspection personnel and transportation funds, service commands are called upon to provide a large part of this point of origin inspection service. In computing veterinary personnel requirements for the various service commands, due consideration has been given the necessity for increasing the number of veterinary officers and enlisted men, Medical Department veterinary service, over and above ordinary station requirements, in order to provide for these point of origin inspections. Thus, the number of veterinary officers and enlisted men previously allotted the Sixth Service Command is approximately one-third greater than would have been made for ordinary station service alone.

GENERAL LULL: Are there any remarks on that? I think the Sixth Service Command and the Seventh Service Command probably have most point of origin inspections. I don't mean the most of them, but they have the larger, do they not, General?

GEN. KELSER: That's right, and due consideration has been given this fact in setting up veterinary personnel for those Service Commands.

GENERAL LULL: Any further discussion on that question?

COL. HILLDRUP: The only thing is that we are being pressed at the present time out there with our present allotment to carry on this work, because a great many requests for inspections come in from other service commands to inspect cheese in Wisconsin and milk

some place else, and they've simply drained our veterinarians out of the camps. They're gone all the time.

GEN. KELSER: Well, that works the other way too, because purchases for your service command likewise originate in other service commands. Thus, from the standpoint of the over-all picture, there is an equalization of the usage of personnel.

COL. WILDRUP: We're not objecting to the inspections, we're objecting to the number of men we've got available to do them. We've got to have more. They want to have sufficient personnel, more than they now have.

GEN. KELSER: Of course, these point of origin inspections have been increasing as the Army increases, and personnel has to be correspondingly increased to take care of needs, but just as you inferred a moment ago, some service commands have apparently had the idea that because these inspections were being done for some other service command, or commands, that the work wasn't a proper function of the particular service command. As General Lull pointed out a moment ago, our packing centers are located in the Sixth and Seventh Service Commands, and they have had a large part of these inspections. It's an over-all policy to utilize personnel locally available rather than to send from another service command over into the service command of the point of origin.

COL. GIBNER: May I introduce a local question: In our service command, we have at the Kansas City Quartermaster Depot a number of veterinary personnel, not service command personnel, who belong to the Depot. However, Colonel Egan uses them for certain of these point of origin inspections. He thinks that if we had that personnel, he could do it with fewer men. Well, that question has been brought up before, I know.

GEN. KELSER: That's right, and a study has been made of it. It all narrows down to what one inspector can do at any one time, and the records of our office show that the volume of inspections done by the personnel of the Kansas City Quartermaster Depot compares, man for man, favorably with that done by the Seventh Service Command and I don't mean that the Seventh Service Command is not doing a good job. I doubt very much that there would be any appreciable saving by transferring the personnel over to the Seventh Service Command.

COL. WALSON: It is believed that there would be economy if all veterinary personnel in the 2d Service Command geographical area were under the control of the service commander. Most of our requisitions for veterinary inspections usually come from the Sixth Service Command, and many of these calls reach us on a Saturday afternoon.

GEN. KELSER: The intention has been that the service commands will handle these point of origin inspections within their service command and the depots, which are independent stations, would handle inspection service at and within the immediate vicinity of depots. It is contemplated that service commanders will have authority to call on depots in the same way that depots have authority to call on service commands for inspections which can be done more conveniently and economically by one than the other. As long as we have independent stations in the Army we are going to have recurrences of questions similar to that Colonel Gibner brought up.

GENERAL HULL: Next question. Request that veterinary officers ordered to active duty with this service command be routed through the Medical Field Service School and the thirty-day course at the Chicago Quartermaster Depot. If this is not practicable, it is requested that they be given the thirty-day course in meat inspection at the Chicago Quartermaster Depot.

Answer: Requisitions for veterinary commissioned personnel, in the past at least, would not have permitted the delay of two and one-half months or more between the time an officer reported for duty and arrived at his station if he received a month's special instruction in meat, meat-food and dairy products inspection and the course at the Army Medical Field Service School.

It must also be pointed out that the special monthly course at the Chicago Quartermaster Depot cannot be given to classes of more than approximately twenty officers, as a larger number would interfere with operational activities in the packing plants. In view of this, eight veterinary replacement training pools have been set up at points where opportunity is afforded for special instruction, particularly of a practical character, in military meat, meat-food and dairy products inspection. With few exceptions all newly commissioned veterinary officers are initially sent to these replacement training pools and the policy is to give them at least a month's training in such pools before assigning them to stations.

Allotments have been made to service commands for the assignment of Medical Department officers to Carlisle and if requisitions from the Seventh or any other service command are submitted with the request that the officer or officers to be assigned be detailed for the Carlisle course prior to reporting for duty in the service command, this can be done, provided the service command or Surgeon General's allotment for the Carlisle course will permit.

GENERAL HULL: That, I think, is fully explanatory; it's the question of time with us more than anything else. We would like to have all officers, not only veterinary but all officers, go t

Carlisle first, but we just haven't had, up to date, sufficient officers and time. We've needed the personnel so badly that we had to get them on duty. We had to send them out and put them to work without first getting them all through Carlisle. Are there any other questions to be asked of General Kelser?

COL. MOORE: General, there is a question in my mind just what should be done in the laboratories, the service command laboratories as well as at veterinary laboratories and depots?

GEN. KELSER: I'm not clear as to precisely what you mean by veterinary laboratories.

COL. MOORE: There is a laboratory at Oakland.

GEN. KELSER: That's a Quartermaster laboratory at the California Depot. Several of the Quartermaster Depots have laboratory installations set up primarily to do chemical analyses of a variety of food products, and analyses not involving foodstuffs -- clothing, shoes, etc. At those depots they have been doing, for a number or years, certain chemical examinations. Now, ordinarily, they have nothing to do with bacteriological examinations, biological examinations or, in other words, any examination that is required for the determination of the fitness of a foodstuff for human consumption such as is ordinarily done at our Medical Department laboratories. Now, Oakland happens to be an exception which came about prior to the present emergency. Bacteriological and biological examinations of food products were being done at Letterman General Hospital whereas the depot laboratory did the chemical examinations and it meant dividing specimens and sending part of them to the depot laboratory, and for biological and bacteriological examinations the other half went to Letterman. Inasmuch as we had at the California Depot, at that time, an officer of our service who was thoroughly qualified in all phases of laboratory work, arrangements were made to have him do the complete job there. With the advent of the service command laboratories, the policy, as far as the Ninth Service Command was concerned, was that the service command laboratory would do all of the routine laboratory examinations as being done by other service command laboratories on all purchases other than those made by the California Depot and that the Oakland laboratory would confine its activities to those foodstuffs for which they let contracts.

GENERAL LUTZ: Next, I'll introduce General Mills, Director of the Dental Division. We have quite a few questions submitted about dental care. This question from the Second Service Command: Can a suitable form be authorized to provide authentic information concerning enlisted men for whom prosthetic dental appliances have been constructed and inserted? Such form should be filled out by the dental surgeon at the time the appliance is inserted and sent to the organization commander for inclusion in the service record. Information indicates that a large number of troops are arriving at staging areas for overseas shipment who have not had the necessary dental corrections, as well as the required immunizations, and the issue of spectacles where necessary. A form of size to permit it being stapled to the service record containing the information shown below is suggested. It would thus be simple to check on any man's denial of possession of such a dental appliance on his arrival at a staging area or port of embarkation. Now, the only thing that I can see about this form is that there is always an objection on the part of The Adjutant General to adding anything to the service record, because they object to putting anything more on the service record. It has grown so in the last fifteen or twenty years that they don't want any more stuff put in there. Now, whether or not this can be done will have to be taken up by this office with the General Staff to see whether they will put it in the record, am I not correct, General Mills?

GENERAL MILLS: That is correct. May I say a few words?

GENERAL LUTZ: Go right ahead.

GENERAL MILLS: Many inquiries reach our office to the effect that some record should be made that a man had the properly fitted replacement made at his home station in order that he would not arrive at a staging area without this replacement. This being recorded on his service record would not in any way prevent the man from throwing the denture away on the way to the staging area, if he wanted to do so. The advantage of such a record would be a protection to the station to show that they did construct him a denture before he left, but it would not prevent the man from throwing it away if he saw fit and say, "I lost it," and that would end it right there. You might have it on his record a dozen times and you'd still have to make him another one just the same before he goes overseas. We recommended as far back as last September that instructions be issued to the effect that no man would be sent to a staging area for shipment overseas who was in Class 1, which included the need of proper replacements. This was never published in the form recommended. Recently we have asked that a paragraph be

incorporated in POM stating that no man would be sent from his home station to a staging area who was in Class I. We believe that will be approved and we also asked that for wider distribution a War Department circular be published. If such a circular is issued and complied with, that will be evidence that they constructed the man a denture before he left his home station, and if he reaches the staging area without one, you will know that he probably threw it away or lost it, unintentionally or purposely. Also, we've asked that in this Circular it be stated that this would not relieve staging areas or ports of embarkation of their responsibility of furnishing complete dental service including prosthetic replacements. If such a directive is issued, there will not be many men reach a staging area who need prosthetic replacements, but in case they do there are ample facilities at all staging areas to take care of them. I believe that all dental service rendered military personnel should be a part of his record. But we are in this war now, and it appears too late to initiate such a change when so many are already in the service and we are doubtful as to War Department approval. However, if any station dental surgeon can get company commanders to accept a certificate that an artificial denture has been made and attach it to a man's record, we have no objection at all to it.

GENERAL LULL: The next question has some bearing on this. Confusion exists as to dental requirements for overseas service. It is understood that regulations require sufficient teeth, artificial or natural, to provide proper mastication of the Army ration. This is a matter of judgment of individual officers and results in men being turned back at the port. Can the matter be clarified so that service command officers and officers at ports speak the same language?

GENERAL MILLS: Dental correction of all Class I cases, AR 40-510, including Change 1, and as far as practicable correction of Class II cases. Attempts have been made to have the above published since September 1942. It is believed that these requirements will be published soon, to be effective before troops leave home stations for staging areas and ports of embarkation.

GENERAL LULL: That was the climax of what you just said.

GENERAL MILLS: We have had numerous requests and inquiries regarding clarification of what is necessary to masticate the Army ration. We contend that you should leave something up to a man's professional judgment. You can't say that a man must have any specified number of teeth. S.G.O. Circular Letter No. 1114 clarifies this.

GENERAL HULL: Next question. Is it the policy to establish dental clinics at the various places, other than camps or posts, where men are held for training for variable periods before being sent to ports? Authorization for dental clinics is based upon War Department Construction Policy, that is, one dental clinic DC-2 for all cantonment hospitals 250 beds or larger. Also one central dental clinic, located in troop area, for each division or station of 10,000 strength or over. Type DC-2 where strength is 10,000 to 15,000 and Type DC-1 where strength exceeds 15,000. DC-3 is allowed for troop area when strength is from 3,000 to 6,000 and adequate dental facilities are not available. I believe this applies to places where they have no dental clinic set up.

GENERAL MILLS: I don't know what kind of a camp it could be where there is no dental clinic, where men would be held pending shipment overseas. I didn't know there was any such installation.

GENERAL HULL: Oh, Fifth Service Command, I beg your pardon. We'll have to wait for Colonel Jones and have him clarify that. Next question, submitted by the Fifth Service Command also. What is the policy of dental treatment for prisoners of war? To what extent should treatment be given? How should reports of treatment be rendered, separately or otherwise?

According to FM 27-10 Rules of Land Warfare, the Geneva Red Cross Convention, and AR 40-510, prisoners of war are entitled to the same dental treatment accorded our military personnel as outlined in Letter AG 703.1 (4-16-42) MO-SP-M, dated 25 April 1942, subject, Dental service during and for six months after the war. I might say that, in talking to the surgeon at the New York Port of Embarkation, and the dental surgeon at the New York Port (General Mills was also talking to him), he said that they had examined a lot of German and Italian prisoners. The Italian prisoners, their teeth were just naturally in good shape. They didn't need very much dental treatment; they had good natural teeth, as a whole. The Germans did not have as good natural teeth. However, he said that the Germans had a lot of dental work that had been done, and when questioned they said that when they came up to join the army they were told, "Go out and get your teeth fixed and come back." That's the way they got it.

GENERAL HULL: What increase, if any, in allotment of dental officers may be expected for the service command? The present allotment is insufficient to provide an effective dental service. Furthermore, consideration should be given to the fact that the service command is acting in the capacity of a training pool, and is subject to War Department call for officer fillers or replacements.

GENERAL MILLS: An officer from the Military Personnel Division, Headquarters, A.S.F., is now visiting or is to visit service command headquarters to study allotment of commissioned personnel. On his return he will submit his study of Medical Department officer personnel required to The Surgeon General's Office for recommendations and comparison with allotments as recommended by this office. The Surgeon General's Office will endeavor to replace officers assigned by service commands as filler replacements. Now, there, of course, we are up against it for personnel the same way, although not to such a great extent as for medical officers, in that we are short of dental officers and furthermore, the demand for dental service is much greater now than it ever has been. We require more dental officers, and we have made an effort to get these dental officers and assign them to the service commands. Colonel Craven and I have always been very liberal, and we try to approve of any request that has come in for increased allotments, but they haven't always been approved by the War Department. You can rest assured that as far as the Personnel Division in our office is concerned, you will be given every consideration for such increases as you can get the Board to recommend for you.

Comments: You see the Army Service Forces' Director of Military Personnel is allowed so many officers for each service command, and as a result, we've got to divide them up among the various branches, among the various corps, and he just tells you that you can have so many and no more. Now, if they take so many for Military Police, over and above what he thinks he's figured on, someone else has to lose. That's the way it runs.

GENERAL LULL: All right, next question. Is The Surgeon General's Office providing additional dental laboratory technicians (mechanics), Classification 067, to stations establishing a laboratory service as they become available without regard for a filler and replacement request? Existing allotment of enlisted personnel is inadequate to provide for this increased service.

GENERAL MILLS: Stations should submit requisitions for dental laboratory technicians (067) when required, to The Adjutant General through service commands for filler or replacements. However, it has been the established policy of The Surgeon General's Office to have these dental laboratory technicians transferred or reclassified if they are in positions where their services cannot be used at their specialty. Heretofore anyone who had worked in a dental clinic was considered a dental technician. In the old regulation they were classified as 067. That was incorrect. A dental technician or assistant is 855 and dental laboratory technician is now 067. The War Department has approved and clarified the duties of each. When a man is inducted, if he states his qualifications and is qualified as an 067, he is assigned to a Medical Department replacement

training center where we get control of him and order him to one of the technicians schools where they have authority to graduate them as 067 or 855, whichever it is felt they are qualified for. Originally they graduated everyone as an 855, but since they got a lot of those men who are qualified dental laboratory technicians in civil life, we ask that they be authorized to graduate those who are qualified as 067. These we assign to stations where we have information from the service command that they are needed. If you are short 067's, send in a requisition for them and we will try to get them there from the next class from the schools.

GENERAL LULL: What dental service will be rendered to Air Corps college training units and Army Specialized Training Personnel students by the service command dental service? If on a civilian contract, are they entitled to emergency and definitive dental treatment by the service command dental service? Some of these colleges are adjacent to Army stations, and definitive dental treatment by station dental personnel is being demanded. For example, in the vicinity of Minneapolis-St. Paul there are about 2,000 ASTP and Air Force students, which throws an extra burden on Fort Snelling. If definitive dental treatment is to be given for these student detachments, an increase in allotment of dental personnel will be necessary.

Answer: These students, being enlisted men, are entitled to dental treatment either emergency or definitive, if required. If contracts with the colleges do not include dental treatment, it will have to be obtained on a fee basis as outlined in AR 40-510, provided an Army dental clinic has not been established or no Army facilities are available in the vicinity. There, again, I think we can keep it down to a minimum, because these boys usually come in with little dental treatment needed -- they are pretty well fixed up when they come in, most of them.

GENERAL MILLS: A great number of these technical schools (Air Corps) have just a few students undergoing intensive training and they don't desire any dental service other than emergency treatment which they can get under AR 40-510, or that for which the school provides. They do not have time to obtain any other treatment.

Comment: Well, as far as the medical schools are concerned, they are going to be in school a long time; they won't be going overseas for a long time.

GENERAL LULL: Next question. Recommend clarification of AR 615-26 regarding classification of dental laboratory technicians, 067, and dental technicians, 855.

GENERAL MILLS: Changes in the specifications for dental laboratory technicians, 067, and dental technicians, 855, have been authorized by The Adjutant General and will be published in the next memorandum revision of the AR. Briefly, to sum up, dental technician, 855, assists the dental officer in all chair duties; prepares patients for dental work; sterilizes instruments; keeps instruments in working condition and order; operates or assists in operating x-ray equipment; cleans teeth; keeps appointment book and other office records; performs such other nonprofessional dental duties as may be assigned. Dental laboratory technician, 067, performs dental laboratory work to include the fabrications of metal, vulcanite, or other composition dentures from impressions; constructs splints, metal clasps, inlays, and bridgework according to specifications, and such other nonprofessional dental duties as may be assigned.

Comment: That is being published in the next revision of AR 615-26?

GENERAL MILLS: That will be in the next change.

Comment: The old one was confusing, as it had the same qualifications in a large part for both of them.

GENERAL LULL: Next question. Recommend clarification of the new dental Form 18b, in space "Kind of Work." Is it correct that a station will report no work in this column unless it is fabricated at that station?

Stations will record on W.D. Form 18b, in space, "Kind of Work," all dentures or gold work inserted, even though the cases have not been fabricated in their own laboratory.

Are there any other questions that you wish to ask General Mills? If not, thank you.

GENERAL MILLS: Colonel Rogers said this question-asking was going to work both ways, so I have given you some questions to ask the service command surgeons.

GENERAL LULL: Here they are.

What provisions are being made for dental treatment of prisoners of war and what type of service is being given? Well, that's been covered in our answer, I hope.

Are the telephonic instructions from the S.G.O. authorized by the Director of Military Personnel, Headquarters, ASF, to service command surgeons concerning the retention of dental laboratory technicians, 067, Service Command Units, being complied with?

GENERAL MILLS: We have information that some of the stations are not, that they still declare all of those men available for full military duty, and they're taking them out and assigning them to tactical units. Particularly one station in your service command, Colonel Hart, Camp Barkeley. They say that they just go right ahead and take them just the same. That was not the intention of the War Department. We can't do the work required if we can't keep those technicians. When requests are received for personnel to be assigned with units which do not have dental laboratory facilities, assign them 855's. The only units that will have 067's are your evacuation and numbered station and general hospitals, etc. None of your regiments will have any 067's with them any more under the new T/O.

GENERAL HUNT: Are dental officers being selected for assignment to dental colleges that have contracts with the Army under the Army Specialized Training Program?

We have promised the dental educators that we would assign dental officers to the dental schools. That is, the dental officer will be the P.M.S. & T. of the dental school. We certainly will have to assign one medical officer to each medical college, in accordance with our promise to the educators.

GENERAL MILLS: We feel it is very necessary on account of the equipment. It is more complicated with the dental than it is with the medical. We will have all this equipment that the Government is going to buy and be responsible for, and the issuance of the books. They'll have to have replacements of instruments if they break them or lose them, and it is essential that a dental officer be there with the college. Whether at a small school where there's not many students, it would be a full time job or whether it can be in addition to other duties and spend half the time in the school, I don't know. That's a decision for the service command surgeon to make. But we do believe that a dental officer should be assigned to all dental colleges that have a contract with the Government and are training men under this specialized training program.

Question: How many have you, General?

GENERAL MILLS: How many what?

Question: How many dental schools have you?

GENERAL MILLS: We have thirty-nine schools altogether, but I don't think all of them have contracts.

COL. HART: Can we use retired officers for this duty? We use retired officers, that is for the medical.

GENERAL LULL: Yes. Wherever we can use retired officers; I believe that that's fine.

GENERAL WILLIS: What would apply to the medical, would apply to the dental in that respect. But I believe that there's some instruction that you can't assign anyone above the grade of captain, or something like that.

COL. REDDY: Well, the First Service Command requisitioned officers in company grade.

GENERAL LULL: That brings up a point, that we should try to, and I think that we're going to. That can be brought up when Colonel Fitts comes over here, because we're going to have him over here. We should try to get the allotment of officers for this specialized training set up like we had the P.M.S. & T.'s, regardless of rank. Then they won't count against you. That means that we can put a retired colonel in one of these schools, and it won't count against your allotment in service command. It's very difficult, for instance, in Colonel Reddy's command, where he's limited to very few colonels, to bring in three or four colonels and put them in these medical-dental schools. And there should be some arrangement made whereby the allotment would not count against the service command.

Question: Will some of these men be just available for that type of duty too?

GENERAL LULL: Yes, yes they would.

Now for instance, in Colonel Reddy's service command, he has a man over seventy years of age at one of these schools, and he's doing fine. He knows that type of work and he is doing a fine job.

COL. WALSON: It is believed that suitable Medical Department officers, Regular Army, should be assigned to each Medical Department school provided for in the Army Specialized Training Program. Ordinarily this will require retired Medical Department officers in the grade of colonel or lieutenant colonel on account of their experience and the lack of the availability of other Regular Army Medical Department officers. The quota, with appropriate grades, of all officers allotted to the service command should be increased accordingly or such officers designated for teaching in Army Specialized Training Program schools should be carried and charged to the War Department overhead.

GENERAL LULL: When requests are made on stations by service commands to furnish commissioned personnel for units, can the required qualification be stated? That is, oral surgeons, etc.

GENERAL MILLS: A station will release the less efficient officers who may not have the necessary qualifications to fill the assignment. I would like to cite an example, and show you what we mean.

There will be activated at a certain camp a numbered station hospital, or numbered general hospital, and the service command is called on to furnish the personnel. They requested the station to furnish two captains or three lieutenants, whatever it might be, and they don't say what for or what their qualifications should be. The station surgeon or dental surgeon will pick out the men he desires to get rid of -- those who are inefficient -- and he'll assign them to this outfit and the first thing you know they're promoted, because the assignment carried a position vacancy. Thus, the good man is left at the station without any promotion. This causes discontent. It has happened in many cases. I want to cite a specific case. There was a man out on the west coast, who got into trouble, so they transferred him out of the Ninth Service Command. Under the above conditions he was assigned to one of the hospitals, and he is now a lieutenant colonel. Now had the qualifications desired been stated, this would not have occurred. He has been promoted to the grade of lieutenant colonel, while well deserving men are left in the grade of captain or major.

Now, what we would like is when you ask a station to furnish men to activate a certain unit, state what they are for, so they'll know something about the qualifications desired, and that there's a promotion possible and let them assign deserving men instead of the men who are inefficient, whom they want to get rid of.

Comment: We get the personnel requisitions from the War Department that simply call for so many dental officers company grade, or whatever it is.

GENERAL MILLS: We'll probably follow this up.

GENERAL HULL: Thank you very much, General Mills.

Medical Practice Division

GEN. LULL: Now we're going to take the Medical Practice Division. I'll introduce Colonel Freer. I hate to keep pushing you this way, but it's the only way we can get through. We have a lot of questions.

Question: Reference Section II, Circular 64, W.D. CS, what is the policy of the W.D. concerning enlisted men with defects, such as those listed under paragraph 15c AR 40-100 and other conditions, such as history of spine fusion, which the W.D. has heretofore considered as unfit for any military service, who are performing satisfactory service in their current status and who have made application for officer's candidate school? This office has held that the provisions of section II, W.D. Circular No. 64, 1943, make it mandatory that they be considered qualified for commission, regardless of whether or not such defects were incurred in line of duty, and that they should not be discharged on CDD when the condition is asymptomatic and is reported incidental to voluntary action on the part of experience and otherwise qualified enlisted men to obtain a commission and thus serve their country in a position of greater responsibility.

Answer: Interpretation of section II, Circular 64, 1943, does not discuss whether or not the defects were existent prior to induction nor do they discuss whether or not they were incurred in line of duty. It merely states that any individuals who are considered physically qualified for retention on active service on an enlisted status should be considered physically qualified to attend certain officer candidate schools. It is thought that line of duty status in such cases does not enter into the question.

GEN. LULL: Does that answer the question, Colonel Walson?

COL. WALSON: Not exactly. These men are often good noncommissioned officers and their organization commanders may want to retain them, but they do not meet the physical standards for commission and then they are forced out of the service under the provisions of this War Department directive.

GEN. LULL: How about that, Colonel?

COL. FREER: Well, there is a clause in there that says, "who are otherwise qualified for commission grade," in other words if it is just the physical condition that is keeping the man from becoming an officer, and we should be able to make up our minds in fact, we're almost forced to do so -- to either separate him from the service with that physical condition, or weigh the defect

and allow him to be commissioned or attend one of the schools, either the Limited Service Type School or the General Service Type School.

GEN. LULL: In other words, if the only thing that keeps that man out is a physical defect, if he has all the other qualifications, it can be weighed regardless of whether it's in line of duty or not.

COL. FREER: That's my understanding. Now let's search it. I think that circular tied around defects with which the man was inducted, for example, we induct a man when he meets the physical standards of MR-19, and then later he comes up as an officer candidate. We don't feel that he would meet the physical qualifications for even limited service. That individual should be discharged on CDD. If, on the other hand, he does meet the physical qualifications of MR-19, and we're a little hard pressed to consider him as officer material, we should allow him to go to a Limited Service Officer Candidate School. I don't think that that should include old soldiers who have developed their physical defects in the service and that we should waive things like diabetes and severe hypertension, and a number of defects along that line. They were not inducted with those defects; they are not forced in the Army with that defect. Those are disabilities that they have acquired while in service and we shouldn't bend way over backward because of our sympathies in that connection. He has his CDD or retirement privileges if he has over twenty years of service, etc.

It seems to me the question of the retirement privileges, of an officer in comparison with the discharge or retirement of enlisted men should have some bearing on the acceptance of a man as an officer with these defects.

Regulations, such as this one, came about through a desire from the War Department, and perhaps due to pressure on them, not necessarily the medical opinion involved in it, that they would not be in a position of forcing a man to serve in an enlisted grade rather than a commissioned grade if the only obstacle to his commission was a physical defect. And we should be able to reconcile those two conditions so that we would say either a CDD, and let him out as an enlisted man, if he has the mental qualifications for an officer, or else waive the defect and let him go on and be commissioned, even though the Government assumes a little additional financial responsibility in connection with his future possibilities.

Comment: I don't like the implication though of that applying to the Medical Administrative Corps more than other branches of the service.

COL. FREER: I don't think I can enlarge upon that much, except that generally speaking it was supposed that they would not be subjected to the same degree of physical exertion and exposure that some of the other branches were. But, as far as I can recall, we have nothing to do with deciding just which branches would be included.

GEN. LULL: You know, that thing came up with reference to certain religious sects. Now the next question:

Question: Can the instructions concerning under-height waivers in excess of one inch, embodied in letter SPX 341 WAAC (2-15-43) PR-I, 20 February 1943, be withdrawn so that service commands can act on all cases of request for waiver in enrollment of WAACs (reference: Memorandum S40-5-42 and paragraph 3a, letter AG 341 (2-25-43) PR-1-A, 26 February 1943?

Answer: On 7 June 1943 The Adjutant General's Office sent a directive letter to the commanding generals of each service command granting authority to waive enrollment of WAAC applicants for certain specified physical disabilities. These physical disabilities were listed in the letter; in this list, also, minor physical disabilities not of a progressive nature were included. The letter of 7 June 1943 rescinded letter SPX 341 WAAC (2-15-43) PR-1, 20 February 1943.

S. C. SURGEON: In that last letter you speak of, however, it says that other cases where still more relaxation of the regulations are considered applicable. Now, the recruiting service of the War Department is to carry on a very extensive campaign for WAAC applicants. And, his duty is to enroll as many applicants as possible. And, I think the service command surgeons have to combat an effort being made to relax or to give more freedom to the physical requirements for WAACs. I feel that we ought to keep the standards that now exist for induction of men for induction of WAACs. Otherwise, we're going to be loaded with a lot of neurasthenics and other women that shouldn't be in the WAAC. Have you anything to say on that, Colonel?

COL. FREER: I concur in the Colonel's idea with regard to adherence to the physical standard for these WAACs. I think, due to a combination of circumstances, there has been, perhaps, from time to time, a tendency to let down on those standards, not through the fault of any individual, but I believe that all concerned with the WAACs are well aware of the fact now that it's a short-sighted policy to have them come in under other than rigid physical examinations and adherence to the established standards. They are soon to be brought into the Army and the regulations are already set up so that they will conform to the physical standards of AR 40-100, as modified, as for other women components. And in the interim, pending their being blocked into the Army, we're attempting, as far as we can, to

have that standard maintained now. It might be well to inject here the statement that on 29 May we received a memorandum from Personnel, A. S. F., that the General Staff had approved the proposal that the WAACs coming in the Army be given physical examination of final type as specified in AR 40-100, which would include all cases that had been brought into the WAAC service more than six months ago, and that those who had come in within six months be not re-examined.

GEN. LULL: Any further discussion on that question? Next question.

Question: Does the W.D. desire that Memorandum W 600-39-43 be interpreted so strictly as to require separation from the service of any enlisted man in whom a diagnosis such as psychoneurosis, mental deficiency, or constitutional psychopathic state has been made without regard to the degree or severity of the condition?

Answer: W.D. Memorandum W 600-39-43 states that any enlisted man in whom the diagnosis of psychoneurosis, mental deficiency, constitutional psychopathic state appears will be separated from the service if he cannot be returned to full duty. This memorandum specifically states "with a view to discharge of those who cannot be expected to render full military duty." The intent of that phrase was to allow individuals who, after an ordinary period of rehabilitation, anticipated to return to full duty should not be separated from the service.

There's a great difference in the psychiatrists. Psychoneurosis is a very flexible term. I don't know what the answer to it is.

Well, I think that's the most mooted question that we've had with us for years, how much a psychoneurotic can do. I mean a lot of us have a certain degree of psychoneurosis and get by with it. It takes a pretty good psychiatrist to tell just what that limit is.

I think there'll be many more rejections down at induction stations as a result of this last instruction. It might help to get a general picture of this subject. I have discussed this with two or three of the surgeons in personal interviews, and I might state that the plan of this office was not exactly that which is now a matter of regulations. It was considered, when that was put up to us, that it was a wise provision, in so far as <u>original</u> classification was concerned, and if a man had passed through the screening at the induction station, and was fairly soon, while the condition was obviously not in the line of duty, found to be substandard in this psychiatric field, then rather than rock along with him and try him out on limited service as we would a man with

some organic defect, we'd better just wash him out. Personnel and other branches beyond The Surgeon General's Office were quite insistent that this be made a uniform policy to cover all and not be limited just to those men for original classification. We anticipated some difficulty with that, as regards specific cases like this. An officer or an enlisted man who broke down under combat service in the presence of severe bombing (and we all know that our mental, like our physical resistance, is relative and that under a severe enough trauma anyone may crack) coming back to a general hospital in the United States making satisfactory recovery and having special qualifications that fitted in as a supervisor of mechanics, would have to be retired if we adhered to this directive. Actually, his condition is in line of duty, and that man would have a great deal of potential value to the service provided he is not sent back to the same environment under which he originally broke down. We stated that there would be a certain number of those cases and that it would be well to limit this directive to the original classification. That was not accepted, so the thing stands as it is now written. There have been a few cases in which these men came before Disposition Boards, and they recommended return to full duty but within the continental United States. To date we have not had any repercussions on that, and it may have gone through. It might be well worth the trial, and if that will go through that's all right. The man is physically fit for full duty, but not back in a theater of operation or combat zones.

S. C. SURGEON: We had a motor mechanic out at the Army Medical Center after the war. He was a fine mechanic, except, when a truck backfired or something, when he didn't expect it, he threw a fit; but I guess no one paid any attention to him and he came out of the fit and was all right. Well, this shows that he's not fit for full duty.

Now, of course, that's one of the limitations for which limited service was set up. But, that has been tried in a few instances. I would agree with the instructions that you carry him in at full military service in the continental United States. He should be, of course; according to our setup he should be carried as limited duty in continental United States. That means he'll never get in a tactical organization to go abroad again.

GEN. LULL: Colonel Halloran, anything to say on this?

COL. HALLORAN: I think the question that Colonel Walson has raised with regard to the repercussions of this limitation on induction is a good one, for the reason that experience has shown, now we've had sufficient experience, that we're getting, in proportion to the total number of psychiatric cases, a large percentage of them admitted to station hospitals. It seems

as though it caused a pattern by which the peak of the curve occurs in about three weeks of training and again in about twelve weeks. One wonders, therefore, in view of this practical experience in hospitals, whether there actually shouldn't be more emphasis on cutting down the actual number of cases at induction. It's a very difficult proposition because we realize that if we eliminated everybody with a neurotic tendency, we wouldn't have an Army. That's from your practical point of view. It does seem as if the experience of this early training period indicates that too many are getting by. The psychoneurotic, as most of you know, has been tried out and has bounced. He's come back into the hospital after trial on limited duties. We agree that there are those who do well, those mild people who have not let changes interfere with their lives, who probably get along fairly well, particularly if there is some type of special duty which is not permitted under regulations now. But I think it is well to bear in mind that the experience now is tending to show that there are too many cases getting into the Army.

Question: We require pelvic examination of applicants as provided for in paragraph 6, AR 40-100, Change 2, dated 27 March 1943, as applied to nurses. Is this correct?

Answer: Yes, the pelvic examination of applicants is required.

In all cases?

In all cases.

According to AR 40-100, as recently corrected.

S. C. SURGEON: I don't think that's right. How about virgins?

Answer: The regulation states that pelvic exam will be made rectally when indicated.

Question: Can anything be done about change in regulations as to discharge of WAACs while on inactive duty? See paragraph 36d(2)(b), WAAC Circular 10. Two letters have been written about this, but no reply has been received.

Answer: The procedure outlined in WAAC Circular 10, dated 9 April 1943, paragraph 36d(2)(b) and (c) is necessary to clear the files of individuals who have been enrolled but placed in the Enlisted Reserve Corps to await actual call to active duty. Some of these individuals develop intercurrent illness or physical defects and, therefore, must be discharged from the WAAC rather than be left on the Enlisted Reserve Corps roster.

Question: Recommend age limit be reduced to 35 for obvious reasons. Can anything be done about it?

Answer: An age limit of 38 years has been recommended on more than one occasion. This recommendation was forwarded to WAAC Headquarters; however, up to the present time they have not seen fit to adopt this suggested age limit.

Question: I'd like to ask if a birth certificate is required.

For a WAAC?

Yes.

Is a birth certificate required for a WAAC?

I don't know. In questionable cases, in the Second Service Command, we inquired if she had references about her age, a certificate or something like that.

The burden of proof is on the applicant. If she says she's so old, she ought to be able to prove it. We had that question come up with a woman doctor. In the early days a woman refused to state her age. She looks younger now. We didn't know how old she was, but she just said she refused to state her age. So, if she graduated from medical school back about 1906, we could tell about how old she was.

Question: What is the policy as to furnishing fever treatment machines in general hospitals?

Answer: The policy of The Surgeon General's Office regarding fever therapy cabinets is to equip each named general hospital with two cabinets. On 12 April 1943 in view of the increasing number of sulfa-resistant cases of gonorrhea, it was recommended that this number be increased to three fever cabinets for each named general hospital. However, recently in view of the very promising reports of the results of penicillin in the treatment of sulfa-resistant gonorrhea, it was deemed advisable to delay the procurement of the additional cabinet for a period of thirty days pending the outcome of certain controlled experiments with penicillin. If the results of these experiments are favorable, it will probably be advisable not to purchase the additional fever cabinets.

Any discussion of that? That report will be out within thirty days.

Yes, we should have knowledge by 1 July whether or not there will be a sufficient amount, and apparently in view of the progress that has been made in clinical experimentation, it

will hinge upon the amount procurable rather than other factors. That ties in with the number of fever therapy cabinets that we have tentatively approved for overseas also and this is very timely.

Question: Policy as to disposition of students who should be discharged on CDD, or who probably will require long hospitalization.

Answer: Policy as to disposition of students who should be discharged on CDD or who probably will require long hospitalization should be as that established in AR 615-360, Disposition of Personnel. They should be treated the same as any others.

Question: What are physical standards for voluntary induction for A.S.T.P.? We require general service under MR 1-9. No limited service. Is this correct?

Answer: Physical standards for induction into the A.S.T.P. are those prescribed in AR 625-5, 26 November 1942, "OFFICER CANDIDATES." Ten percent limited service personnel are allowed for these units. Qualifying the A.S.T.P. students under MR 1-9 is not correct. Authority for this statement is W.D. Memorandum W350-47-43, 1 March 1943, subject, Army Specialized Training Program Organization and Operation, paragraph 9b.

The above was confirmed by telephonic conversation with Colonel Stuart McLeod, who stated that it was planned to send a teletype referable to limited service men at A.S.T.P., and this is not to exceed 10 percent.

Question: Should Medical, Dental, and Veterinary students be accepted for voluntary induction if they qualify for general or limited service for commission in the Army of the United States, or should MR 1-9 apply? If the latter applies, some men will be disqualified who later would be eligible for commissions in the Medical Department.

Answer: Physical standards for induction into the A.S.T.P. are those prescribed in AR 625-5, 26 November 1942, "OFFICER CANDIDATES" and so forth. The question is a similar question to the one asked by the Fifth Service Command. Is that clear? You'll have 10 percent. It will not exceed 10 percent. Now, Colonel Freer, are there any further questions you want to bring up?

COL. FREER: Yes, we have some questions. I'm not sure whether they reached the office to be passed around. This all had to be done on short notice. There are some questions from three of the branches that they would like to bring up and I'll ask General Rankin if he will kindly bring up those pertaining to surgery.

GEN. RANKIN: The first one that we wanted to discuss with you is the question of the inspection service, or probably we should say consultation service, that have proved so satisfactory in the service commands that have them. It's felt that it could be probably extended to some degree to the advantage of everybody concerned. Now, I'd like you to know that there are a few service commands that do not have any consultants at all, medical, surgical, or neuropsychiatric. Some have all three and some have two. I would like to have an expression of opinion both from the men who have the service command consultants as to the utility and their desirability of extending that particular service. As a matter of fact, we've thought that a good deal could be accomplished in extending it, provided you have place in the Tables of Organization for men of the necessary rank.

GEN. LULL: That ties in very definitely with the Committee's work that will be done as far as the personnel and position in concerned. I know that a great many of you gentlemen are up against the fact that you have to cut down your overhead, and the consultants are a vulnerable place where you can cut down. If we could establish something in a directive, I think it would help a great deal. It would help you gentlemen a great deal. I think that General Rankin would like to know what you think about the value of these people. Isn't that right?

GEN. RANKIN: That's exactly what I want -- to get their reaction. We know what we think of them here in the office, but we want to get the reaction of the field, as to what these men are doing.

COL. GIBNER: I think they are very valuable.

COL. FREER: I'd like very much that that be a part of the record there, but that dictaphone is turned away from the Colonel.

GEN. LULL: Will you redirect your statement?

COL. GIBNER: I think it would be a great mistake to do away with the consultants of the service command. I consider them invaluable and I think that the character of the medical service that we're giving would suffer a great deal.

GEN. LULL: Are there any other expressions of opinion?

4th SERVICE COMMAND: Never knew what a joy could happen until I got my consultants there. I had no way of checking up the professional services, either the Medical, Surgical, or the N. P., until I acquired consultants, and I would rather put myself on the list to be moved with two of my assistants in the office -- there are only three of us there -- than to have the three consultants taken away. The only trouble is, that I have only three, and I have 120 installations for them to work on. The result is

that they are gone all of the time; I never have a chance to see them. They are in for a couple of days and then gone for months, but they are doing awfully good work. The people, the commanding officers of the hospitals appreciate the assistance they are giving them.

8th SERVICE COMMAND: I concur in all that has been said, only 100 percent more. I don't see how you can run a service command now without consultants. The thing is that you must have them. In the Eighth Service Command you lay less stress on inspection and more stress on consultation. The consultants are practically out of the office all of the time. That is, I think, as it should be. There is no use for them in the office. They spend about five days in the month in the office, which is ample to write their reports, and they are doing a magnificent piece of work.

GEN. RANKIN: I am sure that I express The Surgeon General's opinion when I say that we are very grateful for these commendations, and we are happy that you have found them so satisfactory. I am sure that we would like to extend the same quality of professional consultation to all service commands. Now, we have a little difficulty here actually in finding the proper type of professional man to keep up this code, because the men that are present in the service commands are quality that is getting pretty scarce and when we search around to find others like them, we don't find them with any ease at all. As a matter of fact we just don't find them, and I think it would be unfortunate if we had to reduce the quality of the men that we sent to you and I don't believe that we will have to. I think that we can find them. I think that is our job to find them, and we will try and get them for you. We do feel that this coordination of activities and recommendations that they make are very useful to everyone concerned, and we were wondering if an extension of this service, a survey by certain types of specialists. Now I have talked to General Kirk the last few days about the question of getting a survey by someone who is familiar with all of the orthopedic surgeons and the surgeons at home. I think that there is a distinction to be drawn there. The average orthopedist that has come on in the last 10, 15, or 20 years is a little different from the old formal orthopedist who used to fix flat feet and do certain other things. The present day man is a different fellow. General Lull has arranged to have a couple of men survey specialties from this office -- anesthesia and radiology. We have now an estimate of the men in those two specialties that I think is particularly useful to us and available to you as to just what kind of people these men are professionally. We were of the opinion that we might extend that a little bit and perhaps survey the orthopedic men, or extremity surgeons, and perhaps the neurosurgical group. We don't have a great

many chest surgeons and plastic surgeons, but we thought we could get a better service by setting up certain hospitals for certain specialized types of surgeons. I think there are 16 neurosurgical hospitals. I think that perhaps that is one way of extending the surgical consultation which will be advantageous, too. Again, we were interested in getting from these consultants information which would be of clinical value on many problems that are clinical, such as pilonidal sinus; I could mention a dozen of them, in fact -- thrombophlebitis, varicose veins, foot disability. We are interested to get through them from the various service commands, information which could be distributed, not only to installations in this country, but installations abroad, and we were hopeful that we could work out a method of distributing this information which would be a little bit different from the old circular letter, which would be something new in form and in content. We are working on that, and I believe all of you would welcome this information if we could get it and have it circulated around in the form that is now contemplated. Of course, there are certain clinical investigations that are going on all the time in all the service commands and that is the only kind of research that is possible under war conditions. I do believe that we could with an extension of the consultation system, perhaps correlate a great many of these clinical problems and have them distributed to you -- distributed to everyone in a little different form because something might come up in each service command that might be different from the other. That was about what we wanted to bring up, wasn't it, Colonel Freer?

COL. FREER: I think that covers it all right from the surgical plan standpoint. There are some of these things as expressed by the Surgery Branch that overlap with other branches; however, it still leaves a few questions from Neuropsychiatry and the Medicine Branch. If it would be more convenient for you, we would be glad to fit in with your schedule and have the other two branches come in at some subsequent time.

GEN. LULL: I think there is no objection to taking it up right now. If you want Colonel Shull and Colonel Halloran to enter into the discussion, I think we might just as well continue here and finish up the Professional Service.

COL. FREER: I think this will go through fairly rapidly. Colonel Halloran, as Chief of the Neuropsychiatric Branch, will you take up your questions there?

COL. HALLORAN: The question, we did overlap on the question of consultants, and I am very happy to get the expression with regard to the utilization of certain men of intelligence. In our branch, it is very essential, as you may imagine, that we have information that your consultants are able to bring in. With respect

to the criterion of diagnosis and disposition in such fields as the psychoneuroses, we have found the reports coming in -- copies of the reports that come to you from the consultants -- very valuable, and I would just like to emphasize that we can make very good use of the copies of those reports. They are exposed to every member of our branch and also we glean from them certain important facts brought in so as to guide us, guide us in the formulation of certain policies. As a matter of fact, certain policies that come to you have directly resulted from the suggestions from those service command reports.

Comment: Don't you get those reports now?

COL. HALLORAN: Yes, we are getting them and we are very grateful for them because it does give us a good picture of the problems in the field.

COL. FREER: Excuse me, Colonel Halloran, may I just enlarge upon that point a little bit. When the service command consultant service was formulated about a year ago, a letter went out from The Surgeon General stating that it is the desire of this office that a copy of the service command consultant's report be sent directly to the office for information here. Now that may seem and may be a little irregular, and if there is any objection on the part of anyone to that, it would serve our purpose provided we got a copy indorsed by you at an early date so that it was current information, a copy sent down to us through channels. We would like to feel that this office is in close touch with your office, because these things are almost entirely professional matters and we haven't, with the year's experience behind us, found where that stirred up anything that any service command surgeon would be reluctant to have seen here. It enables us to view the situation at large and transmit ideas out to others that we wouldn't be able to do intelligently if we didn't have this informative data promptly at hand.

COL. HALLORAN: There is one other point that is raised, too, by Colonel Freer's remarks and that is, possibly once a month, we could have summarized by your consultants some of the main problems that have come to your attention and his attention, I think that would help us to crystalize our ideas, and to put into practice some of the over-all policies that are common to each of the service commands. Now, there has been some question about the organization of the Replacement Training Center, Mental Hygiene Clinics. Those clinics were devised to emphasize, to stress the adjustment or elimination necessary at a critical point, that is the next critical point following the induction center, the replacement training, or the training center, and therefore, these clinics were organ-

ized sometime ago. Last fall we had about 18 authorized and they were then directly under the commanding general of the replacement training centers. Since that time, as you are aware, the clinics have been moved. The medical officers are under the jurisdiction of the service command and recently, there has been authorized by the War Department an extension of these clinics to all replacement training centers. That involves in some instances, an additional allotment under the service commands. In other instances, it was indicated that the allotment for the clinic would come out of the existing number of officers allowed to the service command, particularly in the medical replacement training center clinic. Already some of these clinics have been organized. We have felt, and we have found very practical, in formulating these clinics, that the man who is assigned to them, if he had no experience, he should come for a period of ten days to two weeks under the jurisdiction of one of the already established replacement training center clinics, for instance, Fort Belvoir in the East and Camp Callan in the West. There he saw actual clinics in operation so he knew when he got on the job just what he was supposed to do. There has been also some misconception as to the plan of those clinics. I find that in going around that in some instances they have been designated as a Fort Belvoir plan. Well now, gentlemen, there is no fixed plan. This is simply an over-all guide for the establishment of a clinic at the replacement training center as apart from the hospital. The neuropsychiatric section of the hospital has a full time job and we feel that the neuropsychiatrist at the replacement training center also has a full-time job, but of course should coordinate with the hospital. The jurisdiction of the neuropsychiatric officer should be under the post surgeon. All medical activities are under the post surgeon, but there is no plan, no fixed plan by name or otherwise, to be applied to each clinic. In other words each clinic has its own problem and it is intended under your guidance that the clinic should be set up to take care of that problem under the general policies as outlined.

The next question, the rotation of hospital and induction station neuropsychiatric medical officers, I raise for your consideration whether or not, due to the experience of your hospital personnel whether it would be possible for you to exchange with your induction stations where you have neuropsychiatric medical officers, officers from the hospitals who have already seen the back end of the induction process. They have seen the men breaking in talent to the hospitals; therefore, having more insight than the inexperienced men, inexperienced in medical hospital activities, at the induction station. Whether or not it would be possible to gradually exchange, you couldn't replace of course a whole quota at the induction station, but we will say in certain commands where there are two or three officers to replace, to exchange the

induction station officer with a hospital officer so that you would have then, gradually, men who at the induction center have been experienced with neuropsychiatric breaks. Some of you, I think, are already doing that. Now the question of neuropsychiatric officers attending the School of Military Neuropsychiatry at Atlanta, Georgia. That school was established in January to gradually indoctrinate neuropsychiatric officers who have had all types of different experiences in the community and apparently were quite over their heads when they went out in the military installation, and those of you who have sent men to the school, I think can judge for yourself whether those men have accumulated some ideas as to cutting short the period of disposition which is a primary consideration and also a better insight into a peculiar type of clinical manifestations in the military service. Thus far about 150 officers have passed through the school. I think that the results, as far as we can judge from those who have been through, have been quite satisfactory; but we realize that you are faced, all of you, with sending the men away to schools and in sacrificing their services while they are away. I simply want to appeal to you at this time, on the basis of the importance of recognition, assistance in this specialty, to help us to supply the quota of medical officers in spite of the fact that you may be embarrassed for a short period; because we feel that this is a very helpful period of training, particularly the new medical officers coming in. We have said in the regulations that a neuropsychiatric officer should have had at least one year's experience. That was just to start this school going so that you would have the more or less senior type of man. The man who has had some experience and could go back and teach others, because it will be manifestly impossible to send all neuropsychiatric officers, there are over 1100 already in the service, to send all of them to the school. So if you will help us select someone who you feel can come back and impart the instruction; in other words, spread around through your command, those who choose to go to school. In the last two or three months there has been a dropping off in attendance of the men at the school who are selected from the service commands, from the ground services, from the medical replacement schools of this office, and from the Air Forces. We feel that this is such an excellent service there that if you can help, if you can at least fill your quota, it will help us; because they get a valuable training at the school, we feel, for the brief period they are there.

The next point, the interpretation of the circular letter on limited service: As a matter of fact that is a point that I think has been practically covered. I found in one or two instances that they were still classifying for limited service those who had had psychoneurosis, or some mild mental distur-

bance. That is no longer possible under this new circular, unless they can be returned to full military service. In other words, the simple matter of making a neuropsychiatric diagnosis does not mean that they shall be discharged, it is only if they cannot be returned after a reasonable period of convalescence to full military service, and that by the way is synonymous with full military duty. That question is raised by one man in a command. The full military duty is synonymous with full military service. The question which is a diverting one now is the handling of neuropsychiatric cases since the Veterans' Administration is providing facilities to take them from time of discharge. The new circular letter put out recently directs that the hospitals shall contact the Veterans' Facility and not the state hospitals. The question has recently been raised whether or not it should be optional, if the state hospital is willing to take the case whether they should be contacted. The answer to that is: "No, prefer that the Veterans' facility will interview all cases." However, we can find nothing in the regulation, and this answers a recent question, to prevent the Veterans' facility transferring to a state institution. There is one case in Minnesota where a hospital wants to take the veterans and that will have to be instigated by the Veterans' facility. The question of bed space, of course, brings up a very wide question of policy and I think that is probably covered elsewhere. That is going to be quite a problem from the neuropsychiatric angle. The right of the family to retain treatment and custody of the individual is not revoked by virtue of this new law.

The hospital at Minnesota has a double commitment. They have one commitment to the Veterans and a duplicate commitment to the state hospital and the Veterans o.k.'d the commitment. They are sent by authority of the Veterans to the state hospital. That is the way they handle that.

The last question I have in mind is the necessity of holding on to a neuropsychiatric trained officer. The facts are that there are too few to go around at the present time. We are having a great deal of difficulty in getting qualified officers in the service. It has come to my attention in two or three instances that occasionally men have been released for general duty who have neuropsychiatric qualifications. It will take several years to train a man, and since we are getting down to the bottom of the barrel, and we won't have time to train, it seems essential that those who have had training be red-flagged in your service commands and every attempt be made to hold them because there may be plans for the extension of their use rather than eliminating their use. We are going to need every man that we can possibly have. I think that those are all the questions that I have.

COL. FRENCH: You say in the last two or three months the attendance at your school has declined. In the last two or three months the attendance in our medical personnel has declined, too, so that we are right down to the bone. About the only officers that we can send to that school are from the numbered station and general hospitals. We just don't have them in the service commands. It is pitiful.

COL. HALLORAN: I recognize that problem, Colonel French, and may I say too that we are quite agreeable to having at the school those from the numbered hospitals because those are men who are going to be used.

We are sending all of those that we can from the numbered station and general hospitals. We realize that you gentlemen are up against a shortage of personnel for the whole educational system. It has been very difficult to take these men out of service commands and send them, we know that.

(Colonel Gibner of the Seventh Service Command brings up the point as to what is to be done with psychiatric cases among prisoners of war.)

COL. FREER: There is an Army Regulation that bears on that subject that mentions St. Elizabeth's Hospital specifically, and it is my understanding that in addition to that some other hospital facilities have been set up for caring for insane prisoners of war under other Government agencies than the Army. I am not fully aware of just what that may be. The same applies to tuberculosis. They have set up a separate hospital for tuberculous prisoners of war.

GEN. LULL: I would suggest that they put them in a high priority on the exchange list, if and when we exchange any. All right, Colonel Freer, do you want to discuss some problem in the Medical Service?

COL. FREER: Yes, now the Physical Standards Branch has brought up one comment here that I thought I would read to you and ask you to consider and take such action as is possible to prevent a recurrence of this condition that is embarrassing to the office at times, in regard to West Point candidates. A large number of candidates for the U. S. Military Acedemy have been physically disqualified by the final type physical examination, having previously been given a complete clearance by examiners for preliminary examination. Now we realize that that preliminary examination, and that they are so told, is advisory only, but nevertheless if it could be enjoined on all concerned that they be very careful with regard to that examination, it might avert a number of these disquieting situations that arise later. The disqualifying defects in the

majority of cases referred to are not those that could be questioned or considered border line conditions. They are such definitely disqualifying things as cervical ribs, large hernias, insufficient dentition, and several other conditions. Then the Nutrition Branch has brought up a question, and Colonel Howe is with us here to enlarge upon that or to answer any related questions that one might want to bring up. The nutrition officers in the service command surgeon's office are referred to as our nutrition consultants; those out in the camp are referred to as nutrition officers. The above question is brought up for discussion and opinion.

GEN. LULL: Any of you gentlemen wish to express an opinion as to the value of these officers. Colonel French, I think you brought up something a few minutes ago.

COL. FRENCH: I can say this about the nutrition consultant that has just left us. I think he was instrumental in conserving more food than any other officer in the service command. The wastage of food was tremendous, and we kept after him to cut down, cut down, cut down, until he got them down to just about as much food as they could actually use. In other words, they wouldn't draw 12 dozen crates of eggs, if 6 dozen crates was enough, and have the other 6 dozen go to the bad. The same way with perishable stuff, like fresh fruits and vegetables. They do a lot of figuring in there that I don't know a thing about. They figure on a proportion of carbohydrates and proteins, vitamins, and all that it may be very valuable. I think that the most valuable thing though as I said before is the insistence upon the nutrition officers watching the wastage of food at the various camps and stations and also they have insisted regularly in inspections, making physical inspections of the messes and the kitchens, methods of dishwashing, and they have done a great deal of good in the instruction of preparation of food.

GEN. LULL: Anyone else wish to express an opinion?

COL. HART: Yes, I would like to concur in all that French has said and more. The nutrition officer in the Eighth Service Command has rendered magnificent service. We had recently a committee to come down from The Quartermaster General's Office to show us how to conserve food. That had been put in by the nutrition officer in the Eighth Service Command almost a year before they got there. I think nutrition officers are one of the great assets to the service command office.

GEN. LULL: Colonel Howe, do you have anything to offer?

COL. HOWE: The nutrition consultant in a service command has a particular function in relation to the surgeon's duty to the commanding general. As the Army ration is now conducted, it is a

continuously varying series of food allowances every month. There is no set ration in the true sense of the word. The commanding general's responsibility and the responsibility at all levels of command is going to be reemphasized in the next revision of Circular 16. The adequacy of the ration, or the ration in general, its acceptability and adequacy, is a function of commandant all levels of responsibility, and at no level can it be delegated. That means, then, that theoretically speaking, the commanding general of your service command approves every menu that goes out in all the different stations. The conservation of food that goes on in the Fourth Service Command and the Eighth Service Command particularly, and the others too, but I know more about those, is the result of adapting rations to conditions at local station. That is the level at which the problem of maintaining adequacy and satisfaction is most evident, adjusting it to the activity, to a certain extent, to the habits of the individuals in these places. You review, technically, the menus for your service command. We depend on you to review them for The Surgeon General's Office, at least that is the point of view we have taken. That is done and the War Department, at least The Surgeon General, should know that everything is going as it should. The problem of feeding large numbers of men is a continuous project. It required constant attention. For the small service command, the question might be asked, "Do I need a nutrition officer?" I believe you do. In addition to the checking of service command menus, there are the small installations such as Colonel Reddy has up around Boston that need help more than the larger camps that rate nutrition officers. The service command nutrition consultant can go out and check on what is going on.

There is the question of the prisoners of war: I don't know whether your responsibility is in relation to them or not, but my experience with prisoners of war, or prisoners in general, is that they are the ones who are going to complain most about the adequacy and satisfaction of the food that is presented to them. You could well keep a continuous check on the operations of those camps. Not necessarily having an officer attached, but someone that could go out and be sure that they are operating correctly. Then, when an inquiry comes, you have evidence that is obtained previous to the time that the inquiry starts. As an administrative matter, evidence at the time of occurrence is a very important thing to have. It is hard to get some people to see the need, but I have seen the value of the procedure. The person who is confined, feels that somebody is looking after him as well as possible, and the administrative office in charge that he is doing a decent job. Both sides are benefited by this kind of thing.

I have been wondering about munitions plants. I understand

Colonel Lanza may raise that question. I don't know just what your responsibility is. Colonel Hart takes a very definite interest in what goes on in Government-owned munitions plants. There again, if Colonel Lanza's program goes through, you will want men to participate in his program. That, I think is a nutrition officer's responsibility to work with them.

Going back to the larger stations, I have taken up the smaller service command where there are not so many camps to take care of as they have in the Fourth, Eighth,and Ninth Service Command. In the service commands with many camps, there is a big job. It seems to me you need an efficient officer to help out. Colonel French indicated that he doesn't know how to do the necessary calculations. It can be done very simply, and you can assure yourself that things are right. However, there are difficulties. You realize the menus are planned two months in advance, many substitutions are made; there are enormous losses in cooking, particularly of the labile vitamins. For example, Colonel Freer and I went to a meeting yesterday at which the camp menu was apparently perfectly adequate but biological testing showed that it wasn't when we gave the men a test dose of vitamin C. This happened on the A ration, the ration that planned on paper, figured out over 100 miligrams of vitamin C when 75 is enough. In spite of this the men excreted practically no vitamin C when 50 miligrams was injected into the blood stream, which is one test of the adequacy of the ration. In addition there is the program of waste control. I don't know that the Medical Department has a direct responsibility. If a man has all that he needs, we may not be concerned, but, on the other hand, if he isn't eating all of his ration that is provided, if he wastes a great deal, it does impair the nutritive value of the ration. In this case, there is no question about it. The ration is now planned so close to the requirements that there isn't enough food for the very active man, as compared to the average. There is no plan in this program of rationing to provide for extra food. The ration is planned and has been cut down to where it is adequate for a camp of average activity and not for the maximum activity. There must be adjustments. It is my understanding that it is the surgeon's responsibility to see that that is done properly. If we keep in mind that while a great deal of progress has been made in rationing the average soldier, the output of the energy in the case of some soldiers runs up to about 5000 calories and that the diet is not arranged to take care of that degree of activity. We have an illustration of the need for watchfulness. Of course, there are few organizations that maintain that degree of output for long periods of time. We have taken care of these cases in the past by feeding plenty of food, or in general too much, but that has been a hit and miss approach to the problem. The relative scarcity of food, expecially certain items, and the coming problem overseas in

occupied areas where we may be responsible for feeding our own soldiers and perhaps a great many other personnel will make the review of messing operations even more important. Is there any further discussion about this matter of nutritianists?

COL. HILLDRUP: I haven't found yet a job for my nutrition officer to do in my office. I have propounded that question. I agree with the previous speakers that they are most valuable in the camps, but I have one in my office, and I don't know what to do with him. He has very little to do. Having a small service command, I have very little inspection for him, and I would like an expression of opinion whether other people in the service commands with a few number of camps have need for a nutrition officer in their office on their staff.

COL. JONES: I have had one on hand since a little over a year, a little longer than that, but I sent him to Fort Knox and then I send him out from there. He goes from one post to another. What I have been doing has been working out very satisfactorily. I have him come in about every so often. He has visited all of the camps at least twice, some of them three times, but I keep him at Knox because that is the largest place we have.

COL. REDDY: I have one nutrition officer, but I had him assigned to Camp Devens, but he is my nutrition officer. He gets around to see all the camps and spends what he considers a sufficient length of time at the various stations to find out what is going on.

COL. HOWE: Might I ask, didn't you say that you were going to bring him into your office?

COL. REDDY: Yes, if I can get a couple more men. I will be very glad to have him in my office. I could use him to great advantage if I had him in my office, getting around to all the camps and stations.

COL. HOWE: May I make one remark to Colonel Hildrup? When the nutrition officer was placed in the Sixth Service Command, we had hoped that he would keep in close touch with the Quartermaster Subsistence Research Laboratory. We needed someone to just keep in touch with the things that were going on there. Of course, that might be called an extracurricular duty but a very desirable thing to do. We chose the man and put him there for that duty as much as for duty in your office. At one time you did a lot of work with the Air Corps; that I understand has changed. I think that the Air Force needs a lot of assistance.

There is another factor I didn't mention before, and that is the problem of consolidating the Sanitary reports with regard to nutrition. I would prefer to have the information on nutrition, particularly the factual data consolidated in the

service command and information that is obtained from time to time. There are considerable data of a statistical nature that most of these offices provide for you. These factual data should come to us as one report. To my mind such an arrangement is more desirable than to have it come in attached to each separate Sanitary report. The Sanitary report should carry a paragraph page according to conditions showing the general state of affairs, and let the consolidated report of the service command cover the service command. Extract only the pertinent data of the Sanitary report and add tabular material that comes in. This is, in my mind, the ideal way of securing reports on operations in service commands.

GEN. LULL: Get one of these Manpower Boards to come around and survey it and then try to justify some of your officers and you're up against a wall.

Another thing is about the additional report, too. We have to get that approved by the Control Division before we can get the additional report. I don't disapprove of the advisability of doing it, but they won't allow us to call for any additional reports.

COL. FRENCH: I'd like to find out one other angle on it. The proposed new allotment of Sanitary Corps officers to service command headquarters, at least to ours, calls for only two. We have to have a sanitary engineer and we have to have an industrial hygiene engineer. So unless you can get that allotment raised to three, we aren't going to be able to have a nutrition officer.

GEN. LULL: I think that might be taken up with the Personnel Division when they take the stand.

COL. WALSON: We have a very valuable nutrition officer in the Second Service Command. He covers the ground just about as Colonel Jones said it is done in the Fifth Corps. He has a pleasant personality which is a big asset to him in getting the cooperation of the Quartermaster, the cooks and bakers, and other people with whom he comes in contact. I think he is a very valuable officer to us, but we are constantly being whittled down in the number of officers in our service command, and it becomes a question of whom we can best spare from service command headquarters.

COL. HOWE: If and when these officers should be put out in the field, how would you keep them moving around to cover your area? That is the problem Colonel Jones has.

COL. JONES: I have a regular schedule for him.

COL. HOWE: And you take care of that yourself?

COL. JONES: Oh, yes, that is all done from our headquarters. One reason I put him down at Knox is because they are continually hounding us for cutting down the number of men and the number of officers at headquarters. With this new setup in personnel, it doesn't make much difference where you have him, because he is counted against you anyway.

GEN. LULL: Has this personnel board visited you personally and told you what you are going to get?

COL. JONES: They have.

GEN. LULL: I might tell Colonel Jones that, in his absence, General Kirk appointed him on a committee with Colonel Hart and Colonel Walson to draw up some plan for establishing this setup in the service commands. Is there anything else, gentlemen, that you wish to bring up about nutrition officers? We have with us today Colonel Eanes of the Selective Service, who has a problem that is very closely interrelated with the Medical Practice Division, and especially with the Neuropsychiatric Branch. I will introduce Colonel Eanes at this time.

COL. EANES: I think all of the gentlemen present know that in Selective Service we have been tremendously interested in trying to fulfill our obligation in this neuropsychiatric problem. General Hershey has personally recognized the difficulties of the situation, and it has been our desire in some way to assist in this examination. In spite of much of the criticism which has been directed at us by certain neuropsychiatrists, we feel that the place for the decision to be made after all is at the induction station, except where there is a true psychosis. We have instituted an educational program in the United States for the purpose of attempting to get all of our people to get information which is already in existence in the service commands, or in the home locality, and to present that information with the registrant when he is presented for induction. This has been rather a difficult thing. We met, it is true, with opposition in some of the states. Some said that this information is not available, but on investigation we find that there is information available in most places. There are a number of different programs, because no one program could be suited to all various situations in the states. For instances, in Arkansas, I think they are getting away with it in pretty fair shape, by a very simplified rural system. But in some other places, like New York and Boston, Chicago and Dallas, it is impossible to reach these people except through some social service index. Now to get into that index, has been exceedingly difficult. Selective Service does not want to put up the money to put clerks in those various indices of the social service workers, and they don't think that that would

be justified. In New York State for instance, we have a system whereby the social service workers have volunteered and they do clear through the various state agencies. In New York City, the situation is entirely different. We are continuously informed that New York City is more or less different from any of the rest of the United States, and I am rather inclined to agree with them on that.

In Boston, Colonel Reddy can tell us what has been done there. I was recently in Boston, and I was informed by Colonel Blumber, unfortunately I didn't see Colonel Reddy on my trip, that their system there is invaluable. It has been more or less taken out of the hands of Selective Service for the State of Massachusetts. We have no pride in the authorship of any of these ideas and are delighted to have Colonel Reddy and his service command to handle it and we are more than anxious to cooperate with him in his system. Now in this same service command in Connecticut, there is an entirely different setup, which Selective Service and the State itself is handling. I believe both places are very satisfactory. In fact, the whole of the First Service Command now has a very satisfactory setup on this question. However, in some of the others, and unfortunately I feel in New York City, there is a tremendous amount of information available which is not getting presented to the Induction Station. I would like to see it presented and I would like to have some expressions on the subject. The same thing I understand exists in Dallas. I had my letter written to Colonel Hart, and it is still on my desk sealed, about this in Dallas, when I heard he was going to be here, so he and I will talk it over personally. I would like to hear an expression from any of the service command surgeons with reference to this question. I believe that Colonel Halloran is in support of it. He has concurred in the effort. His office and ours worked together, but at times our hands have been more or less tied. We have felt helpless. We have a man put up by the Mental Hygiene Society in New York with Rockefeller money, who is touring certain of the states to find out what information is really available. What information can be brought up and offered through Selective Service. He slipped a little bit from his strict program, he is helping to make programs, that was never intended. The programs were to be made between the service commands and Selective Service. I understood that Chicago has much information available. However, Colonel Bastian, I haven't had time to talk to Colonel Hildrup, but Colonel Bastian was very much opposed at that time to taking any part in collecting data. He said that he would like to have the information which is in the service command and have Selective Service present it. I want to make this statement clear; Selective Service is most anxious to present it. We believe in it and we would like very much to have it and to present it, but our trouble has

been that we have found in some places, that it is exceedingly difficult to get at it. I would like Colonel Reddy, if he will, to outline the situation in the Massachusetts area. It is being handled right in the recruiting center in Boston, and I think it is the most advanced of any of our ideas.

GEN. LULL: Colonel Reddy will you take the microphone please?

COL. REDDY: In general, the Massachusetts Plan involves the cooperation of local draft boards, State Selective Service, Massachusetts Society of Mental Health, the New England Branch of the American Association of Psychiatric Social Workers, induction board examiners, and representatives of the State Department of Mental Health, the State Board of Probation, and the Social Service Index.

Lists of names of registrants are furnished by the local boards three weeks before they are called for induction. This permits ample time for our induction workers in the Records Clearance Division to search the files of the State Department of Mental Health, the State Board of Probation, and the Social Service Index and to extract therefrom as well as gather from other local welfare organizations all pertinent information that may be of value to our psychiatric examiners. When, from the information thus obtained, it is evident that certain registrants are obviously mentally unfit for induction, they are reported to the medical advisor of the State Selective Service who, if he deems the information conclusive, may direct the local board to classify the registrant in 4-F. With this exception, no man is rejected or accepted on the basis of the pre-induction information obtained, but the information is made available to the psychiatrist for his use at the time of examination to help him in making a more accurate decision. The informative data, obtained by the Record Clearance Division of the induction station, is never under any circumstances returned to the local board or made available to any other agency beyond the Army Induction Examining Board. Every safeguard has been set up to assure that the confidential nature of this material will be respected.

Much of the success of this program has been due to the cooperation of the State Department of Mental Health, the State Board of Probation, the Social Service Index, and social psychiatric workers lent by the Massachusetts Society for Mental Hygiene. The latter workers are being replaced by WAACs as rapidly as they can be trained. The techniques of accomplishing the purpose of the plan is carried out in full collaboration with the State Selective Service System.

COL. EANES: I might say in order to save time, Colonel Halloran has a complete copy of the plan used by Colonel Reddy, and if anyone is interested and wants to see this plan, I believe Colonel Halloran will show him the whole thing in detail.

Recently, as I understand it, well, I went there and saw it and talked with them two weeks ago. There is in these cities, an index of available information from a socialogical, neurological, and psychiatric standpoint. In many places it has been accumulated in indexes. That is true in Boston. They have 20 WAACs assigned to the recruiting service in Boston. It happens to be that the senior one, a first lieutenant, was trained in social service in Richmond, California. That happened almost accidentally, but it was very fortunate. Selective Service prepares in the state of Massachusetts a list of prospective 1-A men as far ahead as they can possibly do it. When the local board meets and declares that a man is going to be a 1-A, they immediately list him. It is sent to our headquarters in Boston. Boston Headquarters sends it over to Colonel Cottam and Colonel Cottam turns it over to the Social Service WAAC workers. Now they take that list and they search the indices for any central information and when a man is identified, and it is quite surprising the number of cases that are identified, the letter then goes out to the various agencies for information. The information is gathered in the agencies, many of them are making photostats of their cards of information, and it is returned to the WAAC officers where it is evaluated and presented to the induction station prior to the time the man arrives. When a man is found with a psychosis, a condition which may be classified at local board level, that information is not sent primarily to the induction station but is returned posthaste to the Selective Service Headquarters, and on the basis that all of this information is official, the Director of the State suggests that the man be classified 4-F and not be presented to the Induction Station. Now the system in New York State -- in fact, it is only in Massachusetts that WAACs have been assigned -- in New York State the situation is variable as I told you. In Rochester, I watched it very closely for over a year. I don't know whether Colonel Walson has given it any particular attention at that station or not, but we have; that's one of his more stable stations as I see the thing, because it has been operating pretty constantly right along from that area around Rochester, New York, and I find that the rate of rejection has not gone up as a result of this. In other words, I believe that the thing works both ways. It works to a more proper system of induction. It excludes some men who might be otherwise included, and it includes some men who might be otherwise excluded. I have felt that a system very similar to the one Colonel Reddy has in Boston could be used in a number of places in the United States. I believe Selective Service is going to push along on this program and it is apt to come up to you in many ways at different times.

Now Colonel Jones, I believe, asked what type of information. Any information that is of a health, neuropsychiatric, or

sociological value. We included health in this problem because there are individuals who have been recorded as having a true rheumatic fever at some time or another, or a rheumatic heart which at the time he comes up to the induction station may not be manifest. In addition to this information, we are particularly interested in the younger group, 18 to 20 years. You will find there are means whereby the secondary school systems will make available their impressions, and their information on the boys just turning 18. That perhaps is further advanced in Maryland than anywhere else. I don't know how much Colonel Burnett has seen of this, because it is not very old, but Dr. Studebaker's office is operating, and I understand there is a movement in Connecticut now and in Rhode Island and Delaware to push this thing forward. That,of course, represents that which may be available in the 18 to 20 year group. Those men have not had the opportunity to demonstrate themselves to the social agencies to the extent the older group has.

COL. WALSON: About one and one-half years ago I wrote to General Hillman about this matter and arranged for a conference between Dr. Stevenson of the Mental Hygiene National Society and General Hillman.

We have been very much interested in the elimination of the mentally unfit since the beginning of induction. Dr. Lang, Assistant Commissioner, Department of Mental Hygiene, State of New York, has been very helpful. Unfortunately, the clearance of social service histories of Selective Service registrants in the State of New York have to be obtained from several files rather than one central source. From the State we get fairly good cooperation, but recently there has developed considerable backlog which is now waiting for clearance. There is also great variance in the number of cases referred to the Commissioner of Mental Hygiene for clearance.

The New Jersey Selective Service System has organized a group of social and psychiatric workers to function as appointed members of the Selective Service System and serve as county and local board social and health counsellors. The county workers coordinate and supervise the work of the local workers who deal with the Social Service Exchanges and other local agencies. There is an Advisory Committee composed of five workers in this field who represent the Department of Institutions and Agencies, the Mental Hygiene Clinics, the State hospitals, the New Jersey Chapter of the American Association of Social Workers, and the State Selective Service System.

In actual operation of the system, a card is prepared for each Class 1-A registrant and upon expiration of the appeal period, the card is forwarded to the Department of Institutions and Agencies for clearance against their files. They

contain information concerning admittance to institutions for the feeble-minded, epileptics, and the insane, as well as penal and correctional institutions. These files also contain information on individuals awaiting admission to some of the above and State Mental Hygiene Clinic records. An abstract of pertinent data found in the State files is typed in the back of the card and the cards are then forwarded to the State Selective Service Headquarters where they are, in turn, forwarded by the Medical Division to the local board. Cards are retained by the local boards until four days before the date of induction at which time they are forwarded to the induction station, under confidential cover.

In the event no pertinent data is located in the State files, cards are sent to the Social Service Exchanges or to the local boards for clearance with local agencies by the Local Council. The advantage in sending cards to the exchanges lies in the fact that a clearance from such exchange indicates any of the local agencies who have had contact with the registrant. The local workers are all on a volunteer part-time basis.

Statistics from the Chief of the Medical Division, New Jersey Selective Service System, indicate 3 percent positive referrals through the State files. It is believed that an additional 10 percent of positives would be obtained if all local agencies were reported in the Social Service Exchanges.

COL. EANES: In Jersey they have a splendid system now -- they do it with their own people; it costs the state very little. The clerical work is volunteered; I have talked to several of our officials there, and it is working very fine in the State of New Jersey. Delaware is trying to get lined up; but our real trouble now is in New York City. We tell New York City people how well New Jersey is doing, hoping to get a little competition so we can some way get New York City to be more helpful. I recognize the fact that New York City is the most difficult city in the whole United States, and yet I believe that this same system which is being used in Boston would actually settle your problems and New York City's, as I see it; but Colonel Walson is familiar with some of our problems in New York City, and they need not be repeated here. At the present moment there are two principles laid down for this thing to make it work. One, as Colonel Walson just stated, that it must be available at the induction station when the man walks in. The second is, that it must be on 100 percent of all registrants placed in 1-A. In New York City they insist upon looking at a fellow and noting the way he looks. They determine that this one must be investigated and that one doesn't need any investigation. I can't see that at all. They say they are very much satisfied and doing an excellent job. Colonel Walson has just stated that in New York City the trouble really began with him,

and I believe that that is the true situation. Now in reference to Colonel Moore's question, Selective Service decides that, the local boards, that is their obligation. And we are doing it in many places. It can be done. We are doing it in Massachusetts. The information is all available at the induction station when the man comes in. It takes anywhere from 12 to 30 days to get a man up to the induction station after the board decides he is a 1-A man. During that time Selective Service is working all the time on the proper procedure. That is the local board obligation and it can't be passed on at all. The prospective 1-A men must come from that source. As I tell you the local boards send to the State Headquarters in Boston or in the State of Massachusetts respective lists of 1-A men. They begin immediately the work with these WAACs that Colonel Cottam has gotten assigned. Now the WAACs simply handle it because Selective Service has not found it practicable to do the work.

COL. JONES: Isn't it the very thing we have been trying to do at the Fifth Service Command ever since this thing has been going on? And when we asked for this information you got after us and stopped us.

COL. EANES: No, sir.

COL. JONES: Yes, sir, we had a very nasty letter back from the Director of Selective Service on our asking boards to give us that information.

COL. EANES: No, sir, Colonel, this is not the same information. That was another proposition, as I see it, entirely.

COL. JONES: You said a moment ago it was on health.

COL. EANES: Yes, it is on health.

COL. JONES: All right, that is what I was asking about.

COL. EANES: It includes all those things. In Louisville to differentiate in your service command, Louisville, I think is doing a very, very good job on this problem. The rest of Kentucky so far as I can understand hasn't done anything.

Comment: The whole thing leads up to the man's history doesn't it -- physical and mental history?

COL. EANES: Yes, sir.

COL. JONES: And you stopped our doing it.

COL. EANES: No, sir.

COL. JONES: We got a very nasty letter there that made us cancel the instruction; it was signed by General Hershey, and said that we had no right to demand something from these boards.

COL. EANES: You were rejecting men on their own say so. We have no objection to the rejection of men on proper documentary evidence. No, Colonel, I think that yours is entirely a different problem. We don't look upon the two problems as the same. You were asking certain specific questions of the registrant. And if the Selective Service hadn't denied the fact that this registrant might have had epilepsy or syphilis or asthma prior to the time he went up, then you rejected him.

COL. JONES: You sent him back to us.

Question: May I ask if there is any definite directive or any definite set of instructions on this? On this whole problem, that has been furnished to each service command, a policy to be adopted, any procedure in this respect about these things you are talking about. Anything definite issued as a directive on it.

COL. EANES: I don't know anything from the War Department. There has been a directive from Selective Service to their people, and they are told to cooperate with you in formulating a program whereby they could get the thing up. You understand, Selective Service first did take this whole burden, tried to carry it and still are anxious to carry it, that is, the most practicable method. In certain places I tell you, such as New York City and Boston, Dallas and Chicago, Selective Service does not believe that they can handle it from a practical standpoint. However, they want to cooperate in those places just as they have in other places.

GEN. LULL: There is a War Department letter which requires or asks that you report the cases, for instance, if they are not complying with this information Colonel Eanes is speaking of.

COL. FREER: I understand that this proposed system is applicable only to certain urban centers where file cards have been maintained and that it is not considered generally feasible to put it into practice in suburban centers. I think that has come up for discussion from time to time.

COL. EANES: That's correct. It seems to me that every state must handle its own individual program and where Selective Service can handle this from a more practical standpoint it expects to continue to do it as best it can. But there are places that are falling down because it is not practical. We do not have paid personnel for this type of work, and no one but paid personnel will put in eight hours a day in an index searching out names.

GEN. LULL: Gentlemen, I think that if any of you want to go further in this, it would be well to see Colonel Halloran before you even get the Massachusetts plan. It may not be applicable to

your state, in order to find out what is being done at any rate. We are going to have to bring our discussion to a close because we have to meet at 1:30 and some of these officers, Colonel Freer, have an engagement with General Kirk at that time. If there is any further discussion we can take it up at 1:30.

COL. EANES: I am delighted at the opportunity of saying what I have said.

GEN. LULL: We are glad to have had you, Colonel Eanes.

COL. FREER: In the absence of General Morgan, Chief of the Medical Branch of the Medical Practice Division, I have a few questions for his branch that I would like to bring up for discussion and see if we can get any additional information on them from the service commands. First, this question: Do those service commands who do not yet have assigned them consultants in medicine (and that would apply to the other specialties) neuropsychiatry and surgery as well, wish these officers be assigned? I think we have the answer to that: That they would like them, if and when they are available. Now this question: Would it be practicable to utilize the services of the same consultants in more than one service command? For example, the Fifth and Sixth, and we know that we have had some discussion of that, and the First and Second, possibly the Second and Third. In the service commands covering the enormous georgraphical area, such as the Eighth and Ninth and probably the Seventh, we know that there would be that objection; the travel time is a tremendous factor. Possibly in some of the smaller georgraphical service commands that might be practicable. As you know, this type of personnel is not readily available and grows increasingly scarce. The type of men that we would like to find in a consultation capacity is getting pretty scarce.

COL. JONES: That question is brought up about the surgical consultant and medical consultant assigned to the Fifth Service Command being also used in the Sixth Service Command. That was taken up with Colonel Bastian when he was out here, and at that time we didn't think it would work. The two men that I have could be assigned to the Sixth Service Command if it were satisfactory for the months of July and August, if the Sixth Service Command wants them. They've covered all the stations in our service command, and I think that in those two months they could cover the Sixth.

COL. HILLDRUP: I believe that the medical installations in the Sixth Service Command would not warrant full-time consultants, and I welcome collaboration with the Fifth Service Command, and I think that I can use consultants for practically half the time, if Colonel Jones can spare them. So far as I know, there has

been no survey made. I had contemplated using the Chiefs of Services of Percy Jones General Hospital for this purpose and Colonel Bastian had promised to let me have them. However, if other men are available I prefer to leave these gentlemen where they are.

COL. JONES: I would say, for the months of July and August and possibly longer, if you felt that you needed them, it will be all right as far as we are concerned.

COL. FREER: I believe that some coordination with this office would be needed on account of the orders between service commands; that otherwise you go ahead and arrange it between yourselves.

COL. WALSON: At present there has been assigned a consultant on the Medical Service and the Neuropsychiatric Service in the Second Service Command. They have proved very satisfactory, and I'd like to have a surgical consultant. There are more hospitals being organized. All of their time will be required to cover Medical Department activities in the Second Service Command. Of course, if we get this officer, or any other officers in the Second Service Command (medical officers I refer to) the War Department should authorize an increase in our allotment to cover the assignment.

COL. REDDY: I feel that we could use consultants, but I'd rather have part-time consultants at the present time. Our area is rather concentrated, and we haven't got too many hospitals at the present time, and I don't believe I would require full-time consultants. At the present time I am using one of my own officers as a consultant in neuropsychiatry, but we have no surgical nor medical consultants. When I find it necessary to send anybody to some of our smaller hospitals, I usually use the Chief of the Medical or Surgical Service at Lovell General Hospital, and I find that more or less satisfactory. Sometime in the fall, we hope to have the Framingham Hospital, a General Hospital, in operation, and I expect there that we will have a very well-balanced staff with an excellent surgeon and an excellent medical chief. I think that with the staffs we have in the Lovell General Hospital, another general hospital, and some of our larger station hospitals that we can very well get along without full time consultants. However, if the Second Service Command could help us out, why we would be very glad to have their assistance. If there are any consultants assigned I would like to have very highly qualified men who would have the professional prestige to have the confidence of all the medical officers so that they could really do a good job; when they made any suggestions or recommendations that the people and our own medical officers would know that these recommendations were coming from men who really understood their business.

COL. FRENCH: I'd like to put in a request for an additional team. I have 120 installations and the best we can do is to visit one station once a year with the present setup. Last year when this conference was held, with about half the personnel that I have now, half the number of troops, the impression here was that I would need three teams. I was so told. Now I have a million and a half men, one team, and they're just on the market.

COL. FREER: I understand, Colonel French, that you would like to have another full team of consultants.

COL. FRENCH: Yes, sir.

COL. FREER: Of course, as has been mentioned before, this type of material is very scarce, and as Colonel Reddy has brought out, we need men of a certain age and experience, ability, reputation, and prestige. We have many excellent younger men in the service who are doing clinical work of a very high caliber, but who would still leave much to be desired from the standpoint of one of these consultants. I would like to ask an expression of opinion as to a workable plan whereby this might be carried out. Would you consider practical that the fellow who has the consultants, loan them to his neighbor when he requests them or that they have a certain proportion of the time when they would be loaned out? Every other month? One month out of Three? Or on call, or just how?

COL. JONES: I think the best way to do it would be for the surgeon of the Sixth Service Command and me to get together and arrange it between ourselves and then ask for orders. Now there may be times when something would come up. When we open our three new general hospitals in our service command in the fall sometime, I would want them at that time. We can probably get cleaned up before then. That's what I had in mind.

COL. FREER: That would satisfy us in this office. It seems to me about the only feasible thing because it would have to be done with a conference and close working agreement between the two service command surgeons whenever a situation arose. The next question: Has the return of patients with tropical diseases from overseas created any special problems of diagnosis, treatment, or disposition to date? That would apply mostly to people who have hospitals near the coast.

COL. HILLDRUP: There is a problem at the present time in Battle Creek, Michigan. The populace are protesting vehemently against the sending of malaria cases out, for fear they will start an epidemic of malaria. We've made a survey, and we find that the only time Anopheles mosquitoes are encountered out there is in the month of September, and we've taken ample precautions to protect the patients at that time. You can't convince these people though. They think they are going to get malaria tomorrow.

COL. JONES: We have practically the same thing and Public Health Service has been after us pretty strong on it. In fact, it was reported to me one day last week that a soldier was seen in one of the railway stations, having a chill, and he gave the history of being on leave from one of the hospitals, and he just came back from the South Pacific. They were raising the devil about it, because they thought we were bringing them in and turning them loose.

COL. BURNETT: In connection with the problems of return of soldiers with infectious disease, inasmuch as there are many parts of the United States in which we are having 99 percent of the troubles that we have in other places throughout the world, inasmuch as malaria is prevelant in many places and we have the problems with us, even leprosy in some parts of the country, I don't think they need to be unduly alarmed about all these things. We're fighting it all of the time, and we'll continue to with the Public Health Service backing us. We're going to have increasing problems of the sort, and population has got to get used to it. As far as I can see, we're going to have men returning from all over the world for the next several years, and we might just as well face the problem, and be sane about it and logical, and with the Public Health Departments in the county and cities we can handle the situations that come up. We've done it throughout the United States this year and last year and the year before and we'll continue to do it. I don't think there is as much danger spreading malaria up in the northern states even with Anophelines present as there is in the South where they already have the proper breeding ground and everything. But they have it in rather a mild form compared with what they bring in from the Southwest Pacific.

COL. FRENCH: There has been some complaint about the way that Army, Navy, and other Government ships land, and airplanes in the United States, directly from yellow fever and malarious countries. The Public Health Division disinfests all public transports very effectively. They apparently run on schedule. These Army planes and Navy planes have you come in and land most anywhere without any notice at all, and it is believed by the Public Health Service that they are not being properly disinfested. There was a directive issued by the Army Air Forces 30 November 1942, which puts this right straight up to the pilot himself to see that this is done. As soon as a plane leaves a mosquito country, it is to be sprayed and again before it lands somewhere else, but the Public Health people do not seem to think that that is being carried out, and there is quite a bit of alarm down there about bringing in both malaria and yellow fever. I was wondering if there wasn't some way of getting together with the air service and seeing if that couldn't be threshed out. It will have to be taken up with the Navy at the same time.

GEN. LULL: I wonder if we can't take that up with the Preventive Medicine Division when they appear. Will you repeat that when the Preventive Medicine Division is concerned at the proper time with their functions?

COL. FREER: The next question: What is the opinion of the plans for convalescent care for patients as outlined in A.G.O. Memorandum W40-6-43, dated 11 February 1943, and what suggestions can be offered for the more effective accomplishment of the purpose of this memorandum? That is the rehabilitative physical exercises so far as the patients are concerned that we contemplate sending back to duty.

GEN. LULL: I don't know whether Colonel Freer was here yesterday when General Kirk made a few remarks about the contemplated establishment of convalescent centers in connection with each general hospital or with certain general hospitals. This was just given to the committee here to think about because I believe he has given a favorable consideration to having convalescent annexes to general hospitals so that the patients to be transferred to the annex can be placed under supervision as far as rehabilitation is concerned before he is sent out. I think that is contemplated.

COL. HART: That will take care of the convalescents from general hospitals but does not meet the great need of those returning from the large station hospitals where we now have the convalescent detachment in the hospital itself. The men being still retained as patients. It seems to me that it is highly desirable that a convalescent detachment be not detached from the station hospitals, be authorized rather than keep these men in the hospital where psychologically they are still under hospital atmosphere.

COL. FRENCH: May I say something on that? At a meeting of the Chiefs of Services -- Chiefs of Medical and Surgical Services -- about eight months ago, Colonel Morgan was down there and criticized us for not having these convalescent detachments in all our station hospitals in the Fourth Service Command. That has been attended to and we are running them not only in the station hospitals but in the general hospitals at the present time.

COL. WALSON: It is my impression that consideration of the convalescent facilities for patients in hospitals we should not overlook the possibility of establishing such facilities in some resort or locality, if possible where there is a general hospital, or preferably at some place where they claim that convalescence care can be given all seasons of the year. In some of our hospitals, it is impossible to carry out satisfactory convalescence program during the whole year. At the same time, nearby there may be ideal facilities for this purpose.

COL. FREER: Are there any suggestions that can be offered for speeding up the procedure of disposition of patients from Army hospitals? That's a broad question of course. I'd like an expression of opinion as to how the CDD departures are now proceeding, and suggestions, if any, for speeding them up. We know that a great deal of improvement has taken place in that respect within the past eight months.

COL. WALSON: One of the important factors in speeding up action on CDD papers is to require a report from hospitals giving name of patients where hospitalization is prolonged, so that the Medical Branch, service command, can check the reasons for such a long period of retention in a hospital. This is more satisfactory than to depend on inspectors in the field. It would save a great deal of labor. And it would be a stimulus to the local surgeon, to clear his cases, knowing that undue delay in hospitalization would be a cause for criticism.

COL. JONES: We should find some way of having the men who should be discharged under section 8, discharged under section 8 instead of on disability; it would hlep. We haven't been able to do anything with it. The local commander simply won't do it. They shove them over to the hospital. That's what we're running in to all the time, and I found that right there at Fort Hayes; the station hospital had a number of men who should have gone out under section 8.

Comment: Turn him out of the hospital. Tell him to handle them. That's the way I do with them.

COL. JONES: Well, do you get any results?

Answer: Sure, if they come back, send them out. They send their drunks and everything else down there.

COL. GIBNER: We have materially shortened the period of time in effecting discharge on CDD, by the use of our consultants travelling around and pointing out ways to shorten it. So far as the medical end of it is concerned, I think we've gotten down to a minimum. The chief cause of delay is on the administrative side. One plan that has been proposed and is working at one of our stations, is that as soon as a decision is made to CDD a man, the proper officer at the hospital calls up the man's organization commander, and that man is immediately transferred to a casual detachment of patients, and his service records come over with him. Then the first page of the CDD form is made up by the commanding officer of this casual detachment. The surgeon was given authority by the post commander to sign the indorsement directing the discharge by order of the post commander. It cut out a number of days that had only been utilized in transmitting these papers back

and forth. We don't know whether we can put that into operation at all the stations or not because many of the post commanders object to giving the surgeon this authority to direct discharge in their name. But, that's one way to do it. Get the patient completely under the control and administration of the Medical Department and handle the whole thing right in the station surgeon's office or the hospital commander.

Comment: That's getting right to home. We have two bottlenecks in the CDD. One is page one by the commander, and the next is the approval, final approval, by post headquarters. Now we've side-tracked that the same as the colonel has. As soon as it is found that it will be necessary to CDD him, we have his service record transferred to the detachment of patients in the hospital. Page one then is made out by the detachment commander at the hospital. Now we've gone one better and had the registrar appointed an assistant post adjutant by the commanding officer. So that he can act as the final word. Now, we can get them out twenty minutes after the Board has completed the form, right up to figuring, and it's speeding it up very materially.

COL. REDDY: We use the same policy in the First Service Command at all stations over which the service commander has jurisdiction, and it works out splendidly. However, at the Coast Artillery stations which are tactical commands over which the service commander has little or no control, it does not work so well, and the execution of discharges on C.D.D.'s is unnecessarily delayed because the New England Sector commander insisted that C.D.D.'s must have the approval of his headquarters. We had to revoke a previous directive from the service command authorizing Coast Artillery station commanders to approve them. The matter was again discussed with the New England Sector commander, and it is understood that Coast Artillery harbor defense commanders will be given authority to approve C.D.D.'s.

Some delay is also occasioned where transients from other service commands are hospitalized, as well as patients remaining from units ordered out of this service command because of time involved in obtaining service records. Transfer of such soldier patients to a Post Casual Company or other service unit complement should expedite matters.

Comment: There is a provision in the regulations whereby you can initiate a supplementary service record and you need not wait for his whole service record before discharging him. You can take action immediately, without waiting for a service record.

COL. REDDY: All right, where are you going to get the information for that supplementary service record?

Didn't The Adjutant General formerly furnish such a data for a supplementary service record? We used to write to The Adjutant General and say, "This man is in the hospital, and the unit is departed; request that the data be furnished in order to start supplementary service record." Of course, he couldn't tell you when he was paid. His pay account, total account, deductions, it's impossible to give a man a final statement and pay him.

COL. HART: The supplemental service record which we make out in the Eighth Service Command only covers that time which he was under our control. He's paid on that. His final payments, of course, are withheld until his service record connects up with his supplemental service record. The man is discharged from the service on a supplemental service record. It's almost as bad to try to get the data from Africa as it is from The Adjutant General.

COL. FREER: I'm sure these are very helpful suggestions and they've undoubtedly resulted in a very definite improvement. The next question: What is the present usual disposition of cases of active tuberculosis from station as well as general hospitals? Are line of duty being discharged directly to the Veterans' Administration from the station hospitals, or are they all being transferred into nearby general hospitals for confirmation or further diagnosis?

COL. HILLDRUP: We have a rule requiring all cases of tuberculosis to be sent to a general hospital for disposition.

COL. FRENCH: When the diagnosis is clear cut the station hospitals waste time sending them to general hospitals, the way we look at it, and he's discharged. We send him to the hospital directly from the station hospital. Cases that can't be definitely determined are sent to general hospitals.

COL. FREER: As far as we know, there's been no difficulty with that problem; it was simply that our office might understand the proceedings that are being carried out. What is the procedure with cases of inactive tuberculosis, discovered in station and general hospitals in examination for Officer Candidates School? That question is propounded by Colonel Long who is not here to enlarge upon it, and I didn't have a chance to talk that over with him.

COL. WALSON: We are guided by the extent of the lesion. If the man would be acceptable under MR 1-9, he's retained in the service. If not, he's CDD.

COL. FREER: That's all the material from the Medical Practice Division.

GEN. LULL: Is there anything else to bring up?

All right, thank you, Colonel Freer.

Personnel Service

Question: May limited service medical officers be assigned to industrial plants when civilian physicians, ineligible for military service, cannot be procured as P-3 (3200), or P-4 ($3800)? Sec. II, W.D. Cir. No. 2, 1943, authorizes procurement of civilian physicians for industrial plants through civil service at higher salary than of contract surgeon. Second Service Command experiences difficulty in interesting appropriately qualified physicians in positions P-3 ($3200), or P-4 ($3800). It would appear to be more rational and certainly more economical to assign limited service medical officers than to procure higher bracket civil service physicians, P-5 ($4600), P-6 ($5600) and P-7 ($6500). Already some physicians are avoiding military service by securing these more desirable positions.

Answer: It is normal for physicians to seek larger salaries and incomes. Employment of physicians by the Civil Service in P-3, 4, 5, 6 or 7 will not avoid military service. Physicians may be employed under civil service ratings in industries for which the service command must provide medical service. Medical officers, when available, may be assigned to such duty.

Question: In view of the assignment to this Headquarters of an industrial medical officer and an industrial hygiene engineer with contemplated complete equipment for industrial hygiene tests and analyses: will it be necessary in the future for surveys and audits to be made in this service command by teams from SGO Occupational Hygiene Laboratory and from O.C.O.? Inspections by the service command industrial medical officer and the service command industrial hygiene engineer, surveys by S.G.O. occupational hygiene laboratory teams and audits by safety teams from Office of Chief of Ordnance have been frequent and apparently poorly coordinated so as to reflect discredit on The Surgeon General's program for occupational hygiene. Such lack of coordination has led to conflicting recommendations and thus has attracted unfavorable comment. For example, at Raritan Arsenal a team from the Office of Chief of Ordnance made an audit before the report of the survey made by a team from the S.G.O. 10-16 February had been received. Conflicting recommendations were submitted.

Answer: The Army Industrial Hygiene Laboratory makes an annual survey of Army operated plants and such special surveys as may be requested. These surveys imply analyses of fumes, dust, and gases, and can only be made in a well-equipped laboratory staffed with analytical chemists. It is not practicable for surveys of this type to be conducted except from a central laboratory and it was for this purpose that the Army Industrial Hygiene Laboratory was established.

The service command industrial hygiene engineer makes check inspections and follows up on the recommendations made by the general survey. Also he can frequently answer questions or deal with situations that arise from time to time in all these plants because manufacturing processes are constantly being changed. His work is in no way a duplication of that of the Industrial Hygiene Laboratory; but is complementary to it. With respect to the surveys and inspections made by safety teams from the Chief of Ordnance and by the auditors of the Safety and Security Branch of the Ordnance Department, we have no direct concern. These Ordnance inspectors are not charged with any responsibility for healthful working conditions or the control of occupational health hazzards. The Ordnance Department appreciates this and is taking steps to control such duplication as has arisen from time to time as a result of these other inspectors not confining themselves to their proper functions. It is planned at the earliest practicable date to hold a conference of Ordnance representatives and representatives from The Surgeon General's Office to adjust such difficulties as have arisen.

Question: Does sec. IV, Circular 122, War Department, current series, apply to numbered station hospitals, and is recommendation for promotion of first lieutenants to grade of captain assigned to these hospitals authorized?

Answer: Numbered station hospitals are T/O installations. It is believed this circular may be so interpreted. If this is so, it would be possible to have all medical officers in these units in the grade of captain or higher. This would work a hardship on the medical officers in the grade of first lieutenant and captain assigned to station hospitals, zone of interior, and other installations in this service command who are eligible for promotion and may not be recommended because of the lack of position vacancies.

This should make assignment to numbered hospitals and other T/O units more attractive.

Question: Under the present setup, the Medical Department at service command headquarters has no control or jurisdiction over personnel belonging to its branch in the field. What can be done to correct this situation?

Answer: One of the purposes of this conference is to make suitable recommendations to correct this defect.

GENERAL LULL: That question was submitted by the 4th Service Command. You might wish to elaborate a little on it, Colonel French.

COL. FRENCH: Last October ASF insisted upon the Personnel Branch of the 4th Service Command taking personnel from all branches.

They actually took them away from us. Civilians, military, and everything else.

I have fortunately through having General Bryden commanding general down there been able to insist that no moves in the Medical Corps be made without approval of my office. General Bryden will retire this fall and God knows what will happen when he goes away and somebody else gets there. This system is bad. It takes about 5 days now to put a transfer through which took 30 minutes before this thing was changed. I think that thing should come up tomorrow under General Robinson's control division. That is one of the things that should be brought up, the delays and extra work involved, and the extra personnel required. I think that is entirely proper to bring it up tomorrow.

COL. GIBNER: We do our own personnel work in the 7th Service Command. We are constantly having to fight to keep it, constantly fighting to retain it in our own office. We write the requests for the officer and it has to be O.K.'d by the division chief.

COL. FRENCH: Personnel Section of the 4th Service Command told me they did not want the job. They didn't know anything about it and knew they couldn't do it. But some thunderfust came down here from Washington and told them there would be hell poppin' if they didn't take it over -- actually take it over, so they had to take it over.

GEN LULL: That brings up something: We have submitted once a month a roster of medical personnel from all stations with the 86c. Now the control division has shown by elaborate setup that we save so many thousands of manhours by not getting that in, and by relying on The Adjutant General machine records. I wish for the purpose of the record to have a consensus as to whether or not the 86c does cause enough additional hard labor on troops so that it should be discontinued. They have worked on us constantly, day after day -- our own control division so that it seems foolish, so we went up yesterday to see a comparison of The Adjutant General's beautiful machine records. They had a record on the board there and his qualifications were that he was a "Source Surgeon." But they had a lot of them labeled as "Source Surgeons." I don't know what "Source Surgeons" are, but that was in The Adjutant General's record. That was his professional qualifications. I don't know how it got in there. But they had Major John Jones, duty Source Surgeon. I don't know what it meant. They don't know what it means. Some term that somebody stuck in. No, it was not post -- this was a thing from Lowry Field and the only thing I thought it might be squadron surgeon. I have seen that term used by stations several times. We don't think we could work to advantage without

knowing what our specialist personnel are doing. We get it from the roster. We get after them about it. You have many ophthalmologists. Going to need this fellow? All right, we will take him somewhere where we need him. I've told them that. Machine records cannot give you everything you want. They can't do it. Another factor about this decentralization. The Commander has the assignment of all personnel in that post. If we don't get an 86c, the changes, the list of the ratings, and the men that are there, what they are doing, any changes in roster, we can't keep in touch with what is being done—physical inspection on the post, what is happening to that hospital. We should fight for the officer roster. They have cut out the exchanges. They may cut it out but we ought to have it. We have to keep up to date on every post.

COL. GIBNER: I will tell you what we have done in the 7th Service Command. We have taken a certain number of Medical Department occupational specialists like x-ray technicians, laboratory technicians, surgical dentists, and such, and receive a report each month as a supplement to the 86c report. There are about 25 of those specialties and we have 3 columns, general service, limited service, and civilian, and each station surgeon has to report the number, not the name. We know how many x-ray technicians he has, general service, limited service, and civilian. That is an aid to us in filling requisitions for cadres, in assigning the numbers to stations that are to be sent to the specialist schools, and in adjusting shortages and overages between stations.

Comment: A blue mimeographed thing - we call it a supplement - to the 86c. We had a hard time getting it through but we were without that information. Machine records couldn't give it to us.

It must be realized in talking about the 86c, that under the present addition of personnel the 86c must have some revision. For instance, there is the question as to how WAAC personnel will be reported. And under the old roster they report the physical therapists and medical dietitians as civilians. That must be revised, though until the revision is published there is no reason why Medical Department dietitians and physical therapy aides can't be shown under nurses, not combined with them but written in under nurses, to show it is a separate branch.

Question: What are the prospects of getting doctors for fiscal year 1944?

Answer: The prospects are very poor. If we were to fill units and installations to our original T of O and allotted strengths, we would require 65,000 medical officers. The War Manpower Commission has informed the Secretary of War the 65,000 physicians cannot be removed from civil life, and we have been

directed to plan to get along with 48,000. In November the Procurement and Assignment told us that they would furnish 575 physicians monthly from civil life (exclusive of interns and residents.) They have not furnished 50 percent of this number.

GENERAL LULL: That is the reason we are behind. Now I might go into that in a little more detail. I have been mixed up in it so much that the Procurement and Assignment Service have finally admitted that they are rather — not exactly failures, but they approach it, and are trying out a system in Maryland whereby they will do away with the essential lists as they are now and declare only a few men essential, just men who can't be replaced; and the essentiality of the other individuals will be determined in each individual case. Now I understand from Dr. Fishbein that in Detroit they took 80 names of physicians and made the physician appear and discuss why he had refused to go in the service. Well, one fellow said, "I just bought an office building in Detroit, and if I go in the service I'll lost it." That was a good reason. He should not go in. They accepted those reasons and Fishbein said, of course, they are logical. They may be logical and they may not. I don't know.. But, they got 20 men out of the 80 who had no valid excuse for not going in. So they told them, "Now you are going in or else," and are putting a little pressure. It started out as a wonderful organization to furnish doctors for the Army and Navy. But developed into a service to protect the civilian public. And they screened out and gave us what was left. Now there are some places that are much worse off than others, and we have had all kinds of trouble and are not going to get over 48,000 this year, and we are limited to 48,000 by the Chief of Staff.

Question: What is the "or else"?

GEN LULL: Well, they hope to make some kind of a deal with Selective Service whereby they will report the man to Selective Service. Of course, that is up to the local board. Now in many states they just say this man is essential; the local board men will say, "All right, we will draft him." In some states they will not draft him. They will determine themselves whether or not he is essential, which they have a right to do. But you see under the present law, since most of the doctors are married and have dependents, they are exempt under Selective Service. Now the only thing we can do is to make a special call and the War Department is slow to do that. And the doctors and the American Medical Association don't want to do that because they are afraid it might be a reflection on the profession as a whole, to say that we had to go out and draft them, but yet I am afraid that is the only way we are going to get the doctors. Now they will try another scheme and then at the end I will go over and sit in a conference and the scheme won't work.

I have been through that so often that I know what is coming. I think that we shall eventually end up by saying, "Here, we want so many doctors," and ask Selective Service to go get them, and Selective Service can take them from any part of the country that they desire to take them. So I think that is what it is going to come to in order to get our 48,000. If we can get 48,000, we can get along. We are not going to get along too well but we are going to get along; however, we are 7,500 medical officers short at the present time. There are a number of medical officers in the southern states that have already filled their quota according to their records, who would like to get in the service, but Procurement and Assignment won't let them. Well, they offered that in the places where the quotas were filled if there were medical men who could be spared, and there are some in the rural areas and suburban areas, they would consider them. But they won't declare them is excess, though they are in excess. Industrial plants are overstaffed. That is all we are ever going to get, 48,000. Now the Army Specialized Training Program is to furnish us with about 4,000 a year. But they'll be largely replacements.

Question: So you think the difference in the figures is what the Manpower Commission says and what Procurement Division states, what are available and what can be retained.

GENERAL LULL: That's right. Officer Procurement Service says they are not getting any doctors in New York from the age group that should be available. And the Manpower Commission agrees with them. May I introduce Lieutenant Colonel Hall to the surgeons? He has just given me some information I think we would all like to have.

LT. COL. HALL: Just for the benefit for those concerned -- in line with the remark made by Colonel French -- in a release from the Procurement and Assignment Service for physicians of the War Manpower Commission during the last week or ten days, to all state chairmen (they authorize the State Chairmen in the socalled frozen states - that is, those who have already oversubscribed their combined 1942 and 1943 quotas) to, first, give these physicians in the urban areas that are in excess of requirements a chance to relocate in the areas of the states in which there is a scarcity of medical personnel, and, if they do not immediately relocate, they are to be declared available to the armed services or to Selective Service.

COL. WALSON: The trouble with the Procurement and Assignment Service of the 2d Service Command is that they furnish the Officer Procurement Service with a bunch of names and when analyzed they find some of them are already in the service, some in the Navy, some are dead. Well, a good many of them aren't even citizens.

GENERAL LULL: This office is keenly aware of what is going on, and we are fighting it all the time, but we are not getting there very fast. We will have some young men ready for troop units in the next two or three months. That is, we are getting about 2,000 men activated about the 1st of July and the 1st of August, who go to Carlisle for six weeks. That will help out the Army Ground Forces and to a certain extent the Army Air Forces. It will only give you gentlemen the limited service personnel, so you are not going to get very far.

COL. FRENCH: This service command is short 1,200 nurses. What assistance can we expect from The Surgeon General's Office to furnish nurses?

Answer: All service commands are short of nurses. The Surgeon General will furnish nurses as fast as they can be procured. Procurement procedures are being pushed. It is desired that Service Commands assist in this by taking an active part in recruiting nurses. The Red Cross Nursing Service recently agreed that the Army should conduct a publicity campaign and actively recruit nurses. The authority to appoint nurses in each Service Command should expedite procurement. The largest numbers should be appointed in the 1st, 2d, 3d, 5th, and 6th Service Commands.

GENERAL LULL: Now as you know one of the charter rights to the Red Cross is to procure nurses for the Army and a lot of nurses don't want to go into the Red Cross, but they can go in directly; they can go in the Army without belonging to the Red Cross. You should go out in the service commands and give every encouragement you can in the recruiting of nurses. Nurses are assigned to the Officer Procurement Service in the district offices and with the local Red Cross chapter, but the local Red Cross chapters are not as much interested in getting nurses in the Army as they are in forming motor corps and in getting certain uniforms for the members and things like that.

There are three channels open now to procure nurses. The Red Cross; the Officer Procurement Service, which will also assist in procuring nurses; and your own office is authorized to procure nurses -- to issue applications to nurses to authorize their physical examinations and appoint them.

Colonel Blanchfield will give you the details as to certification. One thing that slowed up the proposition is the fact that the nurses were all referred back to the Red Cross. Now at least, you can authorize a physical and take their papers, and not let one get out of the office until she is signed up, and start to process it. And the Officer Procurement Service can do the same thing. Suppose she comes back though, and the Red Cross doesn't pass her. Then she would not meet the nurse's qualifications for appointment. That is all they pass on.

Comment: There is the hitch in that, General Lull. We have had lots of trouble recently. For our qualifications, the applicant must be physically sound and have 2 years of high school. Well, the Red Cross has been turning a lot of these people down, because they hadn't completed their high school work. That question is really brought here as a part of the qualifications that they lay down in Army Regulations, and the Red Cross is interpreting the Army Regulations. And they have been refusing nurses who did not graduate from proper schools, but they are going to put it on an individual basis and go on prospects or estimates of individual ability and be more generous in waivers, where two years in high school is sufficient. I think we had better bring this point up with Colonel Blanchfield. Colonel Blanchfield can handle those things, which have to do with the recruiting of nurses. Colonel Hall and Colonel Blanchfield are going up to the conference we are having in Chicago this week.

Question: What is the policy as to grades of officers in a general hospital -- that is, how many colonels, lieutenant colonels, majors, etc., Medical Department? Also for other officers assigned to general hospitals, such as QMCs, engineers, etc.? Also as to numbers of the latter?

Answer: Guides as to grades for various sized hospitals, general and station, have been submitted to Headquarters Army Service Forces for approval. Grades recommended for some positions have been disapproved. If the numerical strength is allotted as Branch Immaterial grades will be granted on a percentage basis.

GENERAL LULL: I think Colonel Hudnall can elaborate on that a little -- Colonel Hudnall and Colonel Paden. They have been through the wars on it.

COL. HUDNALL: There has been quite a study and an endeavor to make a guide that could be published and put out so everybody would follow one system, would have part of a system to follow at least. Some of the grades that were recommended by this office were not allowed. It is probable now that a guide to show grades will not be published under the new system of branch immaterial allotments. Colonel Paden has fought the battle back and forth and probably can add to this.

COL. JONES: The thing that is bothering us particularly is what the office thinks as to the grades in the general hospitals. That is the thing that is bothering us. If we had something which the office believes should be in your general hospitals, we could use that as our guide because under the new setup we are going to get so many officers.

COL. PADEN: This office has previously recommended that in a 1000-bed

general hospital that 3 colonels and 6 lieutenant colonels be authorized. The 1,500 the same number and when you got a 2,000-bed general hospital, 4 colonels, 8 lieutenant colonels, and 21 majors be authorized. That would be about the same -- remain about the same all the way up with never more than 4 colonels authorized, but there just won't be that many physicians available for assignment under this branch immaterial allotment. It was an ideal setup and one which we won't be able to achieve under the present setup.

We've recently recommended a minimum number of Quartermaster Corps of lieutenant and company grade officers for a 1,000-bed general hospital and if the hospital has 2,500 beds we recommended a 3d officer and the senior officer would come in the grade of colonel. A colonel and a company grade officer, Chaplain Corps for a 1,000-bed general hospital, that is, rather, a lieutenant colonel. And after they passed 2,500 beds a full colonel, but that just can't obtain under the present policy. And ASF won't cooperate to the extent of submitting a proposed guide. They have stated emphatically, unofficially not in writing but in personal interviews that they will not publish any guides by grade, but will by number. The guide announced in MR-4 will be rescinded.

Comment: I have almost 50 percent. What percentage did you get?

COL. JONES: Ours has been approved and they are working on it now.

Comment: Have you gotten your percentage of colonels?

COL. JONES: So far as I know I haven't gone into that very much -- there are a certain number of colonels allotted to the Medical Department service command -- I think that was arranged before I got there. It probably is on a percentage basis. The thing that you are going to have to watch though, which is the thing that happened, I just learned of it Saturday morning. The way they figured it, we didn't get our 3 and 3/10. We got 2 and 8/10. Something you have to watch all the time.

Question: Allotted and assigned?

Answer: Yes.

Comment: I'd like to ask a question. What are we going to do with all the colonels we have now?

GENERAL LULL: You know, we have certain colonels; we have a few colonels in the Medical Corps that nobody seems to want, but nobody will reclassify. We will get a man out of the general hospital and order him to the 4th Service Command; we get a wire from you that there is no position vacancy for this colonel at the service command.

Colonel Watts called me on the telephone the day I got back and said, "For God's sake get me a colonel down here for such and such a camp." Of course I don't hold him responsible for that, because he doesn't want this special colonel. The 8th Service Command will have a colonel available down there to assign and call me up and tell me to please take him out of the service command; I will have no place to put him, but will still have a requisition for one colonel, Medical Corps. I know, I can read between the lines, and I know what we're up against, but if we take a man out of one service command we have to put him in another. That is the only place we can put him.

COL. FRENCH: We have had so many down there. That's right. Take all these old birds 60 and 63 in units and the day before they leave they just throw them in our laps. We have colonels down there walking around on a couple of canes. I have had them on recruiting and induction. Now I have got the Air Corps to take over most of that. The aviation cadets are mixed in there, and they have agreed to examine all the rest of them. I haven't any place to put them.

GENERAL LULL: We will have to be hard-boiled on reclassification. It is all in your lap; we can't do it from here. You take one of these colonels or lieutenant colonels, put on a job and if he can't do the job he ought to be reclassified. I don't see what else you are going to do about it. You must be hard-boiled about it and get rid of them. It is the policy as far as we are concerned. We have no way; our overhead is so small. The only place we have is the S.G.O., Army Medical Center, and the school at Carlisle.

COL. FRENCH: It didn't originate in our service command; it originated with the Ground Forces.

GENERAL LULL: That's right. But you have him.

Before we can go on with the next question, Colonel Eanes has a statement here. He says if any service command surgeon knows of an individual doctor who does not have children and who apparently should be in the service, Selective Service will direct an investigation of the doctor's classification and try to reclassify him, providing the doctor is under 44 years of age. Anyone you know in the service command that you think should be in the Army, report him to this office and we will report him to Selective Service.

Under 44. You see that is up to 44 years of age with no children. He can have a wife but no children. Not under 38, 38-44. If he is under 44, as I understand it, he can be brought up for reclassification, and if the local board sees fit they can put him in 1-A. Then we ask the service

command to induct him. Some boards won't put them in 1-A. Some boards will. I think we can probably get them to do it.

Question: What officers are to be assigned automatically by The Surgeon General?

Answer: We will assign commanding officers for named and numbered general hospitals from this office. I think we have sources of information here that we can assign the commanding officers to named general hospitals and numbered general hospitals. We have assigned commanding officers to all the numbered units other than general hospitals from the list that has been submitted by the surgeon of each service command. That has been the only way that we could assign those men, and we know it has been a drain on you, the only encouragement being that activations will be fewer and fewer for the remaining year provided we don't get some unexpected demand. So all numbered hospitals in activation order state that a commanding officer will be furnished by The Surgeon General.

COL. BURNETT: I just sent a reminder out to all our hospitals again to comply with Memo 113, Hq. Third Service Command, 6 Dec. 1942, (based on letter, A.G.210.31, 10 July 1942), and to see that they did not have medical officers that could be replaced by MAC officers, because on a recheck we found several of them, two of them registrars and most of them or a good many of them executive officers. My personal opinion is that an executive officer in any big hospital ought to be a medical officer. You can not leave it to MAC or Sanitary Corps officers under the present conditions especially because of the large number of new inexperienced officers. The directive definitely says executive officers will be replaced. We haven't enough trained MAC and Sanitary Corps officers.

COL. PADEN: This original directive was to submit the names of executive officers at station hospitals 500-beds or larger. It is the recommendation of this office that in each hospital of 1,000 beds or larger that one Medical Corps officer (under our proposed table for guide that we set up) be detailed as the administrative assistant to the commanding officer. He would be in all reality the executive officer. Two Medical Corps officers on the administrative side. We have always had that many for 1,000 beds or more, one man for the administrative assistant - assistant to the commanding officer and, in his absence, will act for him and will be the hospital inspector and supervisor in all administrative matters. He will have an adjutant; an executive officer is probably MAC. He is included in our proposed guide where 30 Medical Corps officers are assigned to 1,000-bed hospitals.

Question: Do you think the registrar should be a Medical Corps officer?

Answer: Well, it definitely says that he will not be. The directive we had is very specific about registrars.

Comment: Authority should be given for hiring dietitians and physiotherapy aides when commissioned personnel cannot be obtained.

Bulletin 63, section 2, 31 December 1942, prevents this. Bulletin 63 publishes an act of Congress. Any change will require amendment by Congress.

Question: Why cannot limited service nurses be sent overseas? Limited service medical officers can be.

Answer: In the opinion of the Personnel Division, limited service female militarized personnel on an officer status are eligible for assignment to duty overseas when they meet the requirements of War Department Circular 349, 1942, and its changes. This subject is under consideration and the decision will be published in a War Department Circular.

Comment: We sent them right along up until 3 weeks ago; we stopped them, because we got a straight conversational note over the telephone from Colonel Blanchfield, from the office down here. She said we must not do it any more. So we stopped it in the last two weeks and a half.

Comment: We put them on the same status as officers and since that time Colonel Blanchfield has agreed to the fact that nurses on an officer's status will be reclassified by the same procedure by which an officer is reclassified and will be allowed the same type of duty. That will be published, I am sure.

Question: Clarify question of terminal leave and travel allowances of nurses discharged for cause. Section 11, Bulletin 63, WD, 31 December 1942, paragraph 10, AR 35-4820, and paragraph 17d(1), AR 40-20, do not agree concerning travel allowances. As to terminal leave, there is no place in Nurses Regulations depriving nurses of terminal leave. Paragraph 10, AR 605-115, Change 3, dated 17 April 1943, deprives commissioned officers of terminal leave under certain circumstances.

Answer: A recommendation has been submitted to The Adjutant General for a change in AR 40-20 to correct this. The change if approved will cause paragraph 17d to read -- Orders to proceed to her home will not be given to a nurse who is discharged -- (1) Prior to expiration of the period for which she agreed to serve, except in the case of one who is about to be discharged on recommendation of a retiring board for disability which existed prior to her appointment. A part of this question refers to terminal leave -- nurses discharged cannot be deprived of terminal leave. Terminal leave for

nurses is authorized by the statute establishing the Army Nurse Corps.

COL. HART: When you have an officer who is discharged or dismissed or resigns, other than honorable discharge, we don't give him any traveling allowance or any terminal leave. Under this ruling, you don't give the nurse any traveling allowance, but you give her leave. Isn't that it?

Answer: The nurses' agreement is when a nurse comes in on an officer's status she will serve for the duration of the emergency and 6 months thereafter.

COL. BURNETT: As I understand it, there is no retirement age for the Army Nurse Corps.

Comment: That's right. A nurse, if she is physically and mentally fit, can be 78 years of age and still be carried on the active list.

Comment: That's right. There is nothing in the bill that prescribes statutory retirement.

Comment: Well, Burnett has one that is 67 and still going strong. She makes the fur fly too. She works harder than anyone.

Comment: Then you are not trying to get rid of her?

Comment: No, not at all.

Question: Requiring nurses to be earmarked by name should be discontinued. Nurses earmarked by name may be held indefinately: subsequent requests require changing list because of shortage. Same for dietitians and physio-therapy aides.

Answer: Earmarking nurses by name, except in affiliated units has been discontinued -- same for Medical Department Dietitians and Physical Therapy Aides.

GENERAL LULL: They may not be earmarked or designated in the same service command in which the unit is being activated. There have been some errors whereby a unit would be moved and no one know where the nurses for the unit are. Under the training program for units, often there are no facilities to put the nurses with their units when they are first activated. It would be a waste of nurses to put them with their unit for the training. It is so much better if they remain in some functioning hospital where nursing service is needed. When you are notified by The Adjutant General to designate 10, 15, 20 nurses for, say, in the X - Station Hospital, you could just set aside that block of nurses.

That unit may be activated in the Sixth Service Command and then be moved to the Eighth Service Command. The nurses still remain where they are in whatever service command they happen to be serving, and then later on, when that unit is moved, there's a letter that goes out. I wanted to show you those, too.

These forms will then go out and be addressed to the same command where the nurses are, to the commanding officer of the unit and to the commanding general of the service command who orders the movement of the unit.

The latter is the man that will have the authority to issue the movement orders to the unit. The commanding general of that service command received this letter which tells him where the nurses for that unit are. The service command holding the nurses will receive a copy of this letter, and it warns him that the commanding general that is going to issue the movement order is authorized to call on him to have the nurses report to the unit or to a designated place.

COL. WALSON: We keep a list of nurses available to fill requisitions. They remain at their station until the port calls for them.

GENERAL LULL: Yes, you see that was our old way of doing it. We notified everybody and you earmarked them by name. The port commander would get the unit there and would say, "Where are the nurses?" The commanding officer of the unit would say, "I don't know; I never saw them." The port commander would telephone this office and say that they are here without the nurses. Well, the nurses have already been earmarked maybe two months ahead of time in another service command; but they were left to follow the port commander, and the port commander would get that notice and throw it away or file it away and then wouldn't have it when the unit got there. He received it too long ahead of time. In this way, everybody will know where the nurses are coming from by number. I think that will help.

A problem that Colonel Walson has just mentioned should act as a stimulant to all agencies recruiting nurses to institute recruiting as fast as you can. These units must go overseas, and the nurses have to come from somewhere; they have to come from civil life. The service commands recruiting must be activated as soon as possible.

Question: Should the same procedures be used for the reclassification of nurses for limited service as is authorized for officers?

Answer: Female militarized personnel on an officer status are subject to the same requirements for reclassification as are officers.

Question: Now, this is about MAC officers. The War Department authorized 170. We had 125 on duty on 1 May and thought we had replaced medical officers wherever possible. Any suggestions as to how additional ones may be used?

Answer: MAC officers should be given duty as registrars. They may be given responisbility for property on groups of wards; they may write parts of medical histories; or they may be in charge of general administration and police of groups of wards. Special training should be given certain ones in mess management or medical supply. Put an MAC officer in charge of all police, discipline, and property in wards. That will be his job, and the doctor would treat the sick.

Comment: The figures that the personnel officer who came down in my service command had of the number of MAC and Sanitary officers for different units were way in excess, in my opinion, of their requirements. I don't believe that we should resort to making MAC officers out of good noncommissioned officers who had been used heretofore to handle three or four wards. We had a good noncommissioned officer who knew that work, and I believe that it's lots smarter to elevate them by giving them a commissioned grade to do something not their old job. That same thing about sanitary technicians in laboratories. You've got them there that are good.

Comment: Well, some of them have.

Comment: That's all right, but some of them have not. Here is a man from the Second Service Command Laboratory who got a commission. He was a good, all-around first sergeant. He got his commission in the Sanitary Corps as a laboratory technician. He has a practical knowledge for a technician, but he doesn't have any of the training nor the requirements for a commission in the Sanitary Corps.

Comment: On the other hand, one other argument, these men are being offered commissions in other branches, and we are going to lose them if we don't get them commissions.

Comment: Is there any objection to putting nurses in charge of overseeing the property responsibility in hospital wards?

Comment: Not any. It is authorized in the new AR 40-20.

Comment: Colonel Beck down at White Sulphur got out an order, which looks to me like an answer to your question and which relieves the medical officer of the care of property and checking property and administration of the wards controlled in this manner. I just got a copy the other day, and I think it is a very good thing.

Comment: It has common logic, but things are not ideal. It is a case of using what we have to go around, and if we cut nearly 20,000 medical officers to our old T/O's and allotments, we have to spread them very thin.

Comment: On the use of Medical Administrative Corps Officers in the wards, it is true that the sergeant did have the responsibility of the ward to the limited extent to police it, but I know from sad, sad experience who took the property on the ward, who actually had to sign for it and who had to actually survey it. The Medical Administrative Corps Officer can assume the responsibility as a MAC officer which he could not assume as a noncommissioned officer.

COL. JONES: As a suggestion, the following extract from Hospital Regulation is introduced from the White Sulphur General Hospital, White Sulphur Springs.

(Extracted from H R 30-5, Ashford General Hospital, White Sulphur Springs, W. Va.)

PROFESSIONAL SERVICES DEPARTMENT
PROFESSIONAL SERVICES OFFICE

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2. ORGANIZATION. A Medical Administrative Corps Officer, designated by the Chief of Professional Services, will supervise the activities of the Professional Services office. His duties and responsibilities are:

a. Assignment and supervision of such Officers as may be required for the property responsibility, policing, and the supervision of military and civilian personnel as may be required in the wards and clinics of the Professional Services Department.

b. Supervision of a non-commissioned officer responsible for the procurement and conduct of duty of enlisted men assigned to the Professional Services Department.

c. Supervision of a civilian assistant who will be responsible for the procurement and conduct of duty of civilian employees assigned to the Professional Services Department.

d. Liaison between the Chiefs of Services and sections, and Ward Officers in order to efficiently determine duty hours, and the training, conduct and relief from duty of enlisted and civilian personnel.

e. Liaison with such Administrative offices as may assist in efficient procurement of medical supplies, food service and other activities incident to the professional care of the patients.

* * * * *

5. DUTIES OF ADMINISTRATIVE ASSISTANTS OF THE PROFESSIONAL SERVICE OFFICE. The administrative assistants responsible for the property, policing, and personnel of the various wards and clinics will be assigned by the Officer in Charge of the Professional Services Office. They will be responsible for all administrative activities within the wards and clinics assigned to them. These officers shall make every possible effort to assist officers in charge of Services Sections or Wards of their areas so as to relieve the Professional Officers of all possible administrative responsibilities. Their duties and responsibilities are as follows:

a. The procurement, safeguarding, exchange and disposition of all property, expendable and non-expendable, required for such wards, offices, clinics and departments as may be designated.

b. The exchange of broken or worn out items of property, and the exchange of soiled linen in their areas.

c. The sanitation and policing of all areas under their jurisdiction.

d. The conservation of utilities, especially water, heat and electric current in their areas.

e. Supervision of military and civilian personnel assigned by the Professional Services Office to their areas.

f. Such other additional duties as may be designated by the Commanding Officer.

Question: Under present setup, medical personnel problems are handled by the Personnel Division of service commands. The service command surgeon is by-passed in many instances which involve vital personnel. This policy seriously affects the efficiency of medical installations. Can not this policy be modified to secure approval of all transfers and assignments of medical personnel by the surgeon of the service command?

Answer: It is the purpose of this conference to make suitable recommendations for changes.

Question: Medical officers are becoming scarce. The Sixth Service Command is considerably below strength necessary for desired efficiency. Almost daily requests for transfer of medical officers to other service commands are received. What can be done about this?

Answer: There is a shortage of medical officers in all forces. Procurement procedures are being pushed, but there is no prospect of meeting all needs if medical officers are not relieved of many administrative details so they may assume the care of a larger number of patients. Property responsibility in wards, operating rooms, clinics and kitchens may be given to WAC and Sanitary Corps officers, to members of the Army Nurse Corps, Medical Department Dietitians, and Medical Department Physical Therapy Aides. See AR 40-20 and AR 40-25. A ward nurse may fill out and sign the W.D., M.D. Forms 73 (Diet Card) see par. 16 Change 6, AR 40-590. A considerable part of the history in many patients can be written by trained WAC officers, noncommissioned officers, or civilian clerks. Clerical assistance should be given ward officers when possible. Medical officers in units under training should be given professional duties in service units including responsiblity for wards and similar duties.

Question: To what extent is the use of civilian physicians being made in induction stations? In only one city in the Sixth Service Command is there sufficient cooperation to get this assistance.

Answer: Should have at least one medical officer. If civilians cannot be obtained additional medical officers may be drawn from stations.

Question: Requests from The Surgeon General's Office for assignments of Medical Department personnel or for school details go to the Personnel Division. Should they not be earmarked for the Chief of the Medical Branch?

Answer: This will be done if it is desired by the Chief of Medical Branch.

Comment: There was a request which came out sometime back, authorizing so many officers in each service command to various schools. I never did get to see that thing until I sent for it the other day, to the Personnel Section, and, by the way, it authorized the Sixth Service Command to send 70 medical officers to school on July 3 which was an impossibility.

Question: Are Medical Department personnel other than flight surgeons permanently assigned to the Air Forces? In the taking over of an Air Force operated hospital by the service command can this personnel be retained?

Answer: Medical Department personnel assigned to duty with the Army Air Forces are on permanent assignments as far as assignments to the Force are permanent. Release from such assignments requires concurrence. When an Air Force hospital is transferred to a service command, the Medical Department personnel there, except flight surgeons should be transferred with concurrence of the Air Force, or remain until they can be properly replaced.

Comment: That question came up concerning the Chicago Beach Hospital there in Chicago which we are going to take over very shortly.

Comment: That's right.

Comment: Will we retain that personnel? Can it be transferred back?

Comment: The people with flight surgeon's ratings can't be kept. You can't keep them, they've got to go, but the others can be retained at least until you can replace them.

Comment: Well, we can replace them.

Comment: Does that include the commanding officer?

Comment: No, the commanding officer is a flight surgeon.

Comment: Well, we'll have to get a commanding officer.

Question: Since the procurement of nurses is no longer a function of the Medical Department, the capable nurses now assigned to the service command have become clerks in the Personnel Division. Is it not a waste of usable talent to keep them on a job that can be accomplished by a $1200 clerk?

Answer: The procurement of nurses is accepted as a function of the Medical Department. Nurses on duty that could be accomplished by a clerk should be relieved from such duty.

Comment: At present indications are that the nurses assigned to the Officer Procurement Service have not been too successful

because a great many assigned to this duty are inexperienced in securing nurses and the methods of appealing to nurses to enter the service.

Comment: We kept our two nurses in the service command there. We have a nurse assigned to each one of the recruiting boards. That's a little different, but we keep the two, and all the paper work and everything. We couldn't get along without them. It wouldn't work, if you didn't do it that way, I believe.

Comment: There you go. It wouldn't work for him.

Comment: Well, it isn't working for me either.

Comment: I don't see how you could make it work.

Comment: Well, that office is way downtown some place.

Comment: That is one reason why we want to get together and have a standardized service command surgeon's office.

Comment: Yes, that's what we need. There are too many vagaries.

Question: With regard to Statistical Report, 3d Section, MD Form 86c. Clarification is requested as to who is to submit MD Forms 86c, with particular reference to schools (not Medical Department) located at military installations and to which Medical Department personnel are assigned to duty with the Medical Department?

Answer: Form 86c, Medical Department, should be submitted by all schools to which Medical Department personnel are assigned. That is, you send in an 86c if there's an officer there or a medical detachment.

COL. JONES: That brings up one question: I don't know whether it's in this or not; I got it over in another place. They make contracts with these schools which provide for all medical attendance. Now, I've taken the stand in the 5th Service Command that we had to have those records made right. That's something that civilian institutions should not be required to do, and what we've done in that setup is to provide a clerk who is qualified to do it, and I've sent a noncommissioned officer out to instruct each one of them.

Comment: Well, we discussed that -- it came up this morning.

Question: Where are you going to get your men for that work?

Comment: We've been asked to do that.

Comment: I've just taken one noncommissioned officer and I've sent him

out to each place -- well, I'm using two now -- and I leave him there for about ten days.

Comment: How many do you have now?

Comment: How many schools? Oh, there's about thirty, I guess.

Comment: Well, that doesn't qualify that very much. That's going to come up on another thing here, I think. But half of those are Air Corps schools and I don't know yet what we're supposed to do with those.

Comment: Don't do anything.

Comment: Well, that's something we've got to straighten out.

Comment: They call for help all the while.

GENERAL LULL: Well, let's concentrate directly on the thing and get this on the record, because one has to talk directly into these microphones. Now here's a question, I think, with reference to Statistical Report, 86c, clarification is requested as to who is to submit it, with particular reference to internment camps located at military installations?

Answer: Medical Department personnel assigned to internment camps should render a Form 86c, provided they have a distinct allotment separate from that authorized for the station complement; otherwise the station surgeon submits it. In the Sixth Service Command, a proposition has been put up about hospitalization of these people, and I think it has been suggested that a section of the station hospital be set aside for them, and that they have only an infirmary. I think that General Kirk is partial to that way of doing it rather than building a separate hospital at every internment camp. I think he's voiced himself as approving it.

Comment: With regard to this Statistical Report, how should the WAAC personnel be shown who are assigned to duty with the Medical Department. Well, that's been taken up. The report is being revised.

Question: Another question as to this report: Should service command headquarters be supplied with the original of 86c for Air Force installations or a copy.

Answer: Paragraph 2e(1), AR 40-1080, required that the original 86c be sent to the corps area surgeon, and one copy to The Surgeon General.

Question: One copy to The Surgeon General's Office? And one copy retained?

Answer: Yes.

Comment: Now I understand that at some of the Air Force stations they have to send it to district headquarters, but they should send a copy of that to you.

Question: What is the responsibility of the service command surgeon with regard to correctness of preparation of Form 86c from Air Force stations?

Answer: There is no responsibility unless there is a consolidation at the service command. At the present time we have no authority over these Air Force stations; at least the authority is very vague, I'll put it that way.

Comment: May I say a word there in reference to the 86c being consolidated?

Answer: Yes.

Comment: We had a roster sent in some time ago from a numbered station hospital that was in training at a service unit. This numbered station hospital did not submit an 86c or a roster. The station hospital was submitting the report for the entire personnel of that numbered unit, consolidated with its own. I've forgotten the number of the unit or the service command it was in, but anyway we've sent a letter out to correct that.

Question: How will physiotherapists and dietitians for overseas service be supplied?

Answer: The Surgeon General will recommend to The Adjutant General that a service command designate or earmark the Medical Department physical therapy aides and dietitians for specific units. This personnel may remain on duty within the service command until required to join their units when movement's directed or the unit is functioning. Instruction to join the unit is issued by the headquarters authorized to move the unit. They will be moved just like nurses, earmarked by number.

Comment: We haven't followed that too completely because of the fact that the recruiting of dietitians and physical therapists has not been quite sufficient. So occasionally physical therapists and dietitians are ordered by name to join the unit.

COL. JONES: They called on us for six the other day, and we only had six in the whole service command.

Comment: War Department Circular No. 99 was rather liberal in allowing the number of nurses and the number of dietitians and the number of physical therapy aides to units. That is now under

revision; the number that is called for in Circular No. 99 is not being supplied to units. So, don't be surprised if there are three dietitians allotted a hospital of a certain size but they get only one, because we do not have them.

Question: Information is requested as to the responsibility of the chief nurse in connection with dietitians and physiotherapy aides in hospitals where such are assigned, when no head dietitian or head physiotherapy aide is assigned, with particular reference to requisition for initial clothing.

Answer: The instruction and functioning of physiotherapy aides and of dietitians are not a responsibility of the chief nurse. They are members of different branches of the Medical Department. This personnel is under the direction of the commanding officer of the hospital who may authorize the chief nurse to assist in, or to direct administrative details. See AR 40-25, changed 9 April 1943. Requisition for clothing may be forwarded by the aide or dietitian through her superior to the quartermaster. That is on the clothing issue only.

Question: Information is requested as to the responsibility of the chief nurse in connection with dietitians and physiotherapy aides at hospitals where such are assigned when no head dietitian or head physiotherapy aide is assigned, with particular reference to correct wearing of the uniform.

Answer: The commanding officer of a hospital or medical installation should direct a qualified person to instruct nurses, physiotherapy aides, and dietitians in the correct wearing of the uniform. This may be the chief nurse or a member of one of the branches. For details as to uniforms, see Changes 14, AR 600-35, 6 March 1943, Changes 17, AR 600-35, 24 April 1943, and Changes 15, AR 600-40, 24 April 1943.

Question: The next question concerns duty hours and leaves, especially when only members of the Army Nurse Corps are available for relief.

Answer: The duty hours and leaves, especially when only members of the Army Nurse Corps are available for relief, are prescribed by the commanding officer of the hospital. Requests for leaves must have the approval of the same authority. It will be necessary in many instances to coordinate duty hours and leaves with those of the members of the Army Nurse Corps.

Comment: We might as well discuss these, because there are several more here with reference to instruction, assignment, discipline, and performance of duty.

Answer: Medical Department dietitians and physiotherapy aides and members of the Army Nurse Corps are militarized female

members of the Medical Department on an officer status with relative rank. No period of initial training is given them, so they need some basic military training at their first stations. The commanding officer of the unit should direct that instruction be given by a qualified individual. Reference should be made to Surgeon General's Circular Letter No. 109, 28 May 1943. In other words the head nurse is not in charge of the physiotherapy aides and the dietitians. They are under the commanding officer of the hospital. Now, if the nurses have a rule that all lights have to be out in nurses' quarters at 11 o'clock, why they'll have to abide by that rule, because they live in the nurses' quarters. The chief nurse doesn't necessarily give the order. The commanding officer of the hospital is the one who directs that, and they work under the commanding officer of the hospital as directed by the chief of service.

Question: May nurses be selected for overseas assignment who have not volunteered for such service?

Answer: Nurses, physiotherapy aides, and dietitians are not appointed for special assignments and may be ordered overseas if they are physically qualified for such an assignment. They do not have to volunteer. They are now militarized personnel.

Comment: In the final analysis the commander runs the hospital.

Comment: That's right.

Question: May a revision of table V, Change 1 to MR 4-2, 9 April, be expected? This table has been of inestimable value to this service command for use as a guide.

Answer: Guides for personnel required for various installations are now under consideration at Headquarters ASF.

Comment: Certainly not by grade as the old MR 4-1 was. Table MR 1-4 will be rescinded, we hope, because the number of medical officers indicated cannot be provided. We have recommended specifically that guides be published.

Question: May civilian physicians and nurses be employed by the military establishment at installations other than Army-owned, Army-operated industrial plants? It is noted that employment of civilian dietitians and physiotherapy aides is prohibited. The employment of civilian physicians and nurses at Army-owned, Army operated industrial plants has been specifically authorized.

Answer: Civilian physicians and nurses may be employed at installations where the service command is responsible for medical care.

Comment: Request authority for the service command to assume assignment jurisdiction of Medical Corps officers on limited service in medical replacement pools. In this connection, this headquarters is now forwarding all Disposition Board cases to The Adjutant General and requesting station assignment.

Answer: This has been a question that has come up from several service commands. Unfortunately, it has come up in those service commands that haven't submitted information to us promptly. The procedure that should be carried out and one that has been recommended for an impending change in Circular 82, is that the report of the disposition be forwarded from the hospital through the headquarters, service command, attention, chief of medical branch, who will make recommendation desired and forward the entire report to The Adjutant General. There is a reason for that. The Adjutant General's records must be changed, the board reports should eventually wind up in the officers' 201 file regardless of what corps he is, or branch, the chief of service should have his records changed. Medical Corps officers cannot be handled differently from other arms and services. There are a lot of factors to consider in the assignment of reclassified officers, those who have been physically qualified for limited service only or limited service continental limits. They must be considered as available to meet the demands of the services as a whole and not a particular service command. If they are given to a service command, the one that has the larger number of general hospitals will consequently get the larger number of personnel. A certain number of these officers are necessary for assignment overseas. They are limited service but there is no provision whereby they can't go overseas, and we have, as you know from the calls you have received to supply personnel, many requests for men overseas. Also, one service command may be more embarrassed, temporarily, than another. Some of these men may have come from an Air Corps station. He may be a qualified flight surgeon.

If the procedure outlined is followed and assuming that Disposition Board of the general hospital reaches the service command within, say, 72 hours, and stays in the service command not over 48 (it won't stay in this office 48, it won't stay in The Adjutant General's Office 48) there will be no delay. One service command where that policy has been rigidly in force is the Fourth. Results are satisfactory. Other service commands are beginning to work into that policy. So if in the procedure mentioned is adopted, approving or disapproving the Hospital Disposition Board, preferably by wrapper indorsement, the simple statement (1) the findings of the Disposition Board are approved, (2) it is requested that this officer be assigned to this service command with station at -----, then we can issue the necessary orders if some

other good reason doesn't exist to his assignment elsewhere.

Comment: We don't see those disposition boards in our service command at all. We don't know anything about them.

Comment: You have to see them.

Comment: No, we do not.

Comment: Some one - the commanding general of the service command - it is his responsibility to approve or disapprove the action of the board.

Comment: The Medical Branch doesn't get a look in on them - he doesn't have one.

Comment: We see them only after action has been taken, and then if we ask them.

Comment: And who in the service command is authorized to act on a medical report of such a character?

Question: Are you talking about disposition boards in general hospitals?

Answer: Yes.

Comment: I think there is a regulation now that disposition boards come direct to your office. The Line Boards get those, but I'm talking about disposition boards.

Comment: Hospital disposition boards will be reviewed by the commanding general of the service command in all general hospitals except Walter Reed where they are reviewed by The Surgeon General.

Comment: Well, I think we've got that cleared up, haven't we?

Comment: A new clarification of Circular 82 is coming out. Theoretically, when an officer is returned from overseas, he is supposed to come to the port of embarkation. The port of embarkation has authority to put him in a general hospital where he has bed credits. He is supposed to issue an order assigning him to that general hospital and to the nearest arm of service replacement pool. He is also supposed to send the chief of branch or arm, the hospital and the pool concerned a copy of that order. There is only one port that is carrying that out implicitly, and that is the Seattle Port of Embarkation, and with them we have no trouble, and in the Fourth Service Command where we've gotten this other system worked out we have no trouble.

Question: The San Francisco Port had that system?

Answer: No, the only port is the Seattle Port of Embarkation; they have played 100 percent as they should, and the Fourth Service Command has also done the same thing. They send us a copy of the order immediately saying that the following officers returned from A.P.O. No. so-and-so have been hospitalized in the following general hospital, and they tabulate them, and say attached hereto is copy of orders, and it tells what pool he is going in, so then we know he's there; we know we can expect the disposition board promptly, and then the disposition board states whether or not he is for limited service, continental limits, or whether he is limited service generally. We can give you prompt action if we get them that way and that I can assure you, from what the man that's rewriting Circular 82 tells me over the phone, will be included specifically in the next revision.

Question: Do any other service commands not see these disposition boards other than the Seventh?

Comment: We don't see them.

Comment: I don't see how the service command can pass on it. It's a medical thing.

Comment: He don't. He routes that upstairs. Some second lieutenant.

Comment: Certainly the Chief of the Medical Branch should rightfully insist that they pass over them. It amounts to the same thing as that a commanding general should have his Medical Branch pass on them as much as he would on a Form 63.

Comment: Bring that up tomorrow when General Robinson of the Control Division comes over here. That's a good point to bring up.

Comment: I might say that this policy is beginning to gradually be worked in all service commands, and it is working better.

Question: Are remaining general service technicians going to be called out of the service command, and, if so, is it assured they will be assigned to numbered medical units?

COL. PERRY: I don't believe there is any assurance at all that they will be assigned to medical units. It hasn't been done in the past, and I don't believe it is going to be done now unless there is something done about it. We've made every effort here to do it, but we've gotten nowhere. A very short time ago -- this is getting a little bit off the subject -- but general service men were taken out of the general hospital and assigned to an infantry replacement training center to learn to shoot machine guns.

Comment: Well, that is something that we have in the mill now. Medical Department technicians ought to be utilized.

Comment: Colonel Wakeman in Training will talk more on this subject when he comes before the conference.

COL. FRENCH: Laboratory men, x-ray men, high-class technicians, learning to shoot a rifle.

Comment: I had a case the other day -- a master sergeant - 17 years' service - in an infantry replacement training center -- making an infantry soldier out of him.

Comment: That's something that is really a serious problem.

Comment: It's under the control of the service command.

Question: Do you have funds in your service commands?

Answer: Yes.

Question: Why may not Medical Department replacement pools be established at service command headquarters rather than at general hospitals for temporary reassignment where shortages are acute?

COL. HUDNALL: Why do you want a replacement pool at headquarters? The answer to that question is the one that's been given already. It is that the replacement pool people must be under the control of The Surgeon General if he is going to serve the Army as a whole.

Question: Why must those men in the pool - doctors in the pool - sit and do nothing? Why can't we send them around -- distribute them around the service command?

Answer: There is no objection to your utilizing those pool officers after they have had their basic training -- any place you want to, on temporary duty as long as they can get back to the pool in 24 or 48 hours.

COL. PADEN: With reference to these numbered units under your control, they are your responsibility. There is no reason why officers assigned to the Fourth Auxiliary Surgical Group or any other Auxiliary Surgical Group that have had their training can't be utilized on temporary duty elsewhere. Likewise in the pools, this office has no objection to the temporary utilization of officers in professional pools after they have completed four weeks' training. Before four weeks' training there is a definate objection. Shortly there will come into professional pools in all named general hospitals some 350 officers whom we believe will be limited service or who are

of doubtful category. Those officers are direct from civil life and will not have had a single day's military training. They will not pass through Carlisle. It is mandatory almost that they have at least four weeks' training at the pool to acquaint them with military details, and you will find that very few officers, unless they are of high rank or are exceptionally well-trained specialists, have remained at any pool longer than four weeks, if that long.

Comment: Numbered medical units have been placed under service command control by Change 2, AR 170-10. It is the service command responsibility, but when men are placed in them like the Fourth Auxiliary Surgical Group there are not enough highly trained men in the country to build more than four or five of those groups. Two of them have gone, and the rest of them are highly selected men who just won't be replacable.

Comment: The commanding officer of that surgical group objected to my taking those men because he said he and the executive officer wouldn't have anything to do if I took all the surgeons away.

Comment: We are a little ahead there about the people in the affiliated units that we have had so many letters about, about people sitting there twiddling their thumbs when we knew that they should have been under some kind of a training program.

Comment: There is no reason why affiliated units personnel can't be used in the service commands provided that you are sure that they don't pass from your control. The Surgeon General and the Secretary of War have made certain commitments to affiliated units as to their intactness as a unit while it remains in the continental limits of the United States, but there is no reason why any part or all of them can't be used in good training throughout the service command as long as they are immediately available for return in the event the unit is alerted.

Comment: We've done that with numbered station hospital training, but until recently not with affiliated ones.

Comment: It can be done with affiliated units, but it is your responsibility to see that the unit always remains intact.

Comment: We are going to have to work them before long because there are not going to be enough medical officers; we are going to have to put them to work.

Comment: We are using all the numbered station and general hospitals, except the surgical teams out at Lawson.

Comment: No reason why you can't use them.

COL. PADEN: There is one thing to consider. The Commanding General, ASF, insists, and our Training Division will insist, that these officers have their necessary basic training, but once they have had that they are your babies, but you will have to cooperate until they do get it. There are a bunch of other affiliated units coming out shortly and once they've had their basic training why then you can utilize them to the fullest extent.

Comment: Most of these affiliated unit officers not already on active duty coming out now are going to Carlisle too.

Comment: I wonder if you could get out a directive to help us in our efforts to get these people for use.

Comment: That is covered fully in Change 2, AR 170-10, dated 14 April. "All numbered units when placed under service command control."

Comment: These general hospitals that we have, they haven't got their full complement of personnel yet.

Comment: Well, you have to use some of this numbered general hospital personnel, too, in those newly activated general hospitals.

Comment: Those five general hospitals that I've got to open between now and the first of October - why couldn't you activate five?

Comment: We're giving serious consideration to ordering an affiliated unit into each one of those things and let them open it and then before they go we'll fill it up with other personnel. That's been given serious considertaion.

COL. PADEN: While not specifically requested, and probably a matter over which the chief of Medical Branch in the service command has no control, some of the service commands are still sending in to The Surgeon General direct recommendations for the promotion of Medical Department officers serving in numbered Medical Department installations. There is absolutely no need for those to come to this office. They should be forwarded by the Personnel Section, Service Command, direct to The Adjutant General.

Comment: You have full control of all those numbered units.

Comment: AR 170-10 again places them explicitly and 100 percent under your control when they are assigned to the service command.

COL. HART: We have one regular officer down; he has been switched around a lot. One regular officer down at LaGarde in command of a numbered unit is still a lieutenant colonel of the Regular Army, who has never been promoted. He has been changed so

often that he just lost out, and he is a lieutenant colonel, who will soon get his colonelcy. I told him the other day to take it up with you. He has never been promoted. He's in command of the unit and he's done a good job. He's at La-Garde and nobody recommended his promotion when he could have written out and gotten it; it's partly our fault, and he's just been lost in the shuffle. I don't know why. Smith is very well satisfied with what he has done. I know, because he told me so.

Comment: The commanding officers of these numbered general hospitals have the authority to promote - recommend promotion of certain officers, but we have to wait six months.

Comment: If an officer has, at any time for a period of six months in the grade which he now holds, demonstrated his fitness for promotion at his present or any other station, he can immediately be recommended for promotion.

Comment: The best way to do in most cases is to have the commanding officer write to his former commanding officer and ask him if he demonstrated his fitness for promotion and inclose that letter with his recommendation.

Question: Doesn't that recommendation have to emanate from the surgeon of the post?

Comment: We have a large number of these at Bragg and we insist on recommending - starting the ball rolling here.

Comment: That's the way it should be; it should originate with the post commander. If the chief of the Medical Branch wants to promote a man ahead of time, even when he has just come there, a couple of weeks, he can write back to his old station, or maybe go back to two stations. The only requirement is that he must have demonstrated his fitness for promotion for a period of six months.

Comment: Suppose that man though, assigned as chief of the surgical service, hasn't had any experience as far as the Army is concerned as chief of the surgical service. Are you going to promote him just because he's been stuck in there?

Comment: That is at your discretion entirely. If you feel that that man, after you have observed him for any period of time - two weeks, three weeks, a month --.

Comment: Suppose he is sitting there doing nothing -- how do we know whether he is a good chief surgeon?

Comment: If he hasn't had a riot, he is all right.

Comment: And recommend his promotion just because he happens to be occupying a position which calls for a lieutenant colonel?

Comment: Well, he can turn it down.

Comment: Colonel Jones, along that line, I believe that the units are for training within the service command and that a unit shouldn't be sitting there doing nothing; they should be sitting there doing something. Are you holding off on account of the man's professional ability as a surgeon?

Comment: Yes.

Comment: The man whom you have as chief of surgical service in a numbered station hospital should spend a great deal of his time assisting or doing surgery in some of your hospitals, so you would be able to estimate that. Don't promote a man unless you were satisfied about it.

Comment: Take Newton D. Baker Hospital, you can assign men there - are you going to promote those fellows just because you assigned them in there?

Comment: That hospital is not taking patients yet, is it? You certainly want to know about a man's qualifications before you promote him, but we referred particularly to the number of men that have been tried out, and no one knew who should initiate the processes in order to do justice to some of these men.

Comment: The commanding officer of the general hospital recommends him. We never see him; we don't know a thing about him.

Comment: You can write back to his former station; that commanding officer - if you're going to recommend him - can write back to the man at the station and see that this man has the qualifications, then you can promote him if you are satisfied.

Comment: You can't promote him until he has been in the service six months any way. You can't promote him until he has demonstrated his efficiency.

COL. FRENCH: The question I would like to raise is on the promotion of the professional consultants within the service command. I understand that these consultants were to come in as lieutenant colonels and to be promoted after they had had their six months' service as such if they were found qualified. Now at the Fourth Service Command they had three colonels in the Medical Corps set for corps area headquarters and there were three Regulars. It came time to promote Colonel Thomas, Chief Medical Consultant, and the Personnel Section said, "No, you don't have a vacancy." Well, they had plenty of

vacancies in some of these other places. I said, "Well, just give me one of these and I'll give you a lieutenant colonel chief for this other place." They don't need two colonels there, for instance, in Camp Croft, with a 750-bed hospital, or something of the sort. Well, no, they couldn't do that, so I just had a terrible time getting him promoted to a colonel, and he had been in the service a year and a half. He had been over here at Meade for a year and down with me for six months, over six months. Now I have my surgical consultant and my M.P. consultant, both of them lieutenant colonels. Both of them will be ready for promotion within the next two or three months. Now I'll have to go through that whole rigamarole again. Couldn't that colonelcy be established for these high-powered men?

Comment: That's one question that will be brought up before this board that is going to meet later - the setting up in the service command surgeon's office of certain divisions, and one of them will be the division of consultants with so many officers in certain grades.

COL. FRENCH: That will be fine.

Comment: There will in accordance with Director, Military Personnel, ASF, and the Control Division, ASF, and General Somervell's desire, never be any specific grades allotted for any specific thing within your service command. It will have to be treated as a whole and it will have to be threshed out locally.

GENERAL LULL: You can use your colonels wherever you see fit to use them, but we will try to get you a percentage, and you will have to do most of the fighting on your percentage.

Question: Now the next question: Is it practical for service commanders to reclassify Medical Department officers to service command assignments rather than wait for War Department orders? That was covered.

GENERAL LULL: Can The Surgeon General utilize colonels, Medical Corps, who are incompetent to administer hospitals? He cannot. That is easily answered. He can't use any incompetent colonels, or lieutenant colonels, or any one else. I mean we have the same trouble - those men will have to be reclassified in the service command, and we had one here not long ago reclassified, and the board recommended that he be assigned in the grade of major. We had another one that came up the other day. He was a temporary colonel and a lieutenant colonel in the Reserve Corps, and they recommended that he be reduced to his grade in the Reserve Corps and reassigned. The lower grades they are - that is, the more useless they are - we can assign a lieutenant or captain, you know, it doesn't matter - he doesn't have to be so hot, but when you get up in the

grade of lieutenant colonel and colonel it is a different matter.

Now some of these fellows can command units, but most of them just can't do anything, and we have quite a few of them scattered around in the 35,000 medical officers we have, and the only thing is to be hardboiled about it even if they release them from the service -- that means there is one more good doctor gone back in civil life. You might as well make up your mind not to have much of the milk of human kindness in your system - get them out. This one that we had in here the other day came and appealed to me - I think a good guardhouse lawyer could beat the case all right because his commanding officer recommended him for promotion and promoted him to the grade of colonel then within three months of the time had him reclassified. That's the fellow we're going to get back. Do you want him as a lieutenant colonel?

Comment: Now, that's the thing you have to consider, too. The Reclassification Board may see it in a little different light from what we do.

Comment: They always do. We have a lieutenant colonel up here in Coast Artillery now who failed to stand up in the Coast Artillery School. He's a doctor and they want to give him to us.

Comment: I had one like that.

Comment: We've kicked about it. If he's not good enough to be a lieutenant colonel in the Coast Artillery, he's not good enough. They put up a story -- said we weren't consistent in our argument - said we needed doctors and here's a doctor we wouldn't take. They finally wound up by telling me very mildly that we would have to take him. So we are going to have totake him in the grade of lieutenant colonel.

Comment: I want to tell you something about this fellow (name). Now, he may have gotten a rough deal. He is a fellow who has been associated with the Coast Artillery ever since before he studied medicine and when he went to the Coast Artillery School he stood in the lower third of the class and they reclassified him in order to get rid of him, they try to do that with all these old fellows, and the chap may have something on the ball at that.

Comment: He had superior reports up to the time he went to this school?

Comment: Yes, he had superior reports up to the time he went to this school, and he may be all right. He may be a fellow who didn't make good at the Coast Artillery School, but he may be a good administrator.

COL. PADEN: General Lull, may I put one other thing in there? We are asking each time we get a chance for numbered units that can handle colonels and lieutenant colonels notably of which are numbered port of embarkation and replacement depots where these older men in higher grades can be utilized; we are trying to ask service commands to take turns, go all the way around, and ask them to supply colonels or lieutenant colonels every time we get a chance. Sometimes you give them to them and they don't like the ones you give - they want Regular Army officers - graduates of Command and General Staff schools, and everything else, but usually they stick; and every time we get a chance we always bear the service command in mind and give them a chance to use these top ranks.

Question: Where is this?

COL. PADEN: Ports of embarkation, numbered ports of embarkation, and places like that, where you don't have to have a troop age officer, where you can have a colonel over age. Every time we get a chance to try to rotate it. If somebody puts in a requisition for a colonel or lieutenant colonel, we try to give the First and then on around - and ask them to furnish one and give them a chance to unload some of the top ranks. They should be good men when you give them to them; we know you will give them the best you've got.

GENERAL LULL: Now if there is nothing else, we have some questions here that have been brought up in our office by Mr. Jones, the Director of Civilian Personnel. If you will go over to the microphone we will bring these up. He wants to know if the general handling of civilian personnel matters has been efficient and effective in the service command -- that is, Medical Department civilian personnel.

MR. JONES: I would like comments from any of you gentlemen on that particular question. We are very much interested in the reaction of the Medical Branches of the service commands to the present method of handling civilian personnel matters.

GENERAL LULL: Any comments - has it been satisfactory?

MR JONES: Do you feel that the type of civilian personnel the hospitals are getting is as good as you can expect under present conditions in the country? The wages and salaries are appropriate to enable hospitals to get reasonably good people.

COL. BURNETT: Do you want me to answer that officially for the record?

GENERAL LULL: Yes, take the microphone. Colonel Burnett, Third Service Command.

COL. BURNETT: There is quite a heavy turnover in civilian personnel in our

hospitals due to many personal reasons, family reasons, and all that sort of thing, so it is not a static, steadily developing, force of people. There are frequent changes -- that's one thing that we are having a little difficulty with, of course. I think that's so all over, but the average of the personnel is pretty good so far as ability goes.

MR. JONES: You don't feel the turnover, then, is because of wage rates or salary classifications?

COL. BURNETT: No, I wouldn't say that. I don't think it is. I think living conditions and family problems and marriages and all sorts of personal things come in, and there is quite a good deal of shift on that account. The average type of civilian employee in our hospitals and offices is - of course, I am considering Civil Service too now of fairly good grade.

MR. JONES: Do you feel that it would be helful if this office was able to participate more closely in civilian personnel administration of the hospitals?

COL. BURNETT: Well, I think that is a matter that has to be left to each service command, very largely, and especially to the post surgeons in our large camps and large stations, and they are working with these civilian personnel officers who have that in charge and who are hiring these people, and so far it has worked out pretty well.

MR. JONES: Do the civilian personnel agencies give proper attention to the employment of Medical Department personnel?

COL. BURNETT: Well, in most of the stations that I have observed, and in my own station before I was assigned to my present duties, at Pickett, required the usual procedure for the local representative who has charge of the hiring of Civil Service to cooperate closely with the post surgeon and the post commanding officer, and they together look up these people that present themselves and they are personally interviewed, and that's the only way that I see it can be handled - through personal interviews.

MR. JONES: You feel then that they are giving good cooperation to you?

COL. BURNETT: Yes, they are giving very good cooperation in the camps, posts, and stations in that matter.

Question: How about the rates of pay for hospital employees - are they equitable when compared with rates for other installations?

COL. BURNETT: I believe they are. Yes, sir, I think they are.

COL. FRENCH: I would like to tell them about the Fourth Service Command.

In the Fourth Service Command we have quite a bit of difficulty in getting civilian employees in many of our large stations because they are so far away from civilization. Take Blanding - 30 miles from Jacksonville, and Rucker - way off by itself -- a lot of these big stations - the transportation facilities - there are no housing facilities on the reservation. We have a great deal of trouble getting civilian personnel and civilian personnel of the right quality. It's sparsely settled down in this part of the South and really high-type clerks and stenographers won't go out and go through all the hardship of getting out there and back every day.

MR. JONES: You don't feel that the rates of pay offered these people stand in the way of their employment, do you?

COL. FRENCH: No, I don't think so. They just aren't there to employ. What we have are very good. Transportation and housing are the two main problems.

Comment: May I say a word about some of the difficulties in connection with civilian employees at Air Force stations. The service command surgeon has no jurisdiction over the hospitals at Air Force stations, yet all requests for the employment - new positions we have to pass on. It's just one of those things that goes with this dual control.

MR. JONES: I think probably that will be changed 1 July from what I hear from the Civilian Personnel Division of the Air Forces' Headquarters here - that the Air Forces' personnel officers in each one of those stations will take on the job 1 July.

Question: And then will we be relieved from passing on whether this hospital needs a CAF-8 or something like that?

MR. JONES: That is my understanding.

GENERAL LULL: Are there any questions you gentlemen desire to ask Mr. Jones while he's here? Of course, this has been highly decentralized - more so than the Military Personnel even --. If not, I guess that is all, Mr. Jones; thank you. Are there any questions you desire to ask Colonel Hudnall, or Colonel Perry of the Enlisted Branch. If not, I suggest we have a little time now that we might run around and see what people we want to. We won't meet again until tomorrow. If you gentlemen can get here at 8:30, we can meet at 8:30. Is there any objection to your being here at 8:30 - any difficulty?

Nursing Division

GENERAL LULL: Gentlemen, at this time I'll introduce Colonel Blanchfield, the Superintendent of the Army Nurse Corps.

COL. BLANCHFIELD: Gentlemen, I am glad to be among friends. I expect there will be many questions. I have a list here of questions, General, the answers of which have been prepared by you, and I will read the questions and the answer and if there is any discussion then, it will be open for discussion. The first question: What steps can be taken to expedite the issue of nurses uniforms? Initial issues are delayed in some instances as long as three months. This necessitates nurses reporting at ports of embarkation and to stations and other service commands without suitable uniform equipment.

Answer: It is believed the delay in the initial issue of nurses' uniforms is due to failure on the part of the Quartermaster Corps officer to follow directions on the filling of requisitions. The letter, War Department, Quartermaster General, 24 November 1942, directed that all requisitions for nurses' clothing be submitted to post, camp, or station at which the nurse is inducted. That any items which cannot be supplied by the distributing depot be extracted to The Quartermaster General indicating an adequate number of all items of the new uniforms for initial issues are available at the distributing depots. If the local quartermaster fails to fill requisition for initial issue for members of the Army Nurse Corps within a reasonable time, then a follow up inviting attention to The Quartermaster General's letter, 24 November 1942, should be forwarded without delay. Apparently the quartermaster has enough of these items on hand and it is a matter of distribution. I have a list of the numbers of items that were reported as being assets on 1-31-43. Caps, garrison 67,734; cape blue 51,672; coat covert blue 50,061; gloves 40,662; mufflers 29,741; overcoats blue 40,330; shoes 148,696, that is black oxfords; shirt covert blue 49,691; sweater blue 46,260; uniforms cotton crepe blue 31,636; and waist blue 108,015. Now if these figures are really true and the quartermaster keeps insisting that there is an adequate supply in the depot, then there is something wrong with the distribution system. That we know, because from every source we get the same report, that is, that the requisitions submitted, even though the required number of items are delivered; they are not in the sizes that have been ordered and many times the requisitions will be filled by sending so many skirts without coats, so many coats without skirts, and so on. Now the letter referred to definately instructed the quartermaster

at the distributing depot to contact The Quartermaster General's Office, if the requisitions could not be filled as submitted. The Quartermaster General then would direct the distributing quartermaster to contact the depot where it was known that the items were being held. I think that we have shown that the trouble is with the Quartermaster Distribution Branch. We are referring all complaints to that branch now and have been assured that this distribution is going to be stepped up and that all nurses should have their uniforms in the shortest possible time. Now, one thing we would like, and that is, a report on all requisitions that are not filled as they are submitted. If there is any discrepancy whatever in the filling of that requisition, if we can have pertinent information as to the discrepancy, we will send it directly to The Quartermaster General's Office, where we are assured that immediate action will be taken in a follow up to find out why the requisition has not been filled as submitted or else why The Quartermaster General's Office was not notified of the lack of items with which to fill it.

COL. HILLDRUP: In the Sixth Service Command after the first of July all nurses being appointed are to be sent to Camp McCoy to be outfitted before they are assigned to their permanent station.

COL. BLANCHFIELD: The Quartermaster General has assured us that wherever there is an induction center set up they will send the uniform equipment so that the nurses may be equipped upon induction. How soon will that be, Colonel?

COL. HILLDRUP: First of July, and they will all be sent to Camp McCoy -- all to Camp McCoy to be outfitted. I'll try to make arrangements with the Quartermaster General to set up a supply depot there. Yes, then the Quartermaster can ship into his local depot a lot of uniforms in assorted sizes so that they can be tried on. If they get the sizes that don't fit, frequently they can't have them tailored to fit. That's true. We have had a lot of complaint about that. Well, we have had a lot of trouble in this respect. We'll order a twelve or fourteen and maybe get an eighteen. Yes. And these large sizes should be rejected, but if we can get induction places, the quartermaster has assured us, that he will be glad to send to those stations adequate supplies to equip the nurses.

GENERAL LULL: There will be some new action upon the design probably for overseas. General Kirk is very much interested in a working uniform for our nurses. From what he saw in Africa, he was very much alarmed about these girls, who are working over there; they had no suitable uniforms to work in. Now, they have a suitable dress uniform. They haven't a suitable work uniform for field conditions. He said they worked in coveralls; they worked in enlisted men's clothing; they worked in

all sorts of clothing that they could get that they thought might be practical. It was a great hardship on these women to wear this clothing. It didn't look well, and it was far from ideal, and he is very much interested in a design of some sort of a work uniform.

On the recommendation of Colonel McEvers of the 73d Evacuation Hospital, we gave consideration to a special nurses' uniform for field service units early in 1942. I think it was in May, and in June we sent our recommendation over to the quartermaster for a one piece coverall suit for women of the Army Nurse Corps, who were assigned to field duty and evacuation hospitals. We have also recommended that the same uniform be made available for nurses who are assigned to duty in maneuvers area with the evacuation and field hospitals in the United States. We finally adopted not a one piece but a two-piece uniform of herringbone twill. They are not yet available but we have been assured they will be about the first of July. The quartermaster says it will, but because I have been told so many times that things will be available on a given date, only to find that they are not at all, I am skeptical concerning these items too.

We have also been assured by The Quartermaster General's Office that the nurses of all units for overseas service will be supplied with all the items of uniform both for the field and fixed hospitals by 1 July. For the time being, the nurses will be equipped with these new items at the port of embarkation. The nurses of the field units will get their equipment upon reporting for duty with the unit. These items will not be carried as part of the nurses' baggage, but will be carried as part of the equipment of the unit and will be issued to them upon reporting for duty at the hospital.

The Surgeon General has had a consultant from the Operations Branch attend all conferences on the nurses' uniform items. We have a display of these over at The Quartermaster General's Office, and we have pictures of all of them posted in our office if anyone cares to see them. We have been assured repeatedly that these items will be abailable 1 July. We have given the quartermaster the number of nurses, who are now on foreign duty at the various theaters, and we are told that shipments are being made at this time of the items of new equipment for issue so that nurses overseas will have their equipment by 1 July. The uniform situation has been deplorable.

COL. WALSON: Are the nurses permitted to wear slacks?

COL. BLANCHFIELD: Yes, they are; in AR 600-40, Change 15, par. 13c(9), 24 April 1943, slacks may be worn in lieu of skirts under such

conditions as the immediate commanding officer of the nurses may deem appropriate. Now, we consider that slcks should be worn by nurses on trains, on duty in airplanes, hospital ships, and transport duty. Since they have to take care of patients, who are placed one tier above another, certainly skirts afford very little protection to the nurses in these situations. Another thing in going abroad, we understand that nurses are not permitted to undress from the time they board the boat until they debark. Certainly, they will be much more presentable having slept in slacks than if they had slept in skirts. Another feature we considered in slacks in that connection was that they have boat drills and have to climb up and down rope ladders. Certainly they are better protected in slacks than they possibly could be in a skirt.

GENERAL LULL: All right, the next question has already been answered. I'll read the question and answer. What change, if any, is contemplated in the present policy of procuring nurses? We went into that in the Personnel Division. The answer is a better coordinated plan for publicizing military needs, and a thorough follow up in order to insure that the greatest number of appointments will be secured from the total number of applications filed, to be promulgated by Service Command, American Red Cross, Office Procurement Service, and Chief of Army Air Forces.

The next question: The utilization of volunteer nurses' aides in some of our Army hospitals will not be possible under the provisions of SPMCN 081-1, 16 January 1943, which states that "The volunteer nurses' aides received no compensation." The vast majority of available aides live in metropolitan areas and travel to and from certain isolated hospitals. It is impracticable because of the distance involved and inadequate transportation facilities. The services of voluntary nurses' aides coule be made available for some isolated hospitals providing meals and quarters at government expense were authorized when unusual conditions of service warrant such action. The question: No changes in the present policy with respect to the utilization of voluntary nurses' aides have been contemplated. However, if it is considered desirable, consideration will be given by this office to a request for appropriation of necessary funds to cover the cost of transportation and meals furnished nurses' aides. It is questioned whether under existing restrictions if further construction of quarters would be authorized in order to make them available for this class of personnel at general hospitals. With the contemplated reduction of Army nurses assigned to station hospitals as a result of the proposed changes in table of allotment, it may be possible to furnish quarters to a limited number of aides, but when it comes to providing meals, the question of appropriate funds has to be considered.

COL. REILY: It seems to me that we might receive a realative number of aides in isolated hospitals if maintenance were provided. Take for instance the hospital at Camp Edwards which is pretty well isolated down the cape. There are very few nurses' aides down in that section. They all have to come from Providence, New Bedford, or some of those nearby places. Of course, they could not make that trip back and forth daily and be of much benefit in the hospital. They would spend most of the day going and coming. When you have a hospital fund as you have down there with $77,000, which will revert to the central fund here, it seems we could well afford to give those girls what meals are necessary during the time they are at the hospital; and again we could get a certain number of nurses to go down there and spend a couple of days, alternating the groups. A certain number would be available for full time if we could provide them with quarters and meals. It seems to me I sent a letter in regard to that and was turned down. Before sending that letter, I did everything I could, under the circumstances, to have them locally authorize meals and quarters for those voluntary nurses during the time they were on duty, but I did not get anywhere with it. I do not know of any funds that are available for that except perhaps the cinema fund that can be expended by the commanding officers of posts for any reason that benefits the entire command. Certainly these voluntary nurses' aides will be badly needed eventually when The Surgeon General's Office orders most of the graduates to foreign duty. Certainly these volunteer nurses will be benefitting the entire command by working at the hospitals, but I do not know that we can get the commanding officer to authorize funds for that purpose, nor do I know whether we can permit them to eat at the expense of the hospital fund. The special services at headquarters said that we could do all right with that and that we could spend money for that purpose. We might be able to take care of it without asking for any alottment of funds. I do not know where it would come from. Do you know where any funds would come from?

GEN. LULL: I think what we would have to do is to go back to Military Personnel, S. O. S., and have the letter amended so as to delete the phrase "without expense to the government" and recommend that where such provision can be made that they be provided with meals and shelter.

I should think that it could be amended so as to state that if quarters were available they could be used temporarily and if funds were available they could be provided with subsistence when on duty.

Will you look into that?

Yes, sir.

COL. WALSON: Of how much value is the service of the volunteer nurses' aides, and how have they been received by the members of the Army Nurse Corps?

COL. BLANCHFIELD: The answer is, wherever their services have been utilized, they have been most acceptable. They are used at Walter Reed and reports indicate that they are doing a splendid job. It is believed many would give more time than they do were it not they have to provide their own meals, so they spend approximately four hours a day between meal time.

COL. WALSON: Would not the utilization of nurses' aides impede the campaign for the enrollment of graduate nurses, and is there not danger of civil hospitals criticizing the Army for using the aides that have been trained for civil hospitals? In the event that they are assigned to duty under the provisions of The Surgeon General's letter referred to, it seems to me they should be subjected to finger printing and taking oath of allegiance.

COL. BLANCHFIELD: I happened to be on a Committee for Nurses' Aides and, of course, I am in contact with the Chairman of a National Nurses' Aide Committee, and at the time the Army was requested to assign aides to Army hospitals, it was thought that it would help their recruiting program tremendously if the military hospitals could utilize them. One of the provisions that we made at that time was to the effect that only those nurses who had given 150 hours of service to the hospitals where they were trained would be considered for military assignment. It has been the opinion of those concerned that the aide, who had contributed 150 hours of service to the hospital responsible for her training, had discharged her obligation to that hospital, therefore, it was felt that this provision would forestall any criticism by the civilian hospitals of the Army in the use of the volunteer nurses' aides. This office has also authorized the training of volunteer nurses' aides in military hospitals that meet the requirements. The provisions for training aides requires the hospital making application to contact the Red Cross Chapter through the hospital's field Red Cross worker. The Red Cross Chapter there upon requests National Headquarters to send a supervising nurse to assist with setting up the program and to have general supervision over the program after it is once established. This is to insure that the standard of training is equal to that given all nurses' aides under the auspices of the Red Cross.

COL. WALSON: How about fingerprinting and the oath of office?

COL. BLANCHFIELD: Well, I think we should ask the legal division about that. It seems to me that the nurses' aide who is patriotic enough to

give her time for training and then offer her services on a voluntary basis would not be the type whose loyalty would be doubted. Of course, we can see where there might be a possibility of a nurses' aide taking this method of securing information that would be helpful to the enemy. Having an aide take the oath of office might have a good psychological effect. We would have to be careful to explain that taking the oath of office does not bring them into the army.

COL. WALSON: Do they have to furnish their own uniforms?

COL. BLANCHFIELD: Yes, sir, they furnish everything; their own transportation and meals, and lodging, and you would be surprised to know the type of young women who is taking up this training now. We find that many young women, who are working in restaurants all day, are taking courses at night and serving at night between 7:00 and 9:00 in hospitals. You know that is really a contribution.

COL. WALSON: What about these government office employees, do they take the first-aid course at night?

COL. BLANCHFIELD: Yes, but taking a first-aid course does not qualify a young woman to do volunteer nurses' aide work though the majority of nurses' aides do take the first-aid course.

GENERAL LULL: This next question was one submitted by you. Is it intended that nurses be promoted to the grade of 1st lieutenant who have been on duty less than six months? This question is raised because of two instances: Nurses have been promoted by the War Department without recommendation of the chief nurse and commanding officer, who have been on duty for approximately one month. It has been our policy to recommend only such nurses as have been on active duty for six months or more as well as MAC officers in the grade of 2d lieutenant who have been on duty for six months. The answer is generally "no", but there are situations which apply to the nurses where the length of active service in the corps is disregarded. One example: Our Chief Nurses with affiliated units, our anesthetists, supervisors, etc. When the nurse comes in with a good background and is known to have the ability and training from her civil occupation to be promoted, especially in affiliated units, the nurse is promoted on recommendation of the unit director immediately when she is appointed to the corps. There have been several occasions when we have promoted nurses who were especially appointed as instructors in anesthesia, and several times it has been necessary to promote nurses, who were known to be qualified to head up an evacuation unit being organized for early activation.

Question: Quite frequently nurses are placed in officers' replacement pools. Should such nurses be assigned from this pool by the service command?

Answer: Nurses in an officers' replacement pool should be reassigned by the service commander or the port commander.

Question: Should not nurses returning from overseas be assigned by the service command? Nurses returned from overseas with a cadre are to be sent to Camp Grant, their names reported by the service command to The Surgeon General's Office. Nurses returning from overseas for physical reasons are apt to be determined by a medical board to be fit only for limited duty, and are referred to The Surgeon General's Office for assignment. They have to be handled the same way as officers. We took that up yesterday about putting it on their record that they are "limited duty." Most of these nurses, I presume, are turned over to the service commands when they are ready for duty. Frequently they are assigned to the hospital receiving them from overseas duty.

GENERAL LULL: But they have to be reported in here in order to get their status cleared up, to keep the records clear, especially when they are reclassified.

COL. WALSON: Changes 2, AR 40-100, 27 March 1943, which require pelvic examinations for nurses should be rescinded.

GENERAL LULL: The decision to require pelvic examination as part of the physical examination of nurses was made on the recommendation of medical officers who have to do with formulating regulations governing physical standards of the Army. This decision was based in part on the report of defects found in women after their entry on active duty which could be excluded by pelvic examination. In view of the large number of women entering military service in a wide range of age limits, including married women with defects that may exist among such individuals, routine pelvic examinations were considered the best policy. The regulations provide that this examination be made rectally as indicated, and made in this manner is the accepted practice of civilian gynecologists in the case of young females. It should be without pain, embarassment or discomfort. It would appear impracticable to exclude any group of women based on age, type of duty, or any other similar considerations since many of the gynecological conditions cannot be excluded on such a basis. This is the opinion of the Medical Practice Division. I think we mentioned that yesterday too. Section 13b, AR 40-20, 1943, has been construed to refer to nurses in their present status. This construction should be changed. Nurses are entitled to sick leave the same as any other officer. The act in question refers to nurses' status which no longer exists.

GENERAL LULL: The answer: The status of nurses has not changed. The rank of nurses is relative to commissioned rank. The law governing leave rights of nurses was not affected by the new pay bill. That was also mentioned yesterday, the basic act about terminal leave for nurses. Several things came up that the basic act has not been changed by any law. But we are still governed by the basic act which established the A. N. C. The proper signature for a nurse should be the rank, A. N. C., below the actual position she is filling. For instance, Jane Doe, Lieut. Colonel, A. N. C., Principal Chief Nurse. The signature of the nurse. In answer to this question reference is made to AR 340-15 military correspondence which applies to all officers. The signature ordinarily consists of first name, middle initial, and last name. The grade, organization, and Arm of Service will follow immediately. The typed or stamped name, May A. Jones, Captain, Army Nurse Corps, Assistant Superintendent. I think that that was in agreement with what you have submitted. That was approved by Headquarters, Military Personnel, ASF. They would sign just as officers.

Question: A great number of graduate registered nurses, otherwise eligible for assignment in the Army Nurse Corps, are being rejected due to the fact that the schools from which they graduated failed to provide them with the necessary pediatric training required by the Red Cross nurses. Many of these nurses may be qualified and excellent nurses with the best recommendations and eager to be assigned to Army Nurse Corps, but due to Red Cross regulations, they are not accepted. Cannot this be corrected?

Answer: The Red Cross does not determine the admission requirements but in evaluating credentials they do try to uphold the standard set by the Army Nurse Corps. The Army Nurse Corps has considered pediatrics an important service because many nurses do not receive experience in communicable disease nursing. This is a service found practically in every Army installation. Even if nurses have not had experience in communicable disease service, if they have had good pediatric experience they will be well prepared in the techniques of isolation. If deficient in pediatrics, nurses have been required to take postgraduate work to qualify for appointment. The Red Cross has been recently asked to consider more carefully all postgraduate experience before requiring postgraduate work in order that more of these nurses otherwise disqualified may be accepted. Now I think that we should emphasize that we set the entrance requirements, not the Red Cross, and if they differ from the Red Cross, the Red Cross is obliged to be governed by our standards. Is that right?

Yes, sir.

If you remember, General Lull, about two weeks ago we went into this study very thoroughly, and we thought we should not lower our standards, but that greater use should be made of waiver. That any nurse who, even though she graduated from a small school, if subsequently she had had experience in large general hospitals such as Cooke County, Illinois, or any of the Pennsylvania or New York Hospitals, especially where that experience could be spread over a number of services, that she acquired training and experience that would qualify her for the Army. So instead of lowering our standards, we are going to make a greater use of the waiver in evaluating individual papers. We also no longer require that nurses, who are qualified in special branches of nursing such as anesthesia and operating room supervision and public health work take refresher courses in general nursing. We feel that many of them will have an opportunity to serve in special assignments; others can get the refresher experience in the Army.

COL. JONES: You are speaking of waivers there, that is more on the education and so on. Now about waivers on physical? The regulation is pretty specific on height, that is the minimum height. Should they be taken if they are under that height, if they are otherwise physically qualified? The reason we ask that is on account of uniform. We can't do it with enlisted men on account of uniform.

We have gone down to size 10 on our uniform. We waived the height regulation for quite a number of nurses, otherwise physically acceptable for affiliated units and if we can do it for the affiliates, I see no reason why we shouldn't do it for the regulars. Your regulations are very specific. This is the minimum height that will be accepted on it, whatever it is, I don't know what it is.

What is this 58?

No.

It was 62 then we set it at 60.

60 - that is what it is now.

But we have waived 59 and I think in one case we waived 58. That came in as a recommendation, and the recommendation was approved. That is the waiver was granted.

We can waive that out in the service command.

I should think so. What do you think, General Lull?

I should think so. I should think that if otherwise qualified

that it would be all right. With enlisted men I know it is a question of uniform and with officers we can now waive the requirements down to 60 inches. We waived that. I know of one case of a very well-qualified man who was a graduate of Harvard, I believe, well-trained, and he was of the proper height for induction, but not the proper height to be commissioned, so he came down here and said, "What would you do if I asked for induction and came in as a private?" About that time we persuaded the Professional Service Division that we ought to waive his height. The uniform doesn't matter with him. He buys his own uniforms.

It is a question of uniforms that is bothering here.

We have plenty of the smaller sizes for nurses.

In the Sixth Service Command we have rejected, during the past month or two, some 40 nurses because of dental disqualifying defects. I arbitrarily ruled out there that the lack of teeth would in the future keep no nurse out. That we had ample provisions for replacement and we needed them so badly that we would take them in and furnish them the necessary replacement. Is that all right?

GENERAL LULL: I would say it is all right. I will approve anything as far as I am concerned in order to get the nurses.

We have done that for enlisted men. I see no reason why we shouldn't.

That is something that is not going to have very much bearing on compensation after the war, the replacement of teeth.

Will a special effort be made to impress on the Red Cross people that these things can be allowed so that they won't turn down quite so many as they have been turning down?

We have had a conference with the Red Cross right in this office, sir, and have their cooperation, I think.

Question: We have a great many applications from nurses, otherwise eligible for assignment to the Army Nurse Corps, who are between 45 and 50 years of age. If these nurses could be accepted, placed in a special group, but at the same time considered War Reserve Nurses and classified as Limited Service, there would be a noticeable increase in assignments. Is this practical?

Answer: The question of extending the age limit beyond 45 has been carefully considered and deemed unwise. Even though on limited service in this country, there are many over 45 who would

not adjust readily to Army nursing and living conditions. It is believed that this group, although eager for Army Service, can best serve in civilian nursing.

GENERAL LULL: We have gone into that here on a number of occasions and it is the concensus of opinion around here that anyone over 45 is a handicap when they are brought in. While in civil life, they can still carry on and do a good job in civil life and replace nurses eligible for Army Service. I think that was our opinion here, am I not right?

That is our opinion. We find that they can raise more trouble and keep the whole group stirred up because this isn't right and that isn't right.

COL. JONES: We have used some of them for the depots; that is, civilians. Yes, that is all right, but we ran into a snag on that on this Manpower Commission, not allowing persons to be transferred from one job to another. Have you hit that?

Well, there is a lot of the Manpower business, in Chicago too, because we are already running into a snag on that. All the civilian hospitals got the idea that their nurses were frozen in their positions and would not be released for military service, but that was never intended. The nurses must be released for military service regardless of whether they are in an essential position or not.

Whether they are for civilian use in the depots?

Well, I should think that would just about parallel being in Army hospitals.

In Cleveland, we had two or three nurses that were willing to go to one of the depots, but the Manpower Commission up there wouldn't let them out.

We just don't know how they are going to settle that in Chicago, but certainly for the military service nobody is frozen to their jobs if they want to go into military service.

Question: We have many nurses, who after giving the date of their availability for assignment to the Army Nurse Corps, and receiving notice of their assignment to active duty, fail to comply with orders because of personal reasons. Because of the fact that the American Red Cross, the official recruiting agency, is not in a position to force these nurses to comply, we lose many qualified nurses. Why cannot this be returned to military control?

Answer: This situation has recently come to our attention and is

being corrected. If a nurse fails to reply to the contact letters within three weeks, the Army nurse assigned to Officer Procurement Service and the Red Cross Secretary of the territory in which the nurse resides, will be informed. They will in turn do the follow-up and report back to the service command.

Of course, you all know the answers. You can't force anybody into the service.

It is just like our medical officers, you know when the Procurement and Assignment put the finger on them. they say that sure they will sign up, so they go down and get a set of blank forms, and then they never send them in and then someone follows them up and makes them send them in and then they won't report for a physical. Then, after fooling around for nine months, they write to their congressman and say that they have been trying to get into the Army for nine months and nothing has happened. We trace it down and that is what usually happens. Are there any other questions that you wish to ask, Colonel Blanchfield?

COL. MOORE: We have tried to get a whole detachment of colored nurses at Camp Irwin.

COL. BLANCHFIELD: Sir?

COL. MOORE: Camp Irwin -- and we have always run up against a stone wall, for reasons we can't understand and we need them urgently and we would like to know why.

COL. BLANCHFIELD: That is something that hasn't been brought to our attention. We have more colored nurses right now than we can assign. The reason so far as we have known there were only a limited number of stations where they might be assigned. Bragg, Livingston, Huachuca, the Air Corps School down at Tuskegee, and we have some now at Fort Clark, Texas. We have five stations. Whose jurisdiction are you under?

COL. MOORE: Ninth Service Command.

COL. BLANCHFIELD: Ninth Service Command is what those nurses are in and other stations.

COL. MOORE: We have telephoned your office on a number of occasions trying to get colored nurses. We could use an entire colored detachment of nurses.

COL. BLANCHFIELD: That is good news to us, because we will be glad to know of other places where we can utilize them. There is pressure being brought on this office all the time demanding that more

colored nurses be appointed.

COL. MOORE: There are a certain number of colored troops, but we have had to use white.

COL. BLANCHFIELD: Well, that's something else again. The Planning and Training Division will have to pass on a question of that kind.

GENERAL LULL: I think, Colonel Moore, if you put it up in a letter, a letter to this office, what you propose to do, and we will get the Planning Division to pass on it. I think we can probably help out, because I know that we can supply you with colored nurses if their assignment is approved by the Planning Division.

COL. WALSON: It is a difficult thing to turn down a lot of applications in the Second Service Command.

GENERAL LULL: Yes, I know it is difficult. It's the same way with colored doctors; it's difficult. We have, at last, struck upon a happy note in the procurement of medical officers. I went to Chicago with a representative of the procurement assignment service and a representative of the colored medical profession, and we met out there and we talked. We only have colored applicants, and we don't know which ones to take because we have so many applications, and a good many of these men are in rural communities where they are needed. If you will appoint a committee to pass on whether or not we shall take them, we will send all applications for those positions to you, and I sent all mine up here to Howard University and he turns down 75 percent of them, says they're needed at home, that leaves only 25 percent of them, and it works fine. He knows the situation all over the United States.

I think the thing might be managed the same way with respect to the Corps of Nurses because only recently we've gotten some very definate figures. There are only 7,000 colored students in the schools throughout the United States, and they are continually calling for nurses for public health in communities where they have a large colored population, and they don't have enough nurses to supply these demands.

They're very reasonable. The colored medical profession is very reasonable about this, and we realize that our proportion of doctors to our racial population is very, very limited, and we really need them in civil life. And even if they're anxious to get in, we're willing to evaluate what they're doing in civil life.

I think that the thing is worth trying.

All right, thank you very much.

COL. BLANCHFIELD: Thank you, I would like to leave a draft of this letter that was sent recently by Mr. Davis, Chairman of the Red Cross. I would suggest that that be put in the records at this point.

Quoted from letter, Mr. Davis, to ARC Chapter Chairman:

"The Red Cross in January of this year was asked to assume the responsibility for the recruitment in your territory of nurses for the Army and Navy. It is one of the most important responsibilities that Red Cross chapters have undertaken.

"The results for the first three months were very gratifying. This was especially commendable because at the same time the chapters were obliged to put every effort into the war fund campaign.

"But since March there has been an alarming slump in nurse recruitment, and this is causing the Army, the Navy, and the Red Cross grave concern. The Army especially is having great difficulty not only in filling requisitions for nurses for overseas assignments, but for the Army hospitals in this country as well. In fact, we are now about 2,000 nurses short of meeting the actual present required strength of the Army Nurse Corps.

"It is understood that perhaps the greatest obstacle in this campaign is the reluctance of local communities to release their nurses. This is only natural, but I believe that an effective presentation of the situation to such communities will bring a patriotic response. Your volunteer nurses' aides and your courses in home nursing should help materially in making it possible for more nurses to enroll in the service of their country.

"Won't you therefore, give this your personal attention and meet with your nurse recruitment committee and your committee on nurses' aides and home nursing to the end that all chapter facilities which can contribute to the success of this supreme effort may be utilized? In the recruitment campaign we are engaged in making possible the rendering of aid to the sick and wounded of our armed forces. There is no service which is closer to the purpose and spirit of the whole Red Cross idea. The Army and the Navy are counting on us, and we must not fail them."

GEN. ROBINSON: I should like briefly to tell you what our over-all organizational policy is and what we are trying to do and then let you all give me questions or raise points where what you have to do doesn't fit in with that - get some idea how we can work something out. As you have probably noticed in the year and a half since the ASF was formed, we've been pursuing a policy of decentralization. We've been trying to get as much work and authority and responsibility out of Washington as possible. We have also been following the policy of building up the old corps areas. When the ASF took over the corps areas had dwindled down to practically nothing. They were in the position, as somebody remarked, of being a loose confederation of states with no authority but some responsibility. We have tried to change that, and we are trying to make the service command one of the major organizational units in the ASF over-all organization. I presume that if we had a year to prepare for this war we would take every activity that the ASF were responsible for, divide the United States up on some kind of regional basis, put all those activities under a commander of that region - and have six, seven, eight, nine little ASF's out in the field - with only a very small headquarters staff here in Washington. That's the ideal. We would take everything - procurement, construction, the works - and do that to it.

That would be the ideal type of organization. Now we don't think we can get there necessarily in this war. Some activities like procurement - I don't think we could ever turn over to a service commander in this war without upsetting the apple cart, but we are trying to take everything else that we can and turn it over to the service commander to operate as a little ASF. Now what that does when you do that is leave the services here in Washington primarily as staff officers to the Commanding General of the ASF. Actually they are in a dual position at the present time. The Surgeon General is in a dual position. He is a staff officer to General Somervell on medical stuff - pure medical stuff. On the other hand he is also an operator.

When you get into the field of procurement, storage, and distribution of medical supplies, he is an operator, as well as being a staff officer, so that as I say, he's got a dual job there. If we went the whole way, he wouldn't have. If we turned around and put everything on a regional basis, he would be purely a staff officer. Now, likewise, when you get down in the service command, we are trying to do the same thing. We are trying to take any geographic location and say, here is General X, and he commands everything at that location

- everything there is there - so that the people in the headquarters are pure staff officers. There are some slight exceptions to that. I never saw an organization in my life in which you had a pure staff, they always had some operating duties, and I don't think that matters. So that in general is what we're trying to do. We are trying to take activities - all we can - put them under the service commands for little ASF's - and try to get things out of Washington. There has been some confusion in the minds of some of the services here in Washington, I am sure, about this role they have. They have felt when we have taken things over, there was no longer any responsibility or any control. Well, that is not what we intend. It won't work that way. For example: We have a staff in the headquarters ASF, but you notice we have no staff in the headquarters ASF for several functions. One of them being transportation. Why is that? There is no use duplicating our chief of transportation, who is a staff officer for the whole works for transportation. Likewise when you come to construction. We have no staff in General Somervell's immediate headquarters for construction, that's the Chief of Engineers. He is our staff officer. When you come to health you have the same situation, The Surgeon General is our staff officer for that. Now as a staff officer we give him full authority to issue orders to the service commander. General Kirk, within his sphere of activities, can issue orders to any service command. Of course, whether he actually signs it by command of General Somervell doesn't bother us at all. We don't care whether he does or doesn't. It's implied: that's the way it works like any staff organization works. Whether it's actually there or not, we don't care. But he has full authority to issue orders. Now a lot of people aren't using that. Probably they don't feel so though they have the authority. Likewise, I know General Somervell expects people like the Chief of Transportation, The Surgeon General, the Chief of Engineers, just as he would expect a G-1, or G-4, or a G-3 in a tactical organization, to be fully familiar with what goes on in his subordinate units and to take any necessary action to correct unsatisfactory conditions without running to him about it. Now certain services started off when we made this change a year ago on the service commands that way. There are several of them that haven't. I don't know why. It's just some kind of a misunderstanding on it. Now there isn't anything new in our ideas. I think everybody in the Army has been brought up to understand the staff type of organization we're trying to use. Now when it comes down to the details of organization in the service command headquarters - there may be some trouble there just as there is trouble right up here in our own headquarters. The difficulty we get into arrives from several causes. One of them is the fact that we got so many activities in the air set-up, and of course everybody that is engaged in any

particular one has the idea that his is extremely important and if he didn't have that idea why he is not the fellow for the job. He wants to be right next to the boss. Well, if we do that we get right back in a situation where the War Department used to be, where General Marshall has 48 people right in Washington trying to report to him and of course nobody can run 48 people. Particularly in time of war, with a big complex affair such as we have. First of all we get into the problem of how many people can the boss handle? And we have to do some grouping to keep the numbers down. At the present time General Somervell has two men. He's got 6 on our so-called staff Division. He's got seven services. That makes 13 plus 10 service commands - makes 23 plus 2 or 3 odds and ends and adds up to almost 30 and those are more people than he can handle. So we're trying all the time to cut them down.

When you get in the service command headquarters you have the same problem. Exactly the same problem. Now whether we've got them arranged right is open to question. Whether we've got them grouped properly or whether we've got them grouped in accordance with their importance out there -- that is a question. I would like a little later to hear any comments you all have to make on that thing. Another problem is that we have several types of things clashing against each other all the time. There are various ways you can set up an organization, and you must have some logical way to do it if you are going to make it clean cut so everybody understands their job and so that you don't have too many groups of people to deal with. One way of doing it is the one we are trying to pursue with respect to the service commands. You can divide your organization up geographically. That's one way. Or you can divide it up functionally like supply, procurement, maintenance, surgery, or something like it, and we have that type of division in our organization. Or you can divide it up by the type of personnel that you are dealing with, doctors, lawyers. The Judge Adjutant General Department is a perfect example of where you divide by Professional Speciality. Or you can divide it up by over-all purposes and that's the type of division that we have in our technical services. By that I mean things like dividing facilities for the Army, like the Chief of Engineers, looking after the health of the Army, and that's The Surgeon General. So we have those things all clashing against each other all the time. There isn't any one way of dividing the thing up, and if you divide it up three or four ways, which we have done, you have them pushing against each other all the time. What we would like to do is to go to the ideal in this and divide it up one way. That is, have a functional staff in Washington and divide all our operations up on a geographic basis, and that's what we are headed for, using the service commands to do that. That's the reason that things at the General

Hospital were placed under the service command. That's the reason that training activities have been recently placed under the service command. That's the reason that we've taken some major operations out of the Chief of Ordnance and placed them under the service command. Every one of those moves is a move to try to simplify the thing by simply having a functional staff in Washington plus a geographic division of all our activities, with a little commanding general of an ASF in each region. That's the theory of the thing and what we're trying to do. That I know isn't the same thing as practice and the same thing as what happens out in the field, and I'd like to hear what you all have to say and what some of your problems are along the organizational line, and some of you probably have a solution, and some of you have questions. Let's don't hesitate. Let's just take your hair down and let's hear what it's all about. How you would like to change. How it works and doesn't work. Anyone.

Comment: It is recommended that the Medical Division be put on the same level with the other divisions in the service command.

GEN. ROBINSON: Well, do you think that you should go back to the systems where you would control all civilian personnel engaged in medical activities in the service command, or just medical officers? How about nurses?

Comment: All but the civilians.

Comment: General, I think that, if the service command surgeon could hold the same relative position that General Kirk holds. (Well, he doesn't. That's true. Why not?) We are now on the second echelon, that's true. If we were in the first echelon in a Division we would not have to function under the Supply Service and as it is now -- as it passes through them they usually take our recommendations, but it's just one more step.

GEN. ROBINSON: Now we have as I remember it eight people on the staff reporting to the service command. Which one would you take out in order to put yourselves on? Well we don't want nine. Because that is too many. Well, I'm just saying not just from a selfish standpoint but which one do you think, which one out there now, relatively in importance of activity isn't as great as yours? Yes, I know that's a bad way to put it. There is one more addition to those directly under the commanding general. Well there are nine, eight now as I remember. One more. With regard to personnel they have the same problem as we have. I want to cut it down to six.

Comment: They have to know the particular qualifications and characteristics in their own personnel, which means that each branch chief has got to keep and operate some kind of personnel

records. We've got to know whether a doctor is an ophthalmologist, a surgeon, or what have you. In addition to that, what his training has been. We have got to keep personnel records.

GEN. ROBINSON: Does that necessarily mean you have to keep your records yourself?

Comment: In practice, yes.

GEN. ROBINSON: Why?

Comment: Because the Personnel Division is not interested in those things. They want to know whether a doctor is a captain or a lieutenant and how old he is.

GEN. ROBINSON: Well, doesn't his 201 file show what he is, everything you want to know?

Comment: No, it does not.

GEN. ROBINSON: Well, suppose we made it show what you want to know. Would there be any reason why you couldn't keep all the personnel records in headquarters at one place?

Comment: As a matter of working convenience, it is less convenient if we have to go there. In our particular service command, it is on another floor, three floors away, every time I want that information. We are consulting our records every day, several times a day, studying officers' qualifications for assignments, and it's a thing that if we don't study continuously, we're out of luck. Now we have to do that through another person all the time. Our Personnel Section allows that. We have a working arrangement with them.

GEN. ROBINSON: I should think any Personnel Section would furnish records to anybody who wants any file.

Comment: We have our own records. We keep our own books on these people. We have to do it. Now they have the main file, yes, and we work through them. But we have a system of our own to keep track of these people, their qualifications and what they are doing, and how they're doing it. It's the only way we can keep track of them, professionally, I mean, and how they work and so on. The total numbers by stations. This information, is not in the 201 file. Somebody is getting very much upset because he is getting the short end of the deal from the number of sick he has. We have in our files, how many doctors, how many nurses, how many MAC's, how many Sanitary Corps are at that station. You never can get that in 201 files.

GEN. ROBINSON: Well, don't you have in your service command headquarters, a

monthly personnel report that shows everything? The type that we have for the Army Service Forces as a whole, I don't know whether you've ever seen it, but we have a monthly report.

Comment: It is just what you are talking about. It is furnished by our office. We may have 25 percent turnover in a month. We have to know each day.

GEN. ROBINSON: Well, wait a minute. There's no system that's going to tell you each day exactly how many medical officers, nurses, etc., there are in every post, camp, and station in the service command. You just set up a system and it breaks down by its own weight. How do you know? You can't know, unless you get reports back every day.

Comment: We know when every order is issued.

GEN. ROBINSON: Well, that doesn't mean the man is actually there.

Comment: He is working that day and we know the time of departure.

GEN. ROBINSON: Well, I think frankly, the way I see this personnel business is this: Here's the way we visualize it. You have one central personnel outfit in each service command headquarters. They do all the routine clerical paper work, and everything else. Now, maybe what they're doing isn't what you need, and that's the fault. About some organizational change. Now, every service commander, just as we do here in the headquarters in Washington, every staff officer there that's dealing in a specialty in personnel, like engineers, or doctors, or maintenance people, or what-not, should and can make recommendations on specific individuals and on the distribution of numbers, and on the distribution of specialties.

Comment: Well, that depends on your relationship with the commanding general.

GEN. ROBINSON: Not the commanding general, but the personnel officers.

Comment: Oh, no, I'd say with the commanding general.

GEN. ROBINSON: This Manual says that the branch recommends policies regarding assignment for transmittal to the board.

Comment: But there is a tendency in this new organization, for the Director of Divisions to usurp power and operate services; that's different from the old general staff. He now has both operations and advisory staff functions. Human nature is such that if a man is given power he uses it sooner or later.

Because of the friendly relations of the staff the present

organization works. But sooner or later, it won't work because the personal relations will become unsatisfactory. I believe the organization should be set up to work under all circumstances. The Medical Branch does not have the authority it should have to control medical service. There should be an operation section in the Medical Department organization setup; 40 percent of the personnel in the service command is medical personnel. Any officer assigned to a position must have the qualifications to do the job. He may have the professional qualifications, but still he won't fit into a particular unit.

GEN. ROBINSON: Now let me ask you a question. How many general hospitals are there in your service command?

COL. JONES: Five.

GEN. ROBINSON: Which service command?

COL. JONES: It is the 5th.

GEN. ROBINSON: Now are you attempting to assign individual jobs in each one of those hospitals? It would seem to me that the commander of that hospital ought to be doing the assigning, not you.

COL. JONES: He is, actually, just that I am called on to furnish a man who has the proper professional qualifications.

GEN. ROBINSON: Well, what I mean is that what we are trying to do with all this personnel business is -- well you all know the old peacetime way of doing it here in Washington; the fact that every officer was picked for every little job right from Washington. Well, we have been continuing to try to do that in our own Military Personnel Division here in Washington. Handling the thing on a retail basis, ten enlisted men here and five officers there. Sam Jones at the other place. It has just completely fallen down and we have recently changed as you probably all have heard something about this bulk allotment -- so that we are going to control personnel in Washington on a wholesale basis to the service commander and just tell him that he can have so many people.

All right, what I am getting at is, and it is one of the things that we have noticed all of the time, we have been pushing things out to the service commanders. The service command headquarters have been doing the same thing, they have just been hanging on, and we think that if we can push from Washington out to the service commander, that the jobs are big enough nowadays and what goes on is so big down there that the service commander in turn ought to push down to his post commanders. Instead of trying to get into the details of a

general hospital, you should be handling the personnel in a general hospital on a bulk basis exactly the way we are trying to handle it in the service commands.

COL. JONES: We are expecting that in the bulk basis there comes a demand for so many officers of this qualification and so many of that. Now we try to give them so many, but we don't attempt to dictate to them who will be chief of the service or who will fill this position or that one. The same way with the station surgeon. The same way with the station hospitals. Practically all of our station hospitals, 4 of our station hospitals are going to be used as general hospitals, we suppose.

GEN. ROBINSON: I just wanted to be sure of that. We have got to handle them in bulk, you can't do it any other way, to make a success of it. You can do that, but you have to exercise a little more control. You may find that some station wants an ophthalmologist. Later on you find that they are not using that man; they have him down in some dispensary. When the monthly report comes in you have a chance to write that station surgeon and say you are not using that man, do you need him there as an ophthalmologist? I am merely using that as an illustration.

COL. FRENCH: We were told when the S.O.S. first started, that it was a simplification of methods with possibly a saving in man and woman power. Now S.O.S. gives the Medical Department functions of hospitalization, sanitation, and evacuation. Now I don't feel with the tremendous number of installations, we have 120 installations in the 4th Service Command, that they can properly function unless the proper officers are put in the proper places. I went to General Bryden and told him that if they took all the control of my personnel, particularly officer, nurses, dentists, and veterinarians, that I could not be held responsible. The medical profession is so specialized that you can't order medical officers around by captains, lieutenants, and majors, the way you can the Infantry and Field Artillery, because the majors will have all different sorts of qualifications and specialties, so that General Bryden assured me that there would be no changes made in the personnel without the approval of my office. Well, now they have done this, they took all of my records out of my office and moved them two blocks down the street and put them under an officer, I think he said he was Cavalry, who said he didn't know anything about medical personnel and didn't want to handle it, but he just had to because he was told to. All right, we get a request for so many doctors to go somewhere. Now that request has to come to me from two blocks down the street. As soon as I get the request, I send the messenger back to where this thing came from and get for

instance that they want roentgenologist. Get my roentgenologist file and see the proper man for the proper job, and as far as saving time, it wastes about a day and a half in time. They took all my personnel over there, they still have exactly the same number of personnel that I had in my office and it just slowed things up and one of these days (General Bryden is going to retire this fall) I am going to get someone in there who will just say, "No." These infantrymen will run your personnel. Now it just can't be done. Physicians are highly specialized. You must have not only round pegs in round holes, but you must have a peg that will just exactly fit that hole or the job is not going to be done right.

GEN. ROBINSON: Now what you're talking about is the officers.

COL. FRENCH: I am talking about everything except the enlisted man. All of the officers, including the nurses.

GEN. ROBINSON: How are you going to fit in with this? Let me ask you this? We have imposed on the Army Service Forces a limitation on the number of people that we can employ. Now I am not just talking about officers, enlisted men, or nurses, or civilians. I am talking about the whole works, all of them, lock stock and barrel. We are turning around and we are going to tell certain service commands that they can only employ a certain number of people. Now the service commander in turn has got to turn around and tell every post commander in the station that they can employ only a certain number of people. If you have the ordnance, engineers, surgeon and everybody else in the service command headquarters independently trying to handle a certain class of specialized personnel, you are not going to be able to control personnel.

Comment: Why not?

GEN. ROBINSON: We'll not wait, we turn around and tell the service commander that he can have so many people, so many human beings. The service commander turns around and tells Fort Bragg that he can have so many people. We're not trying to determine how many of those people will be employed on medical activities, how many of them will be employed on ordnance activities, how many employed on these activities. Likewise, I don't think the service commander can tell the commander at Fort Bragg his number to be employed on ordnance activities, how many on medical activities, and how many of them on this, and how many on that.

Comment: Wait a minute. Then I should be able to tell the service commander.

GEN. ROBINSON: No, because you haven't any record with the service commander.

Comment: The service commander, through me, through a medical officer knows exactly all the medical activities you have in Fort Bragg.

GEN. ROBINSON: What we want to do is to turn around and give the post commander a hunk of people. Then let him determine what his needs are. Well, I mean there is a certain number and they could write it up.

Comment: We think the thing is big enough so you carry it down one more layer. At the present time in the 4th Service Command, 50 percent of the officers are medical officers, and we have about 30 percent of the enlisted men. Now they know the percentage of engineers, the percentage of ordnance, the percentage of quartermasters, finance and all the rest of it.

GEN. ROBINSON: I was talking about more than officers. I was talking about the whole works.

Comment: Well we know the number training under our control. That should not be a difficult job to figure out by percentage because we are all working right now doing our job.

GEN. ROBINSON: Well, we have put a limitation in the number, in these bulk allotments; we have told each service command that he's got a self-limitation. He can't have more than so many doctors. The reason for that is that there is such a scarcity of doctors we have to do it. Now if we had plenty of doctors we wouldn't do it.

Likewise, I should say that the service commander should tell when he gets his bulk allotment. He should also put a self-limitation in there on certain classes of officers, but as for civilians, enlisted men, and nurses, and that sort of thing (well nurses, that is short), but as for enlisted men and civilians, and WAACs, and so on, he should just give so many to the post commander and put no self-limitation on it at all.

Comment: The WAACs, General, are being used as substitutes for technicians or whatever we want to use them for.

GEN. ROBINSON: Well, can't your post commander do a little of that?

Comment: He is not qualified to do it.

GEN. ROBINSON: Well, all right, your service commander isn't qualified to do it either, but the post commander has a surgeon on his staff as well as a service commander has, hasn't he?

Comment: His surgeon is going to be a little bit more experienced.

GEN. ROBINSON: The same old thing that I mentioned a moment ago that the service commands are hanging on to and are not going on to this decentralization the way we are trying to get them to go. In other words, here you are a staff officer on the commanding general's staff, trying to run in detail all the medical activities of the service command.

Comment: Yes.

GEN. ROBINSON: What we ought to be doing, after all, some of these posts like Fort Bragg, they are as big as a whole corps area used to be - what we ought to be doing is treating a post commander the way a corps area commander used to be treated. Then you are his surgeon, do a lot of the detail things that a service commander or corps area surgeon used to do in peace.

Question: General, may I ask you a question?

GEN. ROBINSON: Yes.

Question: Do you think that a colonel of Infantry is as well qualified to place medical specialists as a corps surgeon?

GEN. ROBINSON: No.

Question: Well, don't you think that what we should strive for is the very best medical service possible with what we have?

GEN. ROBINSON Yes.

Comment: Well, all right, then if it can't be done in any other way except by letting a real specialist place specialists, I don't think there is any more argument about that end of it.

GEN. ROBINSON: Well, I think there is more. In this sense that, let me turn the tables on you, do you think that a doctor is a good personnel manager?

Question: A good what?

GEN. ROBINSON: Good personnel manager?

Comment: Well, I don't know why a doctor wouldn't be able to handle it as well as an Infantry man.

GEN. ROBINSON: No, I'm thinking particularly of civilian personnel.

Comment: Oh, I wasn't talking about civilian personnel.

GEN. ROBINSON: There's not a terrific lot of difference.

Comment: Oh yes, a man in uniform and a man not. Take your clerks, they're not highly specialized. We have a lot over in our place that aren't.

GEN. ROBINSON: We have to deal with all kinds nowadays.

We have a Reserve officer who is post commander, and we have Reserve officers who are post surgeons, who haven't had very much background or experience. Well, we could come along and say, "All right, the jobs you've got are too big." We'd have our service commands to handle. We don't do that.

COL. HILLDRUP: One of the biggest objections to this personnel handling is that it is time-consuming and personnel-consuming. Now in my particular instance, I've got four people in the personnel division's office running a job that I could run in my office with two. Furthermore, when I want any information, I've got to go up three floors to get it or send somebody to bring it down or have somebody bring it down, and that's my main objection to it. As far as cooperation, I get 100 percent.

GEN. ROBINSON: How about some other phases besides personnel? How about supply?

Comment: Well, the same thing holds good with us with Plans and Training. We had a beautiful set-up in my office for Plans and Training, and they took it away from me, and I'll tell you how they actually examine medical units now to determine their qualifications for overseas service. They send three inspectors, one is an Ordnance, one is a Medical, and one is Quartermaster, and the medical man doesn't necessarily examine the medical installations, he may get the quartermaster or the ordnance, and the Ordnance man or the Quartermaster will examine the medical.

Well, of course that isn't the way it was managed when it was in my office. I had a man specially qualified to determine whether or not these units were equipped, personnelled, and instructed, drilled, ready to go. I haven't the slightest idea now. Not the slightest. They send an outfit over there, and it gets overseas. The thing falls down. I don't know anything about it, but that is just the way it works, with people trying to do a job that they don't know anything about.

GEN. ROBINSON: Are there medical officers in the training outfit?

Answer: I have one medical officer, the same one that was in my office with me.

GEN. ROBINSON: What does he do? Go and inspect quartermaster?

Answer: Yes, he goes on inspection, and is just as liable to inspect quartermaster or ordnance, or engineers as he is medical.

Question: How can you hold a service command surgeon responsible for something he has no control over?

GEN. ROBINSON: How about supply?

COL. JONES: The problem of supply doesn't amount to so much in the Fifth Service Command. The officer and the personnel were moved over to the Supply Division and, don't ask me about it because I don't know. As a matter of fact we have very little to do with supply anyway. We don't edit requisition. They go direct to the depots so that supply hasn't hurt us at all.

COL. HART: We are going at this matter in the wrong way. We are considering the minor factors without reference to the principal assignment and resposibility of the Medical Department. After all, our principal mission is to treat the sick and to render efficient and adequate medical service to the military personnel. To carry out this task efficiently and economically with the limited personnel available, it must be centralized. It has already been recognized that sanitation, consultant service, industrial hygiene, venereal disease, and nutrition are phases of medical service which are service command functions and are now under the service commander. Likewise, the medical service in all its phases within the service command area should be the responsibility of the service commander.

We must not consider the sick in hospital too numerically. It isn't like counting cartridges in a box. They are human beings and each presents his own problem. Sometimes your hospital will have lots of patients and sometimes you do not have so many, but the thing to remember is that there is a constant change going on, and major fluctuations come without any too much notice. Some central organization must keep track of what is going on in order to anticipate and plan to meet the situation.

I think personally that the medical service is the largest function of the service command at the present time. The chief of the Medical Branch is too far away from the service commander. That is not true in my own case. I am not far from the service commander, but that is a personal rather than an organizational relation. The advise and recommendation of the chief of the Medical Branch is submitted through a nontechnical person and the decision of the service commander follows the same channel. Therefore, he does not get a true picture of the medical condition in his service command. On the other hand, at a meeting of the service commander with his directors, decisions are made without due

regard to the medical factors involved.

The function of the medical service of a service command is vastly different from what it was two and a half years ago. We have had much more detail and eminent connection with the medical service among civilian population, the necessity of this being recognized over two years ago by the assignment of qualified personnel by the U. S. Public Health Service to the service command headquarters as liaison officer.

We have no trouble in handling our personnel because our Personnel Section with its entire personnel was put four floors up in the Personnel Division. The only difference is that the medical officer comes down to see us. I see no advantage to this and a decided disadvantage. We have in our branch a numerical count of our personnel whereas the Personnel Division has the personality and qualification data, for which the Personnel Division has little or no use, as the assignments are made on our recommendation. The administrative procedure, such as the concurrence of our requests for orders so that they may account for the personnel is Personnel Division procedure.

We must look at the medical service within the service command area as a whole, and it must be centralized under one authority. This is necessary in order to make economic use of the limited personnel and in order that the patient may receive more adequate care. We assign medical personnel to a station and should make no effort to control the assignment of the individual in the medical installation. We must maintain at the station a balanced staff, and if we find the commanding officer is not using specially trained personnel for the purpose for which they were assigned, our remedy is to transfer the officer to a place where his specialty can be used.

Now are you going to give him medical personnel to the designed capacity of the hospital or are you going to give him some theoretical number? You cannot give him some theoretical number. You have got to build your personnel as you built your hospital. You have got to base your personnel on the designed capacity of the hospital and the other factors which enter into the medical service of that particular post. There can be no yardstick of measuring medical personnel requirements for Army service station complement functions and activities save that necessary for efficient and adequate medical service. There are no two posts in the Eighth Service Command which present the same factors. The composition of the garrisons differ, and full consideration must be taken to local conditions and variations in their activities. One factor which is common to the medical personnel of the station complement but in varying degrees is that all Medical Corps

officers are not thoroughly trained in their duties, and whereas we have made quite elaborate plans for training tactical units, we have not been so aggressive in the training of medical units of the station complement.

In the Eighth Service Command we realize this and are now carrying on a medical program for training both from a military and professional standpoint in the work which they are performing.

Now there is another thing. Take sanitation. We do not have sufficient Sanitary Corps officers to cover all of our posts. However, it is necessary for us to cover all our posts because we are concerned about water, sewerage, etc. We have sent Sanitary Corps officers to the larger camps and require them to cover smaller camps surrounding the post. You could only do that from a central place. The same way with nutrition officers. I do agree with you that we should decentralize down to the post to the maximum extent, and the service commander is doing that and is decentralizing. However, there are certain phases that you will have to hold in a central place. I think definately the medical service of a service command area should be centralized or controlled by the service commander. I mean that for the Air Corps, etc. We agree to that. General Kirk is fighting the problem on that now. I can't see any difference between a man who has a malignancy of the right arm whether he is in the Air Corps or in the Ground Forces. Our business is and our responsibility is to get that man so he is under the best man to do the best job and to return him in the best possible condition in the least possible time. Why should you make a difference between the Air Corps and the Ground Force man?

GEN. ROBINSON: We agree with you. I would like to ask whether the slim part we have in Air Corps stations with respect to sanitation really means anything.

COL. HART: We have entire charge of the sanitation of every post in the service command. We make sanitary inspections at all posts in the service command area, including Air Force stations.

GEN. ROBINSON: Do you inspect their posts?

COL. JONES: No, we do not. We have responsibility of six Air Corps stations today. I'd like to ask one other thing. We have sent our engineers to request if they would like us to make a survey of their water supply. When we ask them, they do not always say yes.

GEN. ROBINSON: One medical officer could take care of three of those cases.

Comment: We've had instances where -- right across the street were other organizations from the ASF within two hundred yards of each other, -- there are 200-bed station hospitals on air fields that have more medical officers than our average 1200-bed station hospital.

GEN. ROBINSON: Well, that's quite a big problem. It's beyond me and that's something that General Kirk and General Somervell are trying to find out at the present moment. Here's one question I would like to ask all of you. Are there any of you that have had difficulty in having a personal relationship with the commanding general on medical matters? I wouldn't imagine there would be, or with the service commander.

Comment: Not with the service commander; I have had trouble with some of the chief clerks that he's got doing his jobs for him. We have one, the officer in charge of military personnel down here, the answer is always "no" before he is asked the question. He never has yet agreed with me since the 12th of July, when this thing started, and I never expect he will. I just sidetrack him; I go right to the Chief of Staff. If I can't get any satisfaction from him, I go in and see the General. Well, I imagine that is true everywhere. The big fault of the employment in the service commands -- the one big class of employment is in the post utilities of the Engineers.

We average two or three hundred civilian personnel at every station hospital.

GEN. ROBINSON: I don't know whether you know what type of organization we have, or are you thoroughly familiar with the present organization of what we call the headquarters of the Army Service Forces. It consists of six staff divisions, into which have been absorbed all of the so-called administrative services, like the Judge Advocate General, The Adjutant General, and all those people. They are all under six staff directors; then we have seven that we call technical services, of which The Surgeon General is one, and that's our headquarters, here. Now, I take it what you would like to see is the same sort of a thing out there.

The Medical Division is just like the Personnel Division or Supply Division. Let us do our jobs so that they will be done with the greatest of efficiency.

Within that, you would like to have control of every activity that affects medical.

Comment: That's right. They all tie together.

GEN. ROBINSON: Now where are we going to draw the line?

Comment: The Engineers are doing it, right now in the Fourth Service Command.

GEN. ROBINSON: Have they got it all together? Have they got the Engineer's Supply under the Repair and Utility guide?

Answer: Well, I don't know about that.

Comment: No, they haven't got it, but they are handling their own personnel.

GEN. ROBINSON: Where are we going to draw the line? You say all activities. You don't mean that, because there are a lot of activities that affect medical service which have not been under any control by the surgeons.

Comment: What I mean is control of personnel.

GEN. ROBINSON: Are you going to do your own construction? Are you going to do your own repair and maintenance? Are you going to do your purchasing of shades? Where will you draw the line?

Answer: Personnel and Plans and Training:

GEN. ROBINSON: Here's the one thing that bothers me about the personnel situation. There must be some place in the service commands headquarters a central control of personnel, all types of personnel. Now how are we going to work that out in the service commands?

Comment: Personnel Officers.

GEN. ROBINSON: No, that isn't the same situation and that's just the trouble, in my mind. Here General Dalton for General Somervell tells General Kirk how many people he can have.

Question: For what?

GEN. ROBINSON: For only the things that are under the immediate command of General Kirk; not for medical service throughout the Army. You can't divide this personnel up on a functional or activity basis. General Dalton tells the service commander that you can have so many people for all the activities in your service command. All right, let's take that down to the service commander. The service commander or somebody for the service commander must tell each post commander how many people he can have for all activities at that post. The service commander can't turn around and tell the surgeon that you have so many people for a medical activity throughout the service command; the Engineers, you have so many for this; and the Ordnance, you have so many for that; somebody else has so many for that. You can't do anything about running a

control system if you do it.

Comment: You know, running under that system, we do not know right this minute how many people we've got in the Army Service Forces, trying to run under that system. We don't know. That's the fault of that system.

GEN. ROBINSON: As far as medical is concerned when you start to think about all of them now, the work; civilians and all; we have no control over civilians. What we want to know is how many people there are on a station. We don't want to know how many people there are engaged in medical activities, in the Second Service Command. We don't want to know that. The service commander has got to know how many people are assigned to his command because that is the guy you are holding responsible. Not you. You are only staff officers. We have the same problem. Like within our own immediate staff, the ASF. Here's a general responsible for procurement throughout the Army, at least the Army Service Forces. And he brings up the same thing. I have to control all personnel of procurement and production people. He's got probably more specialists than you've got. But the way we are trying to do that is this, and it is working. We have one central place for all personnel records pertaining to all personnel actions in our headquarters. Nobody else keeps any records except the 3 X 5 cards. Know the man's name etc. The general wants to lose somebody or get somebody from the job or something of that kind. All he does is send this central clearing house a message to do so or call him on the phone, but they do all the bookkeeping, record keeping, paper work, and everything else.

A fellow by the name of Mitchell who is director of Industrial Personnel if its civilian. You've got to have one. That's what I'm getting at. Got to have in the service command, particularly. If we had no strings on us as to how many people we could employ, no shortages in any type of personnel, it wouldn't make much difference how you did the thing.

But with all these limitations we have on us and the heat we have got on us to cut down personnel, and a great amount of it is there properly too, I can't see how a service commander can control personnel without one central place to control it. Service command headquarters. You had one before. I'll bet a dollar a year ago the AG of the 4th Corps Area could tell you more correctly the total military population in that corps area. He didn't know anything about civilians. I am not talking civilian; I am talking military. I am worried about the whole thing. The point is, we are allowed to employ so many people, makes no difference whether they are in uniform or not. We are trying to run it in such a way that a

service commander within certain limitations, we give him all the selectability that we have, so that he can replace enlisted men with civilians if he wants to. We are trying to get him to do that. So there must be some central place on numbers of people. I am talking about personnel records and everything else. They control the numbers, the numbers of persons. The records are in three different sources. Of course, when it comes to civilian personnel and this may have some bearing also to enlisted personnel, we believe that the service commander ought to get rid of the records he has got. In other words, it seems this thing has gotten so big it seems perfectly silly to us. The service commander keeps a detailed record on every civilian employee at every post of his service command. All he ought to do is to keep a numerical record when a man works on the post. Now there is something to that too. Officers and key personnel, you are bound to have to go higher. I don't see why the control division needs to be a division. That is a good suggestion. It isn't so much in the name as it is in the number. Supposing this would happen sometime. Would there be any great objection to this? Supposing the professional side of this thing was a separate outfit out in the headquarters of the service command according to records of the commanding general thereof, and in the process of doing that somebody else ran medical supply, would that make any difference? Would that be just as bad as what you have now?

Do you think a system like this would work? Supposing whenever an allotment or an authorization for employment at a post was made up at service command headquarters that you had a whack at it and a review of it from medical activity standpoint, would that answer the question?

Comment: We do have a whack at it. Whenever a request comes in from a station pertaining to employment of any civilian personnel, we send it over for recommendation. Of course, there shouldn't be any request employment.

GEN. ROBINSON: What's going to happen is this. We have given the service command an authorization on personnel, and the way it works is this way: it might read a figure like, say, 200,000, of which not more than so many can be officers, and of which not more than so many can be doctors, for example, and of which not more than so many can be enlisted men, and so on. Now service commanders have got to turn around and tell Post X, you can employ 10,000 people, of which not more than a certain figure can be so and so, that's the way it is going to have to be done. Now you can see that you can't independently control the number of people employed in medical activities in the service commands under a thing like that.

Comment: Why not? We know how many Washington is going to give us - how many medical officers.

GEN. ROBINSON: Well, I'm talking about the whole works now - not just officers. I'm talking about the whole works - civilians, enlisted men, nurses, doctors, everything.

Comment: All right, you know how many the service command is going to get.

GEN. ROBINSON: You won't know how many enlisted men they are going to get - medical enlisted men - because we are not going to tell you that - we are just going to say so many enlisted men. We don't care what the service command makes them.

Comment: We know right now we have 30 percent of the enlisted men in the service commands.

GEN. ROBINSON: But what I mean is this - they are going to tell somebody down at Post X that he can employ so many people. All right. Now if you had a chance to review that - the only thing in it that you could review would be the nurses and the doctors because that is the only thing that will be set.

Comment: In setting up those it is important that somebody, I don't know of anybody but the medical officer, the Medical Branch it is now, determine the type and qualifications that ought to be at that station. Somebody has got to select a highly trained laboratory technician, and the fact that he requires a high standard ---

Comment: I don't see how in the world he can assign those personnel without giving them a careful detailed study by the service commander's staff.

GEN. ROBINSON: All right, you come in and say Post X has got to have 5,000 people on medical activities and you probably come in with a figure that is 2/3 of the whole service command figure. Then what are you going to do?

Comment: You wouldn't have anything like that if you were on the job.

GEN. ROBINSON: It's liable to be that way because the squeeze is on us so tight. My point is this: that supposing you are a division out there -- maybe I'm not making myself clear -- I don't see how you can be given authority, even if you are a division out there, to go down to Post X or write out to Post X and say, you can have so many medical people. Is that what you want to do?

Comment: We don't do that. The service commander does that. He puts

a ceiling. Now in my service command he put a ceiling on each camp and then sent a board out to see how these are apportioned. Then this board makes its report to him and he has the final say on the different apportionments of this personnel. If there is a shortage of medical personnel, he would consult me and we would thresh the thing out, and we would arrive at some equitable figure which would operate. We don't want to go down there and tell them, you've got to have so many doctors here. In a certain situation, we will tell the commanding general how many in our opinion it will take to efficiently run this place - the decision is his - ours purely advisory. The only thing we want is to say who these men are going to be and where we are going to put them.

GEN. ROBINSON: Well, how far down do you want to go on that? You want to say who the post surgeon will be?

Comment: Yes.

GEN. ROBINSON: Do you want to go further than that?

Comment: Yes, we want to say who is going to be head of the surgical department, who is going to head the medical department, who is going to head the laboratory, who is going to head the x-ray, and what not, because we know the qualifications and capabilities of those men. Nobody else knows that. That is one of the troubles with the Medical Department now - that we haven't got information on the various jobs - supposed to check and get them there. The chiefs of services can make inter-service switches - I mean they can take the subsidiary personnel and move them around as they please. We send out ten or twelve captains and they divide those up according to the --

GEN. ROBINSON: Is that quite the situation? Do you want General Kirk to tell you who your assistant is going to be?

Comment: No, he doesn't approve that.

GEN. ROBINSON: That is just what you said. In other words, what you want to do is to determine the specialties required and the distribution that should be made of them within the resources of the service command.

Comment: We want to be able to name competent men to cover these jobs.

GEN. ROBINSON: If the post surgeon is fool enough to put an x-ray man in the laboratory, why that is his fault. You should correct it.

Comment: Well, we can correct it and we do.

GEN. ROBINSON: I swear I don't see why frankly - because that's what we are doing over in our place all the time - much the same sort of thing - why that can't work that way and still have a centrlized place in the service commands headquarters for what I call personnel actions - personnel paper work.

Comment: It does work but it works to the disadvantage that it is time consuming and takes up more personnel than if we had it in our office. We don't want all this stuff down there we want certain personnel there - when we want a man sent from one place to another we'll send up a request for the personnel to put out that order, but we don't want to have to send up there and get all the information we need before we can make up our mind on it. We'd like to do that in our office.

GEN. ROBINSON: You'd like to keep the personnel records?

Comment: Not all of them - not the 201. In practice, we have a 5 x 8 card on each Medical Department officer which has all the information on it that we want.

GEN. ROBINSON: On just officers?

Comment: We have it on enlisted men too. Well certain key enlisted men. We have a station officer file that is a file of these people at their particular station and we move them around - of course, we have to have a smaller master alphabetical file. We don't keep the 201 file. When we get a requisition from the War Dept. for a certain number and grade, qualified as such and such, we know where we can get them and then we pull these file cards. We do care what medical school a medical officer graduated from, how much post graduate training he had, whether he is a member of the American Board of Surgery, or something like that: We have all that on every one of them. That's the kind of information we need to properly place that personnel. It is a very simple system - it doesn't take much work to keep those cards up.

GEN. ROBINSON: I don't see any object to that. The only personnel records in my own office that I keep is a 3 x 5 card on each person and I have some notes on there of my own, and The Adjutant General keeps all the personnel records and takes all the personnel action on everybody in my office.

Comment: We get an order from The Surgeon General's office to send 5 company grade medical officers somewhere, no special qualifications, or 2 orthopedists, 2 interns, 2 psychiatrists. Now we don't have that information.

GEN. ROBINSON: You haven't got these 3 x 5 cards?

Comment: No. We have nothing. We've got to send two blocks down the street and get it.

GEN. ROBINSON: Did you?

Comment: Of course I did, till they took them away from me.

GEN. ROBINSON: Have they kept them up to date?

Comment: Damned if I know.

Comment: In the 3d service command they had it under personnel and they changed it to supply within two months because it didn't work there. I don't know what the next move will be. Which one is that? It is under supply now. It was under personnel, 3d service command. All shifted, all under personnel division. I asked the chief of personnel what was the difference between an orthodontist and orthopedist? He said I'll be damned if I know. There you go. And he is trying to put specialists where they belong. Can't be done. If you all would keep a simple record of the qualifications of your officers at your stations and if there were a better understanding as we have here as to personnel action taken; actually what you want is much different from what you do.

GEN. ROBINSON: How do you manage to keep those up to date?

Comment: We get copies of the orders. You get a special roster of medical officers.

GEN. ROBINSON: What you point out is the way it is organized now makes it difficult to get that cooperation and get a decision. That's what you mean. I would just like to leave a couple of thoughts with you and think you ought to put in the plan the way you see it, regardless of what anybody else says. Number 1. We're trying to keep down the number of people in the staff of the service commands. We can't get it up to the point where you have 20 or 30 people, or I think even 10 is too many. I think we've got too many now. Number 2. You've always got to remember where you are going to draw the line between these things. Because it is true that you are the staff officer for the health of the command. But there are an awful lot of things that affect the health of the command that are primarily somebody else's staff. Where are they? Well, that's the point you were making and I think it is very well stated. What or where are you going to draw the line on the things you control? You can say, there are some points to it, that The Surgeon General ought to do his own construction work. It's some argument. All right, you shake your head on it. Now we go back a little bit further. He ought to buy all the supplies used in medical stations. He ought to buy

all the drugs. Where are you going to draw the line? I think it's important to present something in your paper as to where you are going to draw the line. We only had three functions --- hospitalization, evacuation, and sanitation. Now you've got other things that affect those.

One of them is personnel. Well, they supply that. I am talking about the service command. In the service command, I'm not talking about The Surgeon General's Office, you've got all kinds of things that belong to somebody else. I don't know what any of them are. Well, take repairs and utilities. One of the most marvelous Army Regulations I ever read was the one that tried to define what the post Engineers, what the post Quartermaster, and the post Surgeon each did getting rid of its duties. Well, that's the type of thing I'm getting at. Through habit and custom there are certain things that somebody from Mars might argue that that belongs to me because that affects the health of the Army. But through habit and custom you can shake your head and say, "No." Now there are certain other things that maybe we think shouldn't be primarily yours which are in the same category, but which you say, oh yes, and some of that is through habit and custom and is not necessarily logic. So the point I'm making is that you ought to think of that, and I'd think it would be well to present something in your paper on that. Of course, Army Regulations. Don't let the Army Regulations worry you. We can change those.

We should check so we can tell if we are getting proper training in these units. But we don't do it. That should be planned through this office. We did do it until they took it away from us. You're the representative of The Surgeon General on these things and you should be doing it. I've heard people argue. No service should do any planning except specialist and professional service. All we're asking is inspections with regard to tactics in those forces. We should know if the unit is properly trained, whether or not it knows how to put on a first-aid pack, whether or not it has to do with training and whether it is supplied properly, and proper technical training. There is no one else responsible but The Surgeon General. That's one thing you can't get away from. There's a great deal of flexibility in the Officer's and Regulations Manual under the Supply Service Division, Medical Branch, and other branches, relating to the Supply Service in accordance with the training policies of the Division. It establishes policy with respect to the Training Division. Is there a technician, a doctor on your staff? There was, but now that officer is in the training division. The place that officer ought to be in my opinion is in a Medical Division. The same thing we have with the Air Corps. You're doing the same thing between divisions as the Air Corps has done with hospitalization. We're not taking

them over. The commanding general took them over. Took them away from us. I'd like to offer one other suggestion, that when you present this case it consist of a draft of a revision.

Now we're ready to discuss the draft and the way you want it changed. The actual changes. What other questions before I leave? It's my understanding and of course I don't know anything about the mysteries of the medical profession, but to my understanding the health of the Army and particularly in the United States is exceptionally good. I don't imagine then, that being the case, that any of this shuffling we've done has really bothered what you've done. The practical application - we aren't getting things done very much. We intend to use more effort. More effort! And more work in order to get it done. That goes back again to general personnel. There is a war on. Well, please don't forget that Fort Bragg is, as somebody says, as big as the service command used to be.

It isn't the depots that give us the headache but these little places that don't have enough to operate. All these little things together, isn't that true? We still must give professional care in the little place. You're responsible for sanitation and health. I don't mean by that, General so-and-so, or Col. Smith, or who ever it may be, it's yours, good-by. We don't mean that - we mean, try to get authority and responsibility bound where they actually fit. What should we profit by holding checks on the follows until we know what he is doing? Well, that's what we're trying to do. I hope I've been a little help to you.

GENERAL LULL: I would like to introduce into the record at this time certain questions proposed by the surgeon, Second Service Command, which will be answered by the various division chiefs, and the answers inserted in the record later.

COL. WALSON: May not the provisions of C-1, Memorandum W150-3-43, and paragraph 9b, Memorandum 350-47-43, be amended to provide for the physical examination of individuals for the Enlisted Reserve Corps with a view to undergoing Army Specialized Training instruction in medical, dental, or veterinary schools, regardless of whether or not they hold commissions in the MAC (Inactive) or the CRC, in accordance with the physical standards contained in paragraph 15, AR 40-100, and paragraph 8f, AR 625-5?

Answer: The current provision for examination in accordance with physical standards of par. 8f, AR 625-5, excludes from the Army Specialized Training program and therefore discriminates against those individuals who, if they completed their

professional studies at their own expense, would be eligible for direct commission in the Army of the United States as limited service officers in the Medical, Dental or Veterinary Corps in accordance with the physical standards contained in paragraph 15, AR 40-100.

COL. WALSON: Would it be practicable to pool all Medical Department officers on duty within the geographical limits of this service command?

Answer: Under the present organization, medical officers and medical installations of the Army Air Force and the Army Ground Forces are not under the control of or available to the service command. There is poor economy of personnel. It may be possible by cooperation of the commanders of units involved to arrange in each such locality a coordination of the assignment of duties of medical officers at that specific locality.

This, of course, is only temporizing. A medical officer of any one force may be moved at any time.

The service command is to furnish the medical service for ASTP and similar units. Any method of procedure to provide professional service, whether part time or full time contract, fee system or assignment of a medical officer that is unsatisfactory or uneconomical should be discontinued and practical procedures established. In the case of Navy personnel and Army personnel at one school, a recommendation should be submitted to this office concerning each school for conference and coordination with the Navy Department.

COL. WALSON: Could not arrangements be made whereby Air Forces and Army Service Forces could use the same formula in providing medical care at ASTP installations?

Answer: Within the geographical limits of this service command, in some instances, the conservation of manpower is being defeated through failure to utilize personnel to best advantage. For example, in some localities where a medical officer is assigned to duty which does not occupy his complete time, his services are not used in connection with the ASTP Unit in close proximity to his station.

In other instances, a contract is made with a civilian physician at exorbitant rates, notwithstanding Army facilities were available. In another instance it is known that a civilian physician is employed for a short time at an exorbitant rate, $300 a month for one hour's work, and a nurse at $130 a month. In some cases, while the contract may be made on the basis of so much per man per month, in practice only dispensary care is given to patients and they are transferred

to an Army Hospital. In some instances, notwithstanding a contract above-mentioned, the Army is furnishing dispensary equipment and supplies.

Inspection indicated that in some instances the type of medical care was unsatisfactory. Three cases of septic sore throat discovered in quarters received practically no care. One case of meningitis occurred in a unit which had arrived at the station without an inspection on arrival. Most of those schools do not appreciate the high standard of medical care required by the Army.

COL. WALSON: In view of the fact that at some institutions specialized training programs are being operated by both the Army and the Navy cannot the War Department collaborate with the Navy Department to determine policies and issue instructions which will permit joint operation of medical service at such schools and thus conserve personnel, material, and equipment?

Answer: If the Navy personnel at such schools outnumbers the Army personnel, it would seem feasible for the Army personnel to receive medical care at the Navy dispensary, in accordance with paragraph 4, AR 40-505, and when appropriate the Navy medical officer assigned to such duty to act as surgeon for the Army school. Where the Army personnel outnumbers the Navy personnel, the converse could be effected.

COL. WALSON: Should not paragraph 10, AR 40-205, Change 2, dated 26 March 1942, be further amended to provide for bed spacing on the basis of cubic feet of air per occupant in addition to the present standard of a minimum number of square feet per occupant?

a. Cantonment Barracks as well as many of the rooms in hotels and other buildings now occupied by troops have low ceilings. Double bunking, which is the common practice, places the man in the upper bunk very close to the ceiling which is believed not to be conducive to health, especially in rooms not provided with adequate ventilation system. In cantonment barracks with furnace heaters, many of the men in upper bunks are directly adjacent to the hot air outlets. When, as frequently has been found to be the case, the humidifier attached to the furnace is not operating, a man sleeping near the hot air outlet is exposed to an atmosphere of hot dry air which is predisposing to upper respiratory disease.

Answer: Yes, a basis of allowance of bed spacing in terms of cubic feet of air per occupant should be considered. The Surgeon General has consistently opposed the reduction of space allowance in barracks. The decisions made were command decisions. Preventative Medicine Division intends to bring

amendments of regulations up for consideration later when conditions have become more stabilized.

GEN. LULL: We have with us this morning, gentlemen, Colonel Fitts, from the ASTP Branch. A number of questions have been discussed and answered already, but there are undoubtedly other questions which you desire to ask Colonel Fitts about the Army Specialized Training Program Branch. As you know, he has been detailed over there as The Surgeon General's Representative in the Army Specialized Training Program Branch.

COL. FITTS: Gentlemen, because you will be asked a good many questions about the Army Specialized Training Program, the training in medicine, dentistry, and veterinary medicine, I should like to give you a brief outline of what we are attempting to do. May I go back to last fall when it was decided that since members of the Enlisted Reserve Corps must be ordered to active duty, and since it was not certain that various categories of individuals of collegiate age would be deferred by Selective Service, it was apparent that both the Army and the Navy must take certain steps to train enlisted men at college level in order that they be qualified to enter officer candidate school and also be qualified for technical scientific tasks in the Army for which otherwise they would not receive any instruction. The Surgeon General was asked to prepare a demand schedule of the number of soldiers whom he would desire to be trained in those three categories. The Surgeon General asked that a sufficient number be trained to furnish loss replacements -- annual loss replacements -- for medical, dental, and veterinary officers. It was assumed that fillers could not be obtained from civil life and that each year during the emergency it would be necessary to find loss replacements, not in civil life but from those who are completing their medical, dental, and veterinary training. Accordingly, The Surgeon General requested that 4,200 doctors be produced each year who were under military obligation, 1,100 dentists, and 150 veterinarians. Those figures were arrived at by applying percentages of loss replacements which were furnished by this staff. It was assumed that the maintenance level, shall we say, of medical officers, would be 49,100, and that they would require 8½ percent replacements each year, therefore giving 4,200. The level for dental officers was 20,000, and the percentage of loss was 5½ percent, giving 1,100. The maximum number of veterinary officers required for the 1943 troop basis was 2,600, and assuming replacements at 5 percent, only 150 were required to be replaced each year. Now since professional schools are graduating classes every nine months, requirements were reduced to a 9-months basis;

that is, we wish to graduate from medicine 3,150 soldiers who were Doctors of Medicine, 825 Doctors of Dental Surgery, and 113 or 115 Doctors of Veterinary Medicine. In order to produce that number of graduates, it was necessary then to assume an attrition in medical, dental, and veterinary schools, and to plan to put into the freshman classes of such schools the number necessary to assure the graduation of the numbers referred to. That meant assuming an attrition of 16 percent, which had been the experience of previous years, that 3,750 soldiers should be put into medicine every nine months, and an appropriate number of the other two groups. Also it became obvious that unless some provision was made whereby an adequate number of pre-professional, pre-medical, pre-veterinary, pre-dental students, were removed from the jurisdiction of Selective Service and their training in pre-medicine assured, that there would be no one entering medical schools each year other than women and the physically unfit. At the time that that decision was made, the Bulletin 11 of Selective Service had not yet been issued, and even now it will become necessary in future years because Bulletin 11 required that a pre-medical student must have been accepted by a school in order that he may be deferred, and the schools themselves will not accept a pre-medical student upon entering pre-medical studies. There are some few who will be selected at the high school level and that many may be assured, but it was that first six months to twelve months in pre-medicine in which we anticipated that the pre-medical student will have been drafted, and therefore plans for the training of pre-medical students were part of the program. However, as you know, there are in medical, dental, and veterinary schools a very large number of students who have accepted obligation to the Army through their appointment in the Medical Administrative Corps. This was done principally without physical examination and therefore was only a subterfuge to remove them from jurisdiction of Selective Service. There were also in pre-medicine a certain number who either had been appointed to the Medical Administrative Corps since they had been accepted for matriculation in the next ensuing class in medicine or were under Army jurisdiction. I assure you, as you know, the whole problem was very complicated and there have been many conflicting opinions given from time to time as the program developed. One of the first things that we realized was that not only were the 1943 classes in medicine completely filled, entering classes, but also that the entering classes for the first half of 1944 and the second half of 1944 had been accepted and a large percentage of their acceptances by the medical schools. Therefore, we could see that the Army has absolutely no vacancies in such schools which can be assured can be given to them even by the medical schools for 1943 and the first half of 1944, and in some instances in the second half

of 1944, as I stated. Therefore, we had to make arbitrary decision that only those enlisted men who have been accepted for future entering classes in medicine, dentistry, and veterinary medicine, and only those in veterinary medicine who were in the Enlisted Reserve Corps could be considered for training in medicine until further notice. That was due to the fact that we did not feel that it was up to the Army to attempt to salvage this tremendous excess of pre-medical students which in normal peace times was 50 percent in excess of the requirments for medical schools, or shall we say a 100 percent in excess of the requirements of medical schools at the present time due to the changes made in the admission requirements, whereby two year pre-medical students may be admitted. There was a tremendous excess which could not have been absorbed even if the Army had never gone into the program. Now the tendency is to insist that the Army salvage all this group of soldiers who have had some medical training, pre-medical training, even though in normal peace times selection they would never have been in medical schools. That determined our present policy that at the present time only those who have been accepted for future entering classes, and unfortunately when that telegram was sent out it said those who had been accepted. Accordingly we are getting reports of boys who have been accepted for 1943. Acceptance for us, of course, meant a vacancy to which he could be assigned, acceptance for the others wasn't a question of passing on the qualifications. We are planning to initiate, as you know, medical, dental, and veterinarian training in all the approved schools of medicine, dentistry, and veterinary medicine with the exception of the Women's College, Medical College of Pennsylvania, and at the present time until these two schools, the one school at least down in Dallas, get straightened out (and I want to ask you some more about it today, Colonel Hart), training should be initiated in all of those schools by, at the latest, it is thought, 23 July. We have so far as possible attempted to start training at the beginning of an academic term. That is a quarter or a semester, or where it is possible at the beginning of an academic year. Where an academic year or term starts later than 23 July, we are asking that training be started on or about the first of July. The question of premedical training depends upon negotiations which we are now working on whereby the medical schools will mortgage to the Army a certain percentage of the vacancies in their future freshman classes. The date of the first class at which they wish to mortgage those vacancies must be negotiated with the schools and cannot be arbitrarily decided by the War Department. We have of course the schools' cooperations and if they do not wish to give us any vacancies in future freshmen classes then that is their prerogative. All of the schools have endeavored to cooperate in

every way, even though we have not been able to give them very clear directives. I do not know whether I myself as a dean would be very anxious or even willing to give the Army 55 percent of the vacancies in each future freshman class and the Navy 25 percent, for the simple reason that when we have Army Reserve vacancies assignment will be made on a numerical basis and not on a name individual basis whereby the soldier who had previously been selected or had been selected or accepted by a medical school will be assigned to that school. It will necessarily be on a timely, regional quota basis. Therefore, the son of the old grad will have no assurance whatsoever that he will be sent to the school that his father wanted him to go to unless he is used to fill one of the vacancies which have not been committed to the Army and to the Navy. I think all of us feel that the 20 percent vacancies should be reserved for women and for the physically unfit, but you can see the personal element that is bound to come into it. As I have stated before, for the time being, admitting that certain schools have been able to get the cream, other schools have had to content themselves with the skim of the milk. We are at the present time sending that cream to the cream schools and the skim milk will go to the school that has accepted the skim milk. However, when we have Army Reserve vacancies we will have to assure that there is less skim milk and that there is a good homogenized product which will be assigned as I see it on a numerical basis. There's one thing that we can assure, that is, that it will not be chocolate milk. Negro trainees now accepted by Chicago or Harvard will be sent to those schools by which they had been accepted. When Chicago and Harvard reserve for the Army a certain percentage of vacancies we will not send Negro trainees there. That has been the point which has given some concern to some schools and is one which you cannot decide absolutely or say that an order will not be made; but if it is made, it will be rectified.

There is a perplexing situation which comes out in the Ninth Service Command regarding the College of Medical Evangelists and certainly that situation will be somewhat difficult to handle if the enlisted men who are assigned to that unit should be of that particular faith. They will not be trained in pre-medical units under the same circumstances. I think that that denomination is planning to make full use of deferment by Selective Service in order that their qualified pre-medical students not enter the Army prior to the completion of their pre-medical studies.

I will ask for one way of looking at this thing. Do not regard these trainees as students in uniform. Regard them as soldiers in college, with all the prerogatives of an enlisted man and all the responsibilities. I think that if that attitude is taken and insisted upon with the profession that it will of itself answer a good many questions.

The mere fact that we are re-assigning to the schools those who are now under Army jurisdiction and who may by induction pass under Army jurisdiction assigning them to the schools to fill their own vacancies, makes it appear that all we are doing is putting the student in uniform. It will have to be looked upon that the Army is selecting that particular soldier for assignment to fill his own vacancy. We are rubber stamping for the time being the selection previously made by the school itself. The units, of course, will be established in certain schools which will, and these units will be, shall I say, separate units. We'll say the Medical College of Virginia will have one unit, in which there will be both dental and medical training. On the other hand, at the University of Pennsylvania or we'll say at Ohio State, there will be a unit at the institution and the medical school will be one section of that unit. There will be basic training, advanced engineering, language training, training in psychology, and other type training in that unit, but the medical selected soldier will be assigned to that unit for training in medicine. We are now finished, I believe, working out with the Navy a form of contract which is being sent out to the servive commands whereby the school engages to train under its standard curriculum the enlisted men who are assigned there from time to time, and it specifies certain things regarding their assignment. The Army will pay for all of the expenses incident to the professional training of that individual soldier. Tuition will be paid on the basis of non-resident tuition, fees will be paid which are essential to the academic progress of the soldier. We decided we would not pay the diploma fee; we hope that he will be able to save enough money out of his $50. a month to pay for his diploma. We will ask that he be given a certificate to the effect that he has completed his medicine but not a paper of sheepskin. Instruments, special dental instruments, are a large item. Books and such, all will have to be paid for and will become the property of the Government and will be reissued as indicated in the question of students. The freshman will retain his textbooks and necessary instruments throughout the four academic years. It is necessary for the senior student to refer to his anatomy. On the other hand, books issued to senior students may be reissued each year. Question of housing and messing has been the great problem of this entire thing. There are two aspects to it, one is that the student wants to get the money which is not a valid point, and also that he wants to sleep at home which is not taken into consideration. and the other is the impracticability or the impossibility of group housing and group messing in the vicinity of the majority of medical and dental schools. The third point, of course, to be taken into consideration is that if the group housing is such that studies will be interfered with, that the medical student cannot burn the midnight oil, which has been found by most of us to be necessary, then that

should be taken into consideration in determining the practicability of group housing. The most of the deans feel that, while housing in the first and second year would not interfere with the professional training, the academic program , of the soldier, they do feel that in the junior and senior years, in the clinical years, that it would be very difficult to keep them in one or more places for their messing and for their housing while they were distributed all over certain metropolitan areas for their clinical work. However, the service command has the unfortunate and unpleasant responsibility of making that decision and is being heckled a good deal because of the fact that the Navy decided to pay commutation of quarters, and rations to all students irrespective of any facilities which might be available. Other thing is that since the Navy came out in a beautiful double-breasted blue suit, many of the Army prospective students are very unhappy because they have to dress as you and I are dressed at the present time. You have all heard that reaction, that the Navy was going to be put in Midshipmen uniform and have the prerogatives of an officer and gentleman, while they would only be soldiers in that nasty khaki. I don't believe that that is to be taken into serious consideration. As I say, the curriculum prescribed in medicine will be the standard curriculum of the school that which it has been pursuing in previous years. The amount of military instruction which is being required will be that which was given to medical R.O.T.C.'s and is covered in a mobilization training regulation which recently came out. I think that in those instances where it is possible to assign medical officers to units in onnnection with the medical training that that problem will not be difficult. However, in those schools where there will be no medical officer and where there will be only a line officer things will happen such as happened at Oklahoma, which the dean is protesting that they are taking all of each morning for roll call and calisthenics and Saturday from eight to twelve for drill. That nine hours a week would be taken from medical studies for military training. That is not desired,and in the cases where there will be just merely the line officer there you will have to watch that quite closely. Since it is only feasible to give enlisted men 30 days, one month furlough during the year, we're hoping that, although it is not actually stipulated in the contract, that there will be forty-eight weeks of training during the calender year. That is a difficult problem because of the fact that some schools were planning to have a little bit more academic vacation under their accelerated program than one month in the year. There is, however, one stipulation; that is, that the training will be under the accelerated program, approved by the various associations, in which it is stated that elapsed time from matriculation to graduation would not

be less than 36 months. Upon graduation, training and other specialized training programs terminate. Sixty days prior to completion of such training application will be made, as was previously done in Class A medical schools, for appointment in the Medical Corps of the Army of the United States. Those applications will be forwarded by the commandant to the service command and will be accompanied by the usual papers and by a certificate from the dean or president that it is contemplated that the individual will successfully complete his medical training on a certain date. Those papers will be sent, no doubt, direct from the service command to The Surgeon General, who will transmit them to The Adjutant General. That is coming out in regulations as you worked it up, sir, and appointment will be made and a letter of appointment issued, effective the date of graduation. The day prior to graduation they will be discharged from their enlisted status in order to accept commission the next morning.

Dental students will become newly commissioned dental officers and will be ordered to active duty by you, sir. Medical students commissioned will not be ordered to active duty for twelve months, during which on their own responsibility and on an inactive status they will complete their twelve months of internship. The Surgeon General will order them to active duty at the end of that period.

Veterinary training is a little bit complicated by the fact that the demand schedule is only for 150 veterinarians a year. There are now in the three schools of veterinary medicine practically 1,800 M.A. officers. Now we don't know how many of those will be physically disqualified and how many will not wish to be enlisted. There are also in the Enlisted Reserve an undetermined number of pre-veterinary students who have been accepted by veterinary schools. Upon the recommendation of The Surgeon General we will train those two groups. In other words, they are after the last Enlisted Reserve in the free veterinary medicine accepted in the veterinary schools. There will be no additional Army trainees assigned to veterinary medicine. That will be a blow to the veterinary schools. Military Personnel Division was very anxious that these enlisted men who had been trained in veterinary medicine merely serve as enlisted men.

We would prefer a system that those that we did not need as loss replacements or as fillers not be called to active duty till their services were required. The Director of Personnel approves The Surgeon General's recommendation that with completion of their training they be appointed, discharged from their enlisted status, and called to active duty in such numbers and at such time as their services are required. That will then really create the new reserves that will permit

their utilization by the Dept. of Agriculture or the division during those intervening years.

Now the same situation exists as far as the Negroes are concerned. We would require only about 40 replacements for Negro medical officers each year. There are already at Howard, and I do not know how many other schools, 380 Negro medical students who are in the Med. Admin.Corps. There again there are replacements for almost ten years.

At the completion of twelve months' hospital training,formally, such Negro medical officers as are required by The Surgeon General will be ordered to active duty. There again is the creation of a Reserve; but with a provision whereby they, those men, may be made available.

COL. JONES: One question we wanted to ask is what the responsibility of the service command in Air Corps is.

COL. FITTS: I don't know. Col.Jones, I think that will have to be decided as in the Administrative or Command Function of The Surgeon General.

COL JONES: I think that matter is going to come up. Yes, we are going to have to clarify the relationship.

COL. FITTS: As I understand it any students under the Army Specialized Training Program will be handled the same. No matter whether they are Air Corps or what.

Assuredly the Air Force program is not under the Army Service Forces. It is a training program under the Air Force Training Command. On the other hand all trainees and all personnel of Army Specialized Training units are under the direct control of the service command.

There is a War Department directive to the effect that the senior officer on duty at such a school, or such a unit, command those units. However, that does not solve the problem of his responsibility, particularly in medical records, of the Air Force trainees at that school and the Army Service Force trainees at that service command.

I think that will be cleared up along with the other questions relative to the authority of the service commander over Army Air Force stations that is being taken up now by General Kirk.

Question: Should medical, dental, and veterinary students be accepted for voluntary induction, if they qualify for general or limited service for commission in the Army in the U.S.?

COL. FITTS: Sir, I've recommended that the proportion of 10 percent limited service men who were to be trained under the Army Specialized Training Program not be made applicable to medical, dental, and veterinary trainees, in view of the fact that they may be appointed upon graduation for limited service in any number. The percentage of limited service, so I am informed by Col. Williams, in that group runs about 10 percent. I do not believe that that will cause much difficulty but I am sure that I shall get that point cleared up and that we shall be able, for instance, if it runs to 15 or 20 percent. They may be assigned to ASTP in that service command, I mean for training.

On the other hand, there is a wide discrepency between acceptability for limited service officers, and acceptability for limited service as enlisted men, particularly in vision. The limit for vision for limited service is 20-400 which must be correctable. And in the case of defective vision in fact the lowest vision in one eye, it must not fall below 20-100 in the other. Now that is of wide variation from the limited service for officers. I have put the thing up to Col. Freer and Col. Freer asked me to see him. I think if we can get that settled by him it will be that rather than a man with a certain physical defect will be accepted for limited service with the view that he will ultimately become a medical, dental, or veterinary officer. I think that is not a question which is under the scope of our program service.

COL. JONES: I have a couple of questions here that Col. Wright asked me to bring up. It is the issue of white clothing to the juniors and seniors. He says the Dean of the school and the hospitals feels that should be done because the men are working in the wards.

Comment: Sir, they are included in most of the equipment to be purchased. I mean most instrument or laboratory coats. I do not believe that most medical students working in hospitals have done anything other than wear the rather long white clerk coats. That should be included, if the student has been required to purchase in previous years. That, then, should be a charge against the Government and should be purchased by the school from funds made available by the Government, by the commandant, to the student.

COL. JONES: What he had in mind was the ordinary hospital white clothing. That's what he was talking about.

Comment: I believe that the clerk coats would be a better solution.

COL. JONES: Another one he asked was, about the policy of the physical training of students. He recommends minimum time, the first two years, three hours a week, actual physical.

Comment: Sir, the physical program, which can be worked out individually, should be followed and yet I do not believe that we should prescribe such training because of the complexity of the curicula of the schedule in most medical schools.

COL. JONES: Well, he was having his trouble on that. The deans felt that they should not be given any time for physical training.

Comment: I think that The Surgeon General recommended that only one hour's instruction, a week be given to the medical student. Now the pre-medical student is on a different basis.

But the medical student should only receive one hour's instruction a week in military matters.

COL. JONES: The policy of putting women medical students on ASTP program is being asked by the students and also by the dean.

May I answer it is this way: that until women are enlisted men, they are not eligible for assignment to the Army Specialized Training Program. So they have to be officers in order to come in. They won't be drafted, so there's no danger of them being taken out of medical school.

Comment: Now, if the WAACs are made an equal part of the Army, and if, then, The Surgeon General asks us to train women, we would make arrangements for such, if the WAACs would enlist them for that purpose. There is something to be considered right along that line, which has been brought up. It is the training of physical therapists under this program, to enlistments in the WAACs. The same thing with dental hygenists and others. That has been brought up, as using the facilities of civilian schools for the training of enlisted women of the WAACs, when and if they become such, at the request of The Surgeon General.

COL. JONES: This is more of a personnel question: What is the policy for assigning a medical officer to medical schools for these units where we have had no unit there, like Louisville, Cincinnati, and so on.

Comment: Sir, I believe that it would prove distinctly advantageous. There again is the question of available personnel within quotas that are set up and allotments set up for the service commands.

That question has come up, and we are combing now and intend to comb the retired list and see if we can get any retired officers who are capable for that duty. Otherwise I'm afraid that we will have to assign a medical officer to these medical schools. I don't see how they can run without a medical officer. Of course, General, looking at it from this point of view

of the service command, in the allotment made, the personnel for the service command have not been increased for this purpose. It is an additional responsibility thrown upon them, and they do not have numbers. If you could find them, you would not necessarily be able to assign them to the service command for that duty.

There may be some places where a man can carry on the one hour's instruction a week, in addition to his other duties. There will be a large number of questions that will come up, that could be most satisfactorily solved by a medical officer, or by a dental officer, in conjunction with their dean, in which the line officer would not have the point of view or the traditional insight into such training.

Why couldn't graduates do their internship in Army hospitals? Well, I can answer that question in saying that we told the War Manpower Commission we would take no interns for an emergency in order that civil hospitals could be supplied with interns, because there's an acute shortage. It isn't that we couldn't train them, but the fact that they're needed in civilian hospitals.

In that connection, might I add, sir, that upon the recommendation of The Surgeon General and also of the Association of American Medical Colleges, it has been decided that extracuricula activities such as externships, or internships, or running the elevator, or has been done over at Johns Hopkins Hospital, of using 50 medical students as dishwashers, will not be authorized. If, however, the deans decide that certain employment is an integral point of the professional training of that student, he may then be detailed to that duty.

I've heard that question come up already. May students leave the control of the Army at completion of the day's work and go over for night duty in the hospital?

Colonel, I would say, if that duty is determined by the facts and agreed upon by the commandant as being a necessary part of his instruction.

Not just cheap labor.

To replace male nurses.

I think that's cheap labor. Interference with his sleep, and I don't think that it should be allowed, for a minute. In the 7th Service Command they use a large number of those students to replace interns that they're not able to get.

Well, I can see where that might be possible. To use them that

way. I think if put on the basis that it is part of their academic training, part of their medical training, and determined so, by the faculty, by the dean, that it would be permissable. It would have to be then approved by the commandant, who of course would, if he's a medical officer, weigh it properly; if he's not, then I hope you'll take the proper recommendation of the dean.

I would suggest on account of the shortage of the time, that if any of you have any questions to ask of Col. Fitts, you ask them later that is, any individual questions, because we have on more question to be brought up by Preventive Medicine.

Yes, sir.

Hospital Construction Division

GENERAL LULL: I would like to introduce Colonel John R. Hall of the Hospital Construction Division. The first question appears to be longer than the answer.

Question: May requisitions for construction and for equipment and supplies required for Industrial Dispensaries be edited in Medical Branch, Second Service Command, where detailed information concerning needs is available? Par. 5c Cir. No. 59, WD, 1943, provides that initial supplies and equipment for industrial medical dispensary will be supplied by The Surgeon General. Instances have arisen in Second Service Command where expensive construction and scarce items of equipment have been supplied on requisition from Ordnance, Signal Corps, Quartermaster, Engineers, or other nonmedical sources, to stations having little if any use for them. Examples are, dispensary building of excessive size at Carteret Ordnance Motor Park, Belle Mead Quartermaster Depot, and Sommerville Quartermaster Depot, z-ray equipment at Belle Mead Quartermaster Depot, Schenectady Quartermaster Depot, and Carteret Ordnance Motor Park, and two mechanical respirators at Signal Corps Ground Signal Service, Fort Monmouth, neither of which has been used since purchase a year ago.

Answer: In accordance with policies enunciated by A.S.F., editing of requisitions has been placed as a responsibility of Distribution Depots. It is suggested that in the case of new installations within a service command it might be very well if the Medical Branch of the service command would render assistance in the preparation of requisitions for such supplies and equipment as may be required for those installations.
(Note: The above answer was made by Supply Service.)

GENERAL LULL: Is there any elaboration on that?

COLONEL HALL: I might explain how these things have happened. These depots were constructed without any reference to The Surgeon General's Office as to what medical facilities were required. The civilian contractors put in this equipment without the Surgeon General knowing anything about it. Now, since they have been turned over to the Army, it seems to me this equipment could be distributed within your service command to points where it will be needed. Obviously, many unnecessary items have been purchased and installed. For instance, when certain civilian companies were putting up Air Ferry Command Stations in Africa, they sent in complete obstetrical

outfits including bassinets (laughter). No one in the Surgeon General's Office was responsible for that or for those other freak items of supplies you find.

Question: Is it advisable to construct a special storage building for safety films at large cantonment type of hospitals?

Answer:

a. The accumulation of films at our large hospitals has been so great that additional storage facilities for them have frequently been required. The porch of the x-ray building has normally been inclosed and provided with shelves for this purpose.

b. Since the films are of the safety type, special facilities for their storage are not considered necessary. They are supposed to be no more inflammable than would be a similar amount of paper.

c. The x-ray films frequently constitute a most valuable clinical record which may be of great use to the Government after the war. At certain posts, approval for a fireproof storage vault has been obtained. Recommendations from the field will receive special consideration in each case.

GENERAL LULL: Is that clear?

COLONEL HALL: The point that we wish to bring out and emphasize in that you may need a small special storage building, even a fireproof type of building because the x-ray films constitue a valuable record which must be preserved. We consider special buildings for this reason, and not because films we are now using are dangerous stuff. If you have an accumulation in one of your hospitals of films you wish to preserve, films which probably will be needed by the Veterans' Administration afterwards, you may want a fireproof building for their storage. If you make such a recommendation, we will try to get it for you. It may be possible for us to put up a tile wall with a brick veneer, using a concrete floor. We have gotten some buildings of this type at some of our hospitals.

Question: It is understood that several types of air-conditioning apparatus have been investigated in another service command. Is a standard inexpensive evaporative type of equipment now recommended and available?

Answer:

a. Current War Department policy permits the installation of air-conditioning and ventilative equipment

in hospitals in those localities where the average July temperature recorded by the U. S. Weather Bureau exceeds 75 degrees Fahrenheit. Special consideration may be given to installations in other areas on submission of suitable defense to the Commanding General, Army Service Forces.

b. Ventilative equipment: Ventilative equipment is divided into two general types:

(1) Mechanical air-conditioning equipment is provided for surgeries, x-ray rooms, recovery rooms (usually limited to one open ward), and flight surgeon examining units. Attention is invited to the fact that air-conditioning of surgeries for the prevention of static spark may be necessary in areas of low temperatures where the relative humidity is very low.

(2) Mechanical ventilative equipment is permitted in wards, clinics, patients' mess halls, and barracks and quarters of night duty personnel. It is divided into two types:

(a) Attic exhaust fans are provided in areas where the relative humidity is high.

(b) Evaporative coolers are provided in areas where the relative humidity is low and their efficiency is consequently assured. The use of evaporative coolers in surgery, x-ray rooms, and flight surgeon examining units is not recommended.

c. An extensive investigation has been carried on in the 8th Service Command with several types of evaporative coolers. No one type has been selected to the exclusion of all others. The most common and the most inexpensive type uses a moist excelsior pad. When in prime condition, this type is very efficient. It has the objection of collecting dust and dirt. It usually wastes a considerable amount of water and loses efficiency with use. Replacement of pads is required at intervals depending upon the result of a collection of atmospheric dust. Two other types of evaporative coolers both of which eliminate the objections above are now being developed and should be available within a comparatively short time. Until such improved equipment is available, however, it is suggested that any type of evaporative cooler which is in general use locally and which has proven satisfactory under local clima-

tic conditions be installed. No one manufacture is recommended above others. All division engineers now have standard installation plans for evaporative coolers.

COLONEL FRENCH: I have seen some of these installations in the 8th Service Command and they seem to work very well.

GENERAL LULL: Are there any other questions about mechanical refrigeration?

COLONEL FRENCH: I have a question I would like to ask. What is holding up the program now?

COLONEL HALL: I think Major Souder, Sanitary Corps, who is on duty in my office and who has been working this program for me, can answer any question better than I. The plan for installation of mechanical ventilation and air-conditioning was working very nicely a year ago. Then the engineers and their material section said we were using critical materials which we could not have. They stopped all proceedings until they could make an inventory of manufactured goods.

GENERAL LULL: Will Major Souder come to the microphone?

MAJOR SOUDER: The current holdup is procurement. As you probably know, our request for air-conditioning and ventilation in hospitals was turned down flatly by the Commanding General last fall and the subject was reopened this spring primarily because there was a possibility of recapturing used equipment which is in non-essential civilian use. On that basis the policy was revised in accordance with our original request and War Department policy now permits air-conditioning and ventilation in every place we need it, but being based on this recapture business, we have had to wait for W.P.B. to find out where equipment is and then for the engineers to procure it, and it has been impossible to procure so far. W.P.B's inventory was apparently optimistic. The engineers tell me they have procured practically all the exhaust fans they need; they are prepared to cause the manufacture of all the evaporative coolers we need; but they have not been able to get clearance from Army-Navy Munitions Board to buy new air-conditioning equipment and they have been able to buy so far only about 300 used air-conditioning units of the type we want. I think probably we'll get new equipment before the battle is through, but Army-Navy Munitions Board is very reluctant to permit any manufacture, even though W.P.B. will permit it and even though the Navy and civilian hospitals are now using it. I think as the pressure from the field comes in and is

applied to Army-Navy Munitions Board and they realize that our total requiremnt in critical material is very low, that they will relent and the Staff members on top side will permit manufacture. That will probably take another 30 days.

COLONEL FRENCH: The Fourth Service Command is just burning up right now. If we get those things in next September or October, they are not going to help us any right now. In the meantime we are just up against it.

MAJOR SOUDER: Yes, sir.

COL. BURNETT: Air-conditioning in southern camps, especially in the hot summer months is a life saving device. The temperatures in those operating rooms without such equipment, plus the humidity, is such that it is a risk of life to patients and to operators and personnel on duty. We had last summer in July, in three different camps, or four different camps, ten deaths from heat stroke - the old-fashioned heat stroke. The temperatures in many of the buildings last summer was so hot - those that were not air-conditioned - that men had to leave those buildings and sleep in the open atmosphere in order to be able to sleep at all, and special orders were issued to cover all exercise and troop training during those critical days. I personally have never seen anything like it in the field and I was on duty at that time at Camp Pickett in Virginia.

COLONEL HALL: What about the operating rooms?

COL. BURNETT: The conditions in the operating rooms withour air-conditioning is a very critical and a very serious situation. Temperatures of over 100 - 103, 104, 105, 102 - with a humidity of 78% and 80% is a decided risk of life of patients, especially those already in shock and in critical conditions, and it is almost impossible - and this is a result of personal observation that I saw in at least two places last summer - it is almost impossible for operators to stand on their feet and work under those conditions unless they are protected by this air-conditioning.

COL. WALSON: May I add, relative to air-conditioning operating rooms - it is presumed that provisions are made also to cover post operating recovery rooms. It seems to me there is a factor to be considered of taking a patient out of an air-conditioned operating room and putting him in a proper air-conditioned room for recovery in the most critical cases.

COLONEL HALL: You will notice that in the prepared answer that has been read that recovery rooms are included. I want to thank Colonel Burnett for that very clear statement because it corroborates the arguments we've been using for more than a year with various sections of the staff and with the O.P.M. here is Washington. It has been a battle from the beginning to the end and you have very well stated the arguments and the position The Surgeon General's Office has taken. There has never been any doubt in the minds of The Surgeon General's Office that you needed it, and we were in a fair way of getting it until these various control agencies, both in and out of the Army, interfered with the program. I think it is on again and we very cordially welcome any pressure that you gentlemen can bring in from the field.

COL. FRENCH: You should install them any time you can get them - winter or summer.

COLONEL HALL: Right.

COL. HILLDRUP: Recent research has shown that increase in heat in shock cases is fatal. In other words, shock cases do better at a temperature of 70 than any other temperature, and if you bring it up to 90 in case of shock you kill them.

COL. BURNETT: Well, your perspiration, your flow of water, from the operator himself and your patient - everything has to be considered - dehydration.

COLONEL HALL: There is absolutely not a statement that can be made against giving the patient and the doctor and other personnel who work in the operating room this protection, and we are very fortunate finally to have persuaded everybody responsible that it was just as important to use this critical material for this purpose as for any other purpose. Incidentally, the amount of critical material to be used in these compressor coolers has been reduced by the manufacturer to almost unbelievable minimum. They are going to get along without a lot, and there is no reason why we cannot get them now. I know of no administrative block. The difficulty seems to be the time required by the various administrative procedures. Since we have managed to clear the field and get general authorizations I think that pressure on the local Engineers should get results.

MAJOR SOUDER: We had to give the Engineers a chance to try to buy the used equipment. Army-Navy Munitions Board said they had to have a fair chance. I think it has been pretty well proven that that is not workable, and I really believe

that, backed up with statements such as Colonel Burnett's, we can get them to permit manufacture of new equipment, and it won't take long because all the parts are fabricated and ready for assembly. One company alone could produce all we need in a month.

GENERAL LULL: All right, thank you.

Hospital and Evacuation Division

GENERAL LULL: I introduce next, Colonel Offutt, of the Hospital and Evacuation Division. There are quite a few questions here:

Question: Copies of WD, AGO Form 40 are being received without accompanying copies of Board of Officers Report in mental cases, as required by par. 1d, AR 600-500. In the absence of specific provisions in AR, this headquarters holds that the AR 600-500 Board Report is an essential part of the proceedings under section II, AR 615-360, and as such, the Board Report should be forwarded as an inclosure to the Form 40, and thus afford it the same distribution as is required in the case of CDD forms. Reference par. 16d, AR 615-360. Request consideration be given to the provision of the CDD form for mental cases.

Answer: To begin with I think that question more properly belongs to Professional Service, Neuropsychiatric Branch. I had asked Colonel Freer to take that up. I believe it is a matter that must be studied and worked out between the AG and the Professional Service Division.

GENERAL LULL: I will call this to the attention of Professional Service Division and see if they can work out some way of handling it with The Adjutant General.

Question: Are Circular Letters 101 and 105 current series intended to circumvent the restrictions contained in paragraph 2b (5), AR 40-590 and paragraphs 11d(1) and (4), AR 25-20? This headquarters is receiving an increasing number of requests from municipal, state, and federal agencies (U. S. Employment Service) for information concerning the health and accidant records of former soldiers. Since such agencies are not included in the regulations cited, this headquarters has been unable to recommend the dissemination of such information and has instructed inquiring stations to reply that current regulations require the transmission of records to the Veterans' Administration even though it is understood that the agencies referred to are attempting to place such former soldiers in industry essential to the war effort. It is recommended that the policy of the War Department be stated in Army Regulations or a War Department memorandum.

Answer: With reference to Circular Letter No. 101 which refers to reemployment of disabled soldiers:

I have been working with representatives of the General Staff on the problems of reemployment. As you know, by

law, this is a function of the Selective Service; however, the method of reporting to the Selective Service provided that cases would be reported on the Selective Service form after discharge. This often meant the loss of from 30 to 60 days prior to the man being picked up by Selective Service. During that period of time the discharged soldier had not been contacted regarding reemployment and often did not know that the Government was interested in his reemployment.

Working through Mr. McNutt, who controls the Selective Service, and the War Manpower Commission it has been agreed that the Veterans' Employment Agency of the War Manpower Commission will function as a representative body to carry out the functions of reemployment which are by law, the responsibility of the Selective Service. The Veterans' Employment Agency, through their representatives, will contact the patient prior to discharge from the service and attempt to have employment ready for him when he is discharged.

The Adjutant General's Office is now working on a new form of report for the above cases. This report will give the necessary information regarding the man's disability. As soon as the form for the report is approved and published, a new directive is expected to be issued. Circular Letter No. 101 was published at the request of the War Department as a stop-gap pending the issue of a later directive. It is believed that this whole matter will be clarified in this later directive.

With reference to Circular Letter No. 105 which was issued by the Fiscal Division, it is believed that that division can better answer the question.

Question: Reference Secret Letter, AG 370.05, 16 September, 1942; can instructions be modified to indicate the total number of patients being evacuated from overseas who will require locked ward care in view of the fact that the availability of beds for this class of personnel in a large measure controls arrangements for the disposition of such shipments?

Answer: This matter has been taken up with the Army Service Forces and also with the Transportation Division. I have been assured that the Transportation Division is working on a modification of the information now obtained from overseas and will incorporate a breakdown of the mental cases. To prevent duplication of reports, this office has utilized the reports received through the ports by the Transportation Division. For purposes

of the report, the Transportation Division has requested that any case which might be a danger to itself or others aboard ship shall be classified as a mental case. The result is that the report we now receive classifies as mental all psychopaths and psychoneurotics as well as psychotic cases. With the present report we never know how many locked ward cases to prepare for at this end. I believe that the modification which the Transportation Division has promised to obtain for me will give us the required information.

COL. WALSON: In this connection I don't know whether this is a proper question for Colonel Offutt or the Preventative Medicine Section, but I have been told that these men coming back from overseas have had their clothing disinfested before they leave the overseas port. I have no assurance of that; it is just a sort of rumor. I would like to find out about it. If true, this would probably save us a duplication of a certain amount of work. The patients in returning from overseas are not deloused like the prisoners at the port. We do that at the hospitals and we thought that duplication of disinfestation of the baggage, if done overseas, would save this duplication of work.

Answer: Colonel Stone and I have taken up this subject and discussed it with the Army Service Forces and with Transportation. It hasn't been thoroughly clarified and we can't get assurance that proper delousing will be done on the other side. This is still being worked on.

COL. WALSON: In this connection, the Third Naval District Surgeon only a few days ago called me about a type of fever taken off of a ship at port. He wanted to know about some way to delouse these troops and he didn't know at that time that the port had a delousing plant. I called up the port surgeon (Colonel Melton) and he arranged to delouse the ship's crew.

Question: Prisoner of War Patients. Has The Surgeon General effected a working agreement with the Provost Marshall General concerning the disposition of Prisoner of War patients being evacuated from overseas?

Available information indicates that such personnel will be evacuated in increasing numbers and that during the next thirty days many may be received through the New York Port of Embarkation. It is obvious that the receipt of such individuals will clog up receiving general hospitals and it is recommended that arrangements be effected with the Provost Marshall General authorizing the service commander to ship such personnel, if transportable upon

arrival, by hospital train direct to hospitals designated within the zone of the interior.

Answer: General Bryan of the Provost Marshal General's Office stated to me yesterday that he had given instructions to his representatives in the service commands and at the ports to ship sick prisoners which were determined by the medical officers able to proceed on with the troop train to their destinations in the prison camps. He is now working on a system of obtaining the necessary information whereby he will have available and be able to make available to his representatives at the ports the exact number of vacant spaces in hospitals in the various camps. Just as we keep track of the beds in general hospitals, so that we may know exactly where patients can be sent, he intends to keep track of patient beds in the prison hospitals. As the Provost Marshal General controls the movements of the prisoners, we have very little left to say about where these persons are sent. I have been working with General Bryan on the subject and I think it will be clarified very shortly so that there will be more satisfactory working arrangements than there are at present.

Question: In connection with paragraphs 7c and 15, C-4, AR 615-360, is it the intent of section V, WD Circular 103, 1943, that application be made to the Veterans' Administration for transfer of all cases requiring hospitalization without any effort being made to contact civil authorities in accordance with paragraphs 3b(1)(b) and 9a, AR 600-500? It is believed that any individual having history of previous care by civil authorities should be properly returned to the care of such agencies and not transferred to a Veterans' Administration facility.

Answer: Circular Letter No. 110, Surgeon General's Office, published 2 June, 1943, clarifies this matter. It would appear that it is needless to contact the states as most of the states began declining to take such cases immediately the act of Congress authorizing veterans' care for all veterans of this war, was signed. The only cases which may not be transferred to a Veterans' facility are those receiving dishonorable discharge.

COL. WALSON: That is not applicable everwhere. We have had a few instances where we could get them in.

Answer: You are going to have a war with the various veterans' societies the minute you do this. They are protesting every effort to transfer patients to state institutions.

Question: If this type of people prefer to be placed in state

institutions, what is the objection to doing it?

Answer: There is no objection, and in Circular Letter No. 110 there is provision made that a man's family be notified anyway and given the opportunity to take over the care of the patient should they desire. A form letter accompanies this circular letter, which is to go to the nearest relative in all of these cases explaining the patient's right to hospitalization, but also explaining their rights to take over and treat the patient if they desire.

GENERAL LULL: There is one thing that I would like to interrupt you one minute to tell service command surgeons about pool reports. Some of them are delayed because they come through the service command headquarters. We would like that they come direct to this Office, because we have to make a report, in turn. Report of pool officers of general hospitals. One of the service commands is having reports that are required by S.G.O. Circular Letter 48, come through their headquarters. These pool reports by that procedure are delayed. We have this morning had to send out 32 radiograms to get correct pool information as of a certain date. It is absolutely necessary that these reports reach us as soon as possible. They have not time to go through the service commands.

Comment: There is no objection to the pool sending a carbon copy to their service command?

GENERAL LULL: If the pool sends a service command a carbon copy that is O.K. Then they can ask us for any particular officers you want. Otherwise these are indorsed. The pool report has to be a matter of permanent record and after this indorsement we have to answer a separate letter and it so happened that we have already made all the officers of limited service in the available service command already available to them for assignment. The pool report, or any other report, ought to be direct to The Surgeon General's Office under the SOS manual. It has to be addressed to the Commanding General, attention of The Surgeon General. Direct from the pool. Disposition boards will have to come through headquarters. This is just the pool report of the people present in the pool which the service command has nothing to do with.

Comment: The service commands have nothing to do with the pool. I think we could use those people in the pool.

GENERAL LULL: That is all right. For temporary duty. We are obliged to get these reports in here just as soon as possible and you get a carbon copy of that report. You know who are in that pool, go ahead and use them.

Comment: I tried to get some officers here the other day from the pool at MITC for temporary assignment and I was told by that office that it couldn't be done.

GENERAL LULL: That's a tactical pool. That's different. They are earmarked for the Ground Forces for full military duty.

We shouldn't bother officers that are assigned to tactical duty for the men in the training centers and Carlisle.

Comment: I wanted to be sure I was right.

GENERAL LULL: Just general practitioners, physically qualified for military duty.

Question: This service command needs a hospital unit car. How soon will one be available?

Answer: It is not anticipated that additional unit cars will be built for hospital trains. If there is an urgent need in the Fourth Service Command for a unit car, it is possible that one of the two which are now in service might be transferred to the Fourth Service Command provided that the needs therefore are greater than those of the First and Ninth Service Commands to which they are now assigned.

COL. OFFUTT: The thing is, Colonel French wants a unit car. That is on the record. There are only two unit cars in existence, and they discontinued the building of them after they built those two. One of those has been assigned to the First Service Command because of that Halifax run in which there is extreme difficulty in getting diners for the bringing of patients in from Halifax. The other one was put initially in the Ninth Service Command because of the situation in that lower desert area. Now, the question is whether either of those service commands feel that they need it less than Colonel French does or whether we decide that he needs it worse than they do and they should be detached. The contract that is being drawn up now with the railroads makes provision for the utilization of what they call a "strip diner" which can be rented for so much per day and can be manned by our own personnel. That has not been fully approved yet, but I understand that it will be approved shortly and be in force.

COL. WALSON: We prefer to use dining cars rather than the unit car for food service. We are going to find a great deal of difficulty in finding kitchen personnel to operate the number of cars we expect to have to handle, 51 cars, on the basis of our trains of three hospital cars per train to find experienced personnel to operate dining service when these cars are to be put in operation without much notice. We think the Pullman service which has been doing this work for a long time,

can give us much better service. If we do have to use any other messing service, the question arises as to the advisability of the canned "C" ration. They would be better than trying to run an ordinary mess.

COL. OFFUTT: I might say for Colonel French's information that our Plans Division has been working with various and sundry ideas for a kitchen car and I understand there will be one converted from some cars which the Coast Artillery had and which we are going to give a try. Now, I can arrange to have that sent down to your service command to be given a trial. It will be a kitchen car. I don't know just when it will come out of the shops. It is in the shops right now being converted. Would you like to have that one sent down to you?

COL. FRENCH: It is all right.

Question: What is the policy relative to hospitalization of dependents in camp, station and cantonment hospitals?

Answer: The policy in relation to hospitalization of dependents has not changed. Emergency cases may be hospitalized. AG Letter, 18 December 1940, subject, Medical care of dependents during the national emergency, provides that no facilities will be provided for the care of dependents in cantonment hospitals. The Surgeon General does not interpret this to prevent the treatment of emergency cases.

COL. HILLDRUP: In the Sixth Service Command, the commanding general has directed me to provide hospital facilities in all camps and stations for the care of dependents. He insists on that very strongly. He says that is one of his policies and it will be carried out.

GENERAL LULL: I don't see how it can be carried out because of War Department directives.

Comment: Last year at this same meeting it was stated that where there was not civilian medical care nearby to take care of dependents and it did not require putting in extra personnel in isolated stations, because of the great improvements it made in the morale of both the officers and enlisted men, that it could be done unofficially. Now, we have done that in the Fourth Service Command at all of our isolated stations. Just how long we can continue it with our decrease in nurses and doctors, I don't know, but it is a great morale booster and no question about it.

GENERAL LULL: No doubt it is good for morale. I believe that the thing should be left as it is as far as instructions are concerned.

COL. GIBNER: Colonel Foster is putting in a request to convert one of his

wards to a maternity ward. Bowen is doing the same thing.

COL. OFFUTT: I might say that I took up personally that question with General Kirk to see whether there would be any change in policy from that held by General Magee. He expressed himself rather strongly against officially establishing such departments in any of our cantonment hospitals. He feels that the War Department directives should be followed except for emergencies.

GENERAL LULL: I see no reason why the regulation should be changed. If you read it carefully, there is a certain flexibility there --- extenuating circumstances, permanent hospitals, and other angles where you can do a certain amount of hospitalization of dependents where it is absolutely essential.

Comment: Now that the Army Emergency Relief will take care of dependents, that is, if they cannot afford treatment, I believe the gap is partly closed. Then there is this thing which has just been passed by the state; the state has the money now to take care of dependents.

COL. OFFUTT: Money was recently appropriated to the Children's Bureau of the Labor Department for allocation to the states which have met certain arrangements for the care of maternity cases and children under one year of age who are dependents of soldiers, class four and below. I think that this is functioning now in 30-some states.

Comment: Well that takes care of maternity cases and children under one year of age in all grades, class four and below, from sergeant down. Above that they do not care for them.

Comment: That is all right. That works all right around big community centers like New York and Chicago and places like that, but you get down in some of our posts thirty or forty miles away from the nearest habitation and it just doesn't work. There is no one there to take care of them and there aren't any civilian doctors around there. We will probably have to care for them in the interest of humanity. Well, that is what we are doing and we are going to keep on doing it. I am not talking about regulations; it is a matter of judgment.

Question: Hospitalization: Reference is made to WD Memorandum W40-9-43, 6 March 1943. May additional general hospitals who have outstanding men in the specialties designated be added to the list of hospitals mentioned in above memo? If not, what is the attitude toward permitting these hospitals to handle the casual cases that may develop in the mentioned specialties.

Answer: WD Memorandum No. W40-9-43, 6 March 1943, has been rescinded and WD Memorandum No. W40-14-43, 28 May 1943, substituted

therefor. It is believed that the new memorandum clarifies the questions asked. It is possible that at a later date additional hospitals for specialized work may be added.

Question: Hospitalization: It is the opinion of the Medical Branch, Headquarters Eighth Service Command, that no bed credits at general hospitals should be given to station hospitals. The service command should transfer suitable cases to general hospitals under their jurisdiction or obtain authority for those located in other service commands.

Answer: Bed credits at general hospitals for station hospitals were set up as a means of decentralizing the authority to transfer cases to general hospitals, and by placing the authority to make the transfer in the station to shorten up the time lost in obtaining authority to make such transfers. It is believed that the delay in transferring cases requiring general hospital treatment to general hospitals has been largely eliminated by the bed credit system.

COLONEL HART: We put the question in because in taking up the patients that were transferred from the station hospital which we had no knowledge or control of, many were found to be cases which should not have been transferred. I checked one hospital which had 26 from one station; 22 should never have been transferred. Most of them were transferred for C.D.D. only. They should have been discharged at the station as easily as they were at the general hospital. I don't think any time is lost when requesting the proper transfer of general hospital cases.

COLONEL JONES: The question of bed credits at White Sulphur when they carry on maneuvers in the mountain area down there - I don't know whether that has come up to you or not.

COL. OFFUTT: The Ground Forces Surgeon recently approached me and has promised to give me the necessary information. We will have to make some bed credits available to them at White Sulphur and Woodrow Wilson, both in that area, to cover that maneuver.

COLONEL JONES: Also, at other hospitals over in West Virginia when it opens up this fall.

COL. OFFUTT: At Martinsburg, you mean? Yes.

COLONEL JONES: That is right near the area.

COL. OFFUTT: Yes, it is in the area but it may not be ready at the time maneuvers start.

With regard to Colonel Hart's statement in regard to patients transferred that shouldn't be transferred, I would like to

ask Colonel Hart if he doesn't think that matter should be controlled by a service command directive pointing out the types of cases you desire, or that you feel are being improperly transferred.

COL. HART: We are attempting to correct it by the use of consultants who are checking up on the transfers received at general hospitals and called it to the attention of the post that transferred them, but that is going to be a continuous process. Many will be transferred to general hospitals which should have been kept at the station hospitals which are well equipped now. Some of these hospitals have 2000 beds as well equipped as general hospitals. Special cases, of course, will have to be transferred.

GENERAL LULL: Another question: Recommend that boards on insane patients as prescribed by AR 600-500 and AR 600-505 be discontinued for the duration due to the fact that they serve no purpose now.

COL. OFFUTT: The question of boards under AR 600-500 is a matter for Professional Service to answer.

AR 600-505 applies only to cases which are transferred to St. Elizabeths Hospital or other hospitals under the Federal Security Agency. It is not necessary to hold a 600-505 board unless the patient is to be transferred to one of the above-named hospitals. Under the present law pertaining to veterans of the present war, it is anticipated that few cases will require such boards.

GENERAL LULL: This will be referred to the Professional Service for answer as to the 600-500 boards.

Question: Hospitalization; Recommend that form 40, Certificate of Disability for Discharge, be simplified by elimination of some of the data now required as it serves no useful purpose.

Answer: This question does not state which data are to be eliminated. It will be necessary to have the views of the surgeon of the Eight Service Command as to which parts are considered nonessential.

COL. HART: I'll send you in a revised form as soon as I go back.

GENERAL LULL: I think it would be a good idea and would let us work on the suggestions for a revised form. I might say that if any other services or service commands have any ideas as to the revised form, we might get opinions from all of you if you have any ideas about it, and combine them. That is something that will have to be coordinated with the Statistical Section and The Adjutant General, too.

Comment: Another thing is the question if we could have that form revised so that it would cover 600-500 cases, too, so that we wouldn't have to render two reports. That would cut out a little labor.

Answer: That might be done.

Question: Accomplishing C.D.D.

Under changes 4, AR 615-360, cases requiring CDD are to be transferred to station complement. Air stations do not have station complement. Should all station hospitals establish a Detachment of Patients or assign these cases thereto? The C. O. of the detachment could then initiate the Form 40, saving several days' time, completing disposition.

Answer: The office of the Commanding General, Army Air Forces, advises that there is a station complement at air stations. It is not believed necessary that station hospitals should establish a detachment of patients to assign cases requiring CDD action to. Recent changes in AR 615-360 require that action be expedited by the commanding officer of the station complement.

GENERAL LULL: I think that was discussed yesterday, and at some places where it has already been done that they have transferred immediately to the station complement or other detachment of patients of the hospital.

Comment: The objection to transferring to the station complement is you have to count them against your strength.

Comment: Well, they may be transferred to the casual detachment at most of these big camps. They have casual detachments all right.

We had 300 or 400 in that detachment.

Comment: Well, that is all right; their papers could then be accounted for and closed by the commanding officer of the casual detachment.

COL. OFFUTT: This matter was written up in The Adjutant General's Office, but I rather got the impression that what he meant by station complement was the casual detachment of the station complement. In other words, their idea was to get the man out of the field organization and have him in the station where somebody could be responsible for his records and make it possible to hold the commanding officer of the service command unit responsible for expediting the action on the Form 40 rather that having the hospital chasing the field unit around trying to get the papers completed and away from them.

Question: Hospital Facilities for WAACs.

If station hospitals do not have wards for female persons, is use of civilian hospitals justified?

Answer: When station hospitals do not have wards in which they can take care of female patients, if the anticipated number of WAAC patients will justify construction, it is recommended that they request an additional ward or else that one of the wards in the hospital be modified for the use of WAACs and other female duty personnel. It is not anticipated that WAACs will be at many stations where there are not nurses and for which the necessary hospitalization for some female patients would ordinarily be provided. The Fiscal Division advises that WAACs may be hospitalized in civilian hospitals as an emergency matter when suitable hospitalization is not available at the station.

COL. OFFUTT: I took that up with the Fiscal Division and they said they would pay the bill if it was an emergency. If you have no hospitalization at the station, they can be placed in a civilian hospital.

COL. GIBNER: In Kansas City there were 1500 WAACs going to the radio school, and no hospitalization.

COL. OFFUTT: They should have been authorized hospitalization in a civilian hospital when necessary.

Question: Specialized treatment.

Are all special cases (amputations, NP-blind, etc.) to be transferred to general hospitals designated for such treatment, or should local facilities be utilized to fullest extent?

Answer: All major amputees will be transferred as early as practicable after the primary amputation to general hospitals designated as amputation centers for revision of stumps or fitting of prosthesis (S.G.O. Letter No. 91, 26 April 1943). Patients requiring specialized treatment and whose disability was incurred in the Continental United States will be treated in the general hospital to which originally transferred unless, in the opinion of the commanding officer of the hospital, adequate facilities do not exist for their proper treatment, in which case they will be reported to The Surgeon General for transfer to designated specialized hospital. (Memorandum No. W40-14-43, A.G.O., 28 May 1943).

NP and blind cases will be transferred to general hospitals designated for such treatment.

GEN. RANKIN: Could I say a word about that? I just had a letter this morning from one of the consultants in the service command asking that question over again and I don't think there is any misunderstanding among you gentlemen as to just what that circular letter meant. You have Neurosurgical centers in each one of your service commands. You don't have chest centers, but you don't have chest cases. You don't have plastic centers, but you don't have many plastic cases. I dare say those people are being taken care of perfectly satisfactorily in any of the hospitals that they are assigned to. However, I do know that in certain places orthopedic men are doing nerve suturing. And I think that we're going to have to have some adjustment in a matter of neurosurgical cases associated with compound fractures occurring in the command as well as battle casualties because 15% of the battle casualties of extremeties are associated with peripheral nerve lesions. I don't believe we ought to allow those cases to be taken care of by anybody but neurological surgeons if it is at all possible to get a neurological surgeon. I don't mean that you ought to send every fracture with a nerve injury to some general hospital in your own service command, but I think it depends a good deal upon the character of the case. And I think we will get into trouble if we, for instance, allow orthopedists to do a lot of these nerve cases, and I think, on the question of skin grafting now, burns are going to raise another question. We are going to have to be conferred with and are going to have to stand a lot of pressure in plastic surgery. Because as you know, taking care of burns now, they are frequently grafted in from 7 to 10 days. I believe that just because a man has one of these specialized things in a service command I don't believe any of us would want to keep him in the hospital in which he originally went. But that is what I am trying to get at, all the service commands, I am sure, have enough specialized hospitals to take care of these specialized cases.

GENERAL LULL: Any question?

COL. BURNETT: Relative to General Rankin's statement about neurosurgery in station hospitals, there are a considerable number of severe cases of trauma requiring immediate surgery every week in all of our big station hospitals where we have what we consider qualified general surgeons. Now we have orthopedic surgeons and others there, but we haven't at these hospitals neurosurgeons and yet the very nature of the injury and the shock, the terrific lacerations that have occurred and destruction required immediate action on the situation. So that we have to rely on our local station hospitals in these areas to do the immediate work by our general surgeons necessary to prevent future trouble. And I assume that that is perfectly legitimate. I am sure that you can't do otherwise. In many of those cases, they can't be moved for a long time because

of special apparatus and a whole lot of things that go with the treatment. The longer you let them go the less chance they have of nerve recovery. But I think that is all right to do, the first man that sees it.

Question: Who will furnish the permanent medical personnel for hospital trains?

Answer: Manning tables are now in the process of being published on the basis of which service commands can requisition personnel to operate hospital trains assigned to their jurisdiction.

Comment: Now, that doesn't say where you are going to get them; that just says you can requisition them. You can requisition them and we will do the best we can to take them from one to the other. You give us an allotment.

Comment: General, You mentioned yesterday, I believe it was, you stated that The Surgeon General would designate the commanding officer to new named general hospitals.

Answer: That's right.

Comment: Further, I heard your comments about those below the commanding officers.

GENERAL LULL: Well, I'll tell you what we try to do, Colonel. We have here a list of our pool officers, and we try to give you a commanding officer and maybe an assistant commanding officer. We have done that in most cases. Then, General Rankin picks out of the pool any surgical material that he has available, the Medical Division picks out the key men of the Medical Service, and we pick out a medical supply officer available. We give you everything we have in the pool that is available for these new named general hospitals. Now, so far we furnished most of the staff, I think, for the general hospitals. We will continue to do it just as long as we have men available, because we realize that when you have a big unit opening up in your service command you can't man it from the service command very well. We want to continue to give you those personnel just as long as we have them available. As they come in, we evaluate what they are able to do and put them in a professional pool. We have them in our named general hospitals for preliminary training in a similar position in which they are going to occupy in a new hospital and then we make them available. Now the men we have in our pools right now are getting down pretty low of qualified men, but we have several general hospitals that are going to open up in the near future.

Comment: We have some out there in the Ninth Service Command due to

open by fall.

GENERAL LULL: We will try to furnish as well as we can with personnel. We have pools at Tilton, Billings, Lawson, Stark, one at Letterman, San Antonio (Brooke); we have about eight pools in general hospitals.

COL. OFFUTT: While we are on the subject, I had one matter I wanted to bring to the attention of the service command representatives in regard to these new general hospitals. In some of the service commands the chief nurse has had the idea that she could wait until the "86ab" came in to tell her how many nurses she needed at the general hospital. With the present situation of evacuating patients from overseas and not too many general hospital beds, the hospital is rarely well opened before we have to send a trainload of patients. To wait for the "86ab" would tend to make a shortage of the necessary nurses present to take care of the patient load. It is therefore suggested that the chief nurse in the service command try to have nursing personnel at the request of the commanding officer rather than waiting for a statistical report which may leave the nurses a week or two behind the patients. On two or three occasions this situation has forced us to put patients in hospitals where the commanding officer had only the chief nurse and one or two assistants and the patients were there before duty nurses were assigned.

GENERAL LULL: We try to put in when the hospital is under construction, long before it is built, a commanding officer to go there and we have told him, the ones who have been in this office, to keep us informed of what he needs - for instance, the first thing he needs is a medical supply officer - you need one very shortly, and he needs an adjutant - tell us when he wants the men sent in. Now, if he notifies us far enough in advance we try to pick out those men and get them in there ahead of time. He ought to have his dental surgeon in there before the dental clinic is set up. He ought to have a laboratory man in there before the laboratory is fully equipped because if the laboratory man is there he will see that the thing is put up right. He ought to have the chief of the surgical service there before the operating rooms are all fixed up. They can help him fix those things up. When the commanding officer gets in there -- sometimes we send him in there shortly after the ground has been broken -- now it is true that he doesn't have much to do for quite a time because he is just marking time, but he is there and there are a lot of things that he can do in that community while he's there - keep us informed of the men he needs and then we try to push them in to him, and he can notify us ahead of time when he needs nurses. That should be part of his duty to notify the service command.

COL. WALSON: Getting back to hospital trains a moment. This is getting to be a very troublesome problem to us of providing personnel for these trains. They are not designated as units; they have no home of their own. There is no way to provide them with a special hospital fund -- no provision like there is for hospital trains in the theater of operations. It seems to me that it would be practicable to put them on a table of organization basis like there is for hospital trains in the theater of operations.

Comment: I thought a hospital train was on a T/O basis.

Comment: No, they are in the theater of operations.

Comment: There won't be allowed a T/O unit in the United States. They have to operate on what they call a manning table, or something similar to that.

Comment: But it is a unit; that is no sign it can't have a fund.

Comment: We got a $200 loan from The Surgeon General to start ours off with. I hope it has been paid back.

Comment: It is a unit even if it has no T/O.

Comment: It is a company; carries a company fund. It is a hospital train company.

Comment: I don't know of any regulation that provides for a hospital train company for the zone of the interior.

Comment: We have had a lot of correspondence on this, and we have never gotten anywhere so far.

Comment: I think you can set them up now when this manning table comes out as a service command unit. Each one of your trains has a service command unit.

Comment: It will be a hodgepodge unit, but as long as you can set it up as a service command unit and have a company fund, that will help.

Comment: We can give it a service command unit number. I can appreciate that but still there is no provision for that personnel.

Comment: The manning table is coming out, though. The Planning Division has already sent it to the A.S.F. for approval. They don't call it a T/O. First we used to call it a guide and now they won't let us do that. Now they call it a manning table but it is all the same thing basically -- the number of people who are required to do a job.

COL. FRENCH: I would like to ask Colonel Offutt a question.

GENERAL LULL: Colonel French.

COL. FRENCH: I would like to know if the Provost Marshall General knows the capacity of the hospitals in prison camps.

COL. OFFUTT: I am not too sure that he has proper knowledge of them.

COL. FRENCH: Well, I'll tell you what happened at Forrest the other day. They sent 1600 prisoners in there; 50 who were sick, had to go to the hospital, and they had a 100-bed hospital. The next day the Provost Marshall General called up the commanding general of the post and told him he was going to send him 200 sick German prisoners in there. Now, they had 50 empty beds.

COL. OFFUTT: That was a matter I took up with General Bryan as I told you, and after a discussion that finally wound up yesterday, he has promised me that he is going to make immediate arrangements to have telegraphic information as to the number of vacant beds. I foresaw that just such a situation would occur and have insisted on his obtaining the information.

COL. JONES: The standard contract with colleges provides medical care. In the manual the complete dental treatment is included except inlay and bridgework. In the contract it provides only for the relief of pain. Condition of first-aid treatment. How will proper dental treatment be provided for these students? One student required fifteen fillings and the college authorities are requesting action.

Answer: The contract for medical service in the ASTP provides for complete medical care of any part which may be decided upon by the contracting officers and the University authorities. It is the desire of The Surgeon General that military personnel attending universities be given adequate medical and dental care. If the university obligates itself to give complete medical and dental care it must do so as long as the provisions of the contract are in effect, even though it must hire civilian physicians and dentists on a fee basis to do the work. AR 40-510 prohibits the employment of civilian dentists at Government expense for the treatment of chronic lesions, filling operations, prosthetic replacements, and other prolonged or extensive procedures, such as those required following the relief of an immediate emergency, until specific authority for such employment has been received from commanding generals of service commands. In the event civilian dentists are employed, the unit commander should forward the dentist's itemized bill, properly certified, to the service command headquarters serving the area in which the university is located. The service command headquarters will then prepare a voucher covering the bill and forward all documents to the appropriate Medical Department fiscal branch office. Someone has to certify that the service is not covered by the contract.

COL. JONES: The trouble with the thing is that the contract provides for relief of pain or acute septic condition or first-aid treatment -- that will mean what we have told them out there -- they would be responsible for temporary filling, extractions where necessary -- well, they are not satisfied. The standard contract that was sent out provided for complete dental treatment. There was a contract actually signed that only provides for relief of pain or acute septic conditions, and we have sent that out to them saying, all right. What we mean by that is temporary filling, and extractions where necessary, and I think that's all we should give them. You are going to have an awful dental bill if you don't. Here is an example of this, one kid came in the day he actually came to school for 15 fillings. Now just one other thing. It comes into this. The majority of these men have been at replacement training centers. They weren't given any dental treatment and came there needing

S. C. SURGEON: In the vicinity of St. Paul-Minneapolis we have 2000 students. There is little military dental personnel at Fort Snelling and can't take on an extra 2000.

S. C. SURGEON: Why can't you enlarge it?

S. C. SURGEON: I can't get the personnel.

S. C. SURGEON: Can't get dentists?

S. C. SURGEON: No, my allotment won't permit it.

S. C. SURGEON: There are so many dental officers spread over the service commands.

S. C. SURGEON: Yes, if I could get dental officers and equipment. If I could get enough dental officers to work them on a two shift basis. Can't even do that. They said at the dispensary that we had anything we needed including six dental chairs. Well, that matter of policy, I don't know how you are going to decide it. The men are all enlisted men in the Army. Of course, they are entitled to full medical and dental care, and I don't believe you can hold a university responsible. You can hold them responsible I think if they sign a full year medical contract. Coming back to spectacles why not have universities fit glasses and give prescriptions to the Army to get the glasses? They've all agreed to that. That's all right, so long as it is clear in the agreement.

COL. ROBINSON: Anything that is clear in the agreement is perfectly all right. It might be well in one of the contract revisions for you to insist on the contracting officer's putting some of these statements in there, so it will be clear. We must remember that these bills must be passed by the Comptroller General and the General Accounting Office.

S. C. SURGEON: Does the Navy do it?

GEN. LULL: I guess the Navy does it; I don't know. I expect to have Colonel Fitts over here tomorrow.

COL. WALSON: All sorts of contracts are being made; part-time and full-time contract surgeons, medical officers on full time and part time, also so much payment per man per month. There is also a great variation in pay.

COL. ROBINSON: Air students have to have a Form 64, which requires a stereoscopic view of the chest. There are universities right now that have run out of x-ray films (14 x 17 films). Where they are going to get replacements, I don't know. I suppose they will have to fight their own way through the civil supplies of War Production Board to get the replacements of their x-ray

all this dental treatment. We are going to have an awful load if we are going to hire a dentist to take care of those. If you have to start very expensive dental restoration you can't finish it at the training centers. That's the reason so many of them are not completed. They're doing it at Grant. He will be held only a limited period of time at the center, and they have to go whether you are finished or whether you're not. Well I wasn't thinking about the replacements -- I was thinking more of the fillings that they require. I know they can't do the replacements. Everybody in the camp wants to be under priority for emergency dental work.

COL ROBINSON: General Lull, may I make a remark on this specialized Army Training Program as a whole? There has been a great deal of leeway given to the contracting officers with regard to how they write the contracts, and it seems to me from a medical service standpoint we are going to have every possibility in the world. If an Army dispensary or Army hospital is in proximity to the school, I don't think there is any question but that that hospital or dispensary should be utilized to the utmost; therefore, that in itself will alter the provisions of the contracts or should alter them. Some universities, particularly the medical schools, should be able in their clinics and dispensaries to furnish complete medical and dental care. Most of them will very likely to be pretty far removed from Army facilities. As a consequence, to save money and pay the bill. In those instances, I am quite sure that it is the opinion of the Army Specialized Training Division that a lump sum, say so much per man a month for complete medical care, should be put into the contract. All kinds of things are going to come up. Do we consider spectacles are included in the university contracts to give full medical care?

GEN. LULL: That question was asked. Now we can go ahead and answer it.

COL. ROBINSON: Spectacles may or may not be considered to be part of full medical care.

ASFS: I wouldn't say so; I don't know of any ruling anybody ever made on it. What we have told them and what we are trying to do is to get the refractions made and prescriptions, send it in and purchase the spectacles from the Army Contract. The university has to fit them.

COL ROBINSON: Is that in accordance with the contract? The university contract provided for full medical care. I doubt you should do that for them. I don't think, however, there is a ruling on it. We are furnishing glasses as part of medical care now, as far as The Surgeon General is concerned. And therefore, if the university contracts do furnish full medical care, I think they should do it also.

films. It seems to me with a little coordination those boys could have been run through the induction station and got their films on the 4 x 5 films and saved all this film. It is a very critical item. I have advised the Air Forces to do this -- to work out a plan whereby they can run these boys through the induction station to use the 4 x 5 film. It is a fact that there just isn't enough film to go around.

S. C. SURGEON: There was a backload of those students, and overnight they had to do something with them. The result was they dumped them in these colleges without making any provision for knowing really what the colleges were. In fact, they had one in a college in Kentucky where there is no hospitalization in that town. There are only a few doctors there and still there is to be training with planes.

GEN. LULL: I don't know what they can do on that kind of thing. General Grant told me that he was out at Wright Field one time about a year or year and a half ago and saw a unit marching out. He said, "What unit is that?" They told him that it was one that wasn't supposed to be activated for two months. They had no directive to activate it; they had no medical personnel with it whatsoever. He finally got the medical personnel with it. They activated it two months ahead of time without any directive. These Air Corps training schools don't come under the Army Specialized Training Program. They do to some extent. Well, I think we can handle it by getting some uniform contract for a basis. If the Army Specialized Training Corps is going to handle all schools we will get some uniform contract basis. But, if the Air Corps is going to handle those alone, not Army Specialized Training Program, we are never going to get to first base. They must be under one head. We will take that up with Colonel Fitts when he comes over and see what we are going to do about it.

Question: Request information of action being taken to provide service commands with initial supplies and equipment for newly activated installations in the zone of interior.

Answer: The present procedure is to forward copies of requisitions for initial equipment for newly activated installations to the commanding officer of the new installations through the distribution depot. The engineer and the district engineer receive a notice showing installation items. A copy of this letter could be sent to the commanding general of respective service command if desired.

COL. ROBINSON: General Lull, you are going to have Colonel Hays up tomorrow. We should wait for him to elaborate on that question.

S. C. SURGEON: The first two questions are spectacles and dental care applied to the WAACs.

COL. ROBINSON: Yes. We are doing the same thing for members of the WAACs as for military personnel insofar as medical care is concerned.

Questions: A number of stations still report difficulty in having requisitions for artificial teeth filled. The matter of supply and equipment for the large station prosthetic laboratories should be reviewed. The present allowances of the more critical materials such as acrylic and teeth is not sufficient. Many stations report that their allowances of both straight and angle handpieces have not been received.

Answer: Teeth are stocked only in one depot to keep our dispersal loss to an absolute minimum. Over two million teeth have been issued within the last three months. About 300,000 teeth were received from the contractor on 5 June. At present, the depot has about 400,000 teeth on hand and has back orders for 87,000 posteriors and 7,000 anteriors. Within the next two weeks stock should be available to take care of these back orders.

The two equipment lists involved in supplying various Z/I installations with dental equipment and supplies for laboratory work are 9N175 Central Dental Laboratory and 9N281 Dental Laboratory, Camp, Z/I. It is the opinion of the Dental Division, Professional Service, S.G.O., that item 56120 Teeth, Vulcanite, appears in these lists in sufficient quantities to properly take care of any station in the zone of the interior. There are sufficient teeth in the Central Dental Laboratory to provide approximately 6000 dentures, and in the Dental Laboratory Camp, Z/I, to provide approximately 3600 dentures. Likewise, there is sufficient denture base material in these lists to adequately provide for the needs of the installations concerned. In the Central Dental Laboratory there is sufficient acrylic to make approximately 14,600 dentures, while in the Dental Laboratory, Camp, Z/I, equipment list there is sufficient material of this kind to make approximately 4,600 dentures. It is the opinion of the Dental Division that all supplies appearing in equipment lists are adequate, that proper provisions have been made for obtaining additional supplies by means of requisition whenever circumstances indicate, and that difficulty in obtaining supplies is a matter of production and procurement rather than of initial allowances and distribution. This is particularly true of the above-mentioned items. Additional quantities of pink acrylic have been purchased and the general condition of this item will be good by the first of September.

With regard to handpieces, the situation with respect to the straight handpieces is such that stocks should be adequate within one month for all needs. With respect to the angle handpieces, the situation is improving. However, stock

conditions will probably not be good until sixty to seventy-five days will have elapsed. Every effort possible is being made to expedite delivery of quantities now under procurement. Such quantities, when delivered, will be adequate.

COL. ROBINSON: I don't know that I can add much to that, General Lull. I do know this, that the dental supplies are receiving all the attention and all the force that our service can give them, and that isn't anything new. I mean the matter has been receiving a lot of attention for a long time. I don't think there is any question but what the situation will improve, even if we have to freeze the country's supplies to get it.

S. C. SURGEON: We have had other complaints about dental equipment.

GEN. LULL: I guess more relatively than for any other single item.

COL. ROBINSON: I think we have. But I think the situation is going to improve.

COL. WILSON: Should not intravenous fluid and alkaline therapy be administered immediately preceding the use of sulfonamides when the patient enters the hospital, particularly if they are dehydrated and large doses are to be employed intravenously?

(a) Patients with infectious disease are dehydrated and, occasionally, acidotic on arrival in hospital. Use of sulfonamides, particularly sodium sulfathiazole and sodium sulfadiazine frequently cause renal irritation and even anuria because of the low solubility of these agents and their consequent concentration and crystallization in the urinary tract under such circumstances.

S.G.O. Circular Letter No. 17, 23 February 1942, does not emphasize the protective value of preceding fluids intravenously and the value of bicarbonate and other alkaline therapy immediately preceding chemotherapy.

(b) Note 2, page 2 of Circular Letter No. 17, 23 February 1942, states "The routine use of bicarbonate of soda is unnecessary in sulfonamide therapy. This applies wherever such therapy is recommended in this circular letter."

(c) The recent report of Gilligan, D.R.; Garb, S.; and Plummer, Norman, Proc. Soc. Exper. Biol. and Med., 52; 248, (March) 1943, and the editorial and viewpoint expressed in J.A.M.A., 29 May 1943, page 311, Prevention of Sulfadiazine Crystalluria, emphasizes value of bicarbonate therapy.

Answer: This office still believes that intravenous alkaline therapy should be given sparingly and cautiously. It should be given if at all, only in restricted doses to patients whose medical condition is familiar, with definite indication of need for alkalies. It should be noted that the editorial mentioned (J.A.M.A., 29 May 1943) refers to the oral use of sodium bicarbonate, which is another matter.

It is agreed that very sick patients, including those who show dehydration and will presumably receive large amounts of a sulfonamide should receive intravenous fluid promptly and repeatedly as necessary to keep up the daily intake to a satisfactory level. Alkalization of the urine is undoubtedly beneficial. It may be done by the oral use of sodium bicarbonate, or perhaps, with better results, by the intravenous use of M/6 sodium lactate (slowly given in amounts of 1 liter), which has been extensively used by pediatricians who report great satisfaction with it; it has recently been used with

satisfaction by certain hospitals in the Fourth Service Command. At the moment, however, sodium lactate is not on the Medical Department Supply Table.

GEN. LULL: Is there any discussion to that?

Comment: I would like to state, General Lull, that that question and several others in this group that you have for today belong to Colonel Freer, and he is available any time to come in. I talked to him a few minutes ago.

GEN. LULL: I don't know whether there is any discussion in this matter and whether you want to call Colonel Froer, whether the question and the answer as it will appear in the minutes will be satisfactory. If this is satisfactory, we will go on to the next question.

COL. WALSON: Is any change intended in current instructions concerning the treatment of gonorrhea of patients being hospitalized? S.G.O. Circular Letter 74, 25 July 1942, and Circular Letter 32, CS, recommend sulfathiazole and sulfadiazine 1 gram four times a day for five days. A rest period of five days and then a second course, similar to the first, is recommended. Since many training days are being lost in administering this low dosage to hospitalized patients who are under close supervision, it is believed that dosage of 2 grams immediately upon admission, followed by 2 grams in two hours, and 1 gram every four hours, day and night for seven days will result in a higher percentage of cures without causing any important increase in the frequency of toxic manifestations.

Answer: Changes in current instructions concerning treatment of gonorrhea patients in hospitals are being considered, but definite instructions cannot be outlined at this time.

COL. TURNER: We feel that the interval between courses can be reduced to three days, and it is contemplated that instructions will be issued to that effect. It is probable also that the recommended dose for hospitalized patients will be increased, but that the dose for duty status treatment will not be changed.

COL. JONES: How long will that require a man to be held in our venereal clinic where we put all of the selectees coming in? How many days?

COL. TURNER: For two courses. That would be 5 days for the first course, 3 days rest, then another 5-day course. We feel that they should be hospitalized if they are not symptom free after 2 courses. We hope that penicillin, which may soon be available, will materially shorten the treatment time.

COL. JONES: That will result in your holding them in your venereal clinic longer than we figured.

COL. TURNER: I don't see how we can help it. About 80 percent of them should respond to the first course.

COL. JONES: We set up a venereal clinic on the basis of not to exceed 10 days.

COL. TURNER: Except for a small percentage of the patients, they would fall into that class. About 20 percent of them will require longer treatment.

COL. JONES: It will overload us, I think, if you do that. That is we will get kicks about holding men so long in the venereal clinic. Ours have dropped down in the 5th Service Command. We built a venereal clinic at one place for the whole service command. Did it on the recommendation of our office. We figured roughly 10 days for the ordinary uncomplicated case. We finally got bed space up to 1250. We haven't been getting the selectees in, and we have turned that bed space back. We have run something like 10,000 through the clinic since we started it. They are averaging now about 300. The states are calling on us, have been after us to increase the numbers. We increased the numbers that they can send in in May, and still we are down below what we can care for. One objection -- one thing that we have run into is this, the service command will allow us to send syphilitics only to replacement training centers. In other words, a lot of our selectees go direct to combat troops, but we are allowed to send syphilitics only to replacement training centers. The induction of syphilitics has to be governed by the number that can be sent to the replacement training centers. That has held the numbers down that we can accept. The average stay in the clinic for the syphilitics is 6 days, and for gonorrhea patients 9 days. As I say, we have run something like 10,000 through the clinic. We had a backlog of the chronics when this thing started. They finally put the heat treatment machines in Billings General Hospital, and they are gradually being cleared up. We have only about 25 or 30 of those left now.

This new regulation permitting inductees to go home for 14 days and then later for 21 days is going to add to your venereal load. We have done everything we can to get these men to come right in and take their treatment and then get their furlough, but only about 60 percent agree to come in immediately. We have done everything we can to get the remainder, but they won't do it.

COL. TURNER: The Surgeon General's Office has made recommendations on three occasions that these patients be held legally. The last one

was made about two weeks ago, and I believe we may get concurrence on that. The probable plan will be to hold them in the induction station, or under the jurisdiction of the induction station for two weeks, and allow those with infectious lesions only one week's furlough. But that has not come through officially yet.

Comment: I don't believe we'll get it; it's in the law. It's in the Selective Service Act too.

GEN. LULL: I think it's only a regulation.

COL. BURNETT: May I say something on that? As Colonel Turner knows, this subject is right near my heart. On the 16th of March I wrote a letter to our commanding general, 3rd Service Command, through the Director of Supply and Service Division. I stated that a telephone message this date from Camp Lee, Virginia, states that since the venereal disease treatment section of Camp Lee has been receiving patients, 16 gonorrheas were allowed the privilege of a furlough for seven days at their homes -- the same as any selectee, free of disease. If this is a common practice, as the induction office of this headquarters informs me it is, and if it is allowed under induction regulations, it is a nullification of venereal disease control, and in my opinion is a violation of most state laws prohibiting travel of individuals with transmittable disease. This practice, affording widespread opportunity for spread of venereal disease in the civil population, is in my opinion reprehensible and a menace to the public health, especially if it is allowed under Army and induction station procedure. The methods of the Army and public health authorities are supposed to control venereal disease and not spread it. If the regulations allow it, they should be changed at once. We are fighting venereal disease from one angle, and spreading it from another. It is urgently recommended that no individual with acute venereal disease be allowed the 7-day furlough privilege, but that each individual be sent at once to a reception center and controlled enroute. Now, our procurement section, the induction people said this: "Paragraph 16a, Army Regulation 615-500 directs that inducted men whoso desire will be given the opportunity needed after induction to return to their residence to arrange personal, financial, or business affairs. It is the opinion of the undersigned that no exception can be made unless the regulation is modified so that venereals can be shipped direct to reception centers immediately following induction. Now 87 percent of our individuals with venereal disease refuse to go to reception centers before they have their furlough, and we consider 67 percent of them infectious. The Surgeon General has been so much interested in this that he sent out on May 10th an information request on what we considered the proportion of these cases that are infectious. Now, the furlough has been

increased from two to three weeks, I'm not sure which yet; it was to be two, then three, and we have three weeks for these young men or older men to go back. Unless that induction paragraph is changed, you can get the picture of thousands of these men distributing themselves in communities all over the United States. We're spending millions of dollars trying to pick up infected women and control prostitutes, and at the same time we're sending them back into communities the very disease which we're trying to control through the women. And if that's not a misapplication of effort and a violation of all public health methods, I don't know what is. When they get back to the reception centers for treatment, they are in all stages, semi-cures, chronics, or complications. I have talked with many of them. They had patronized quacks and drug stores. Now that is a hit and miss proposition that we're allowing, and I think that we're responsible for correcting it. I was interrupted there, but I believe that it is not in the law; it's a matter of regulation that they're given a furlough.

Comment: It's paragraph 16; it's Army Regulation 615-500.

GEN. LULL: That can be corrected administratively.

COL. BURNETT: We tried to get a regulation through locally, to have these men sent directly through order of the commanding general, but the induction people said we had no authority to do that under the law, under the regulations.

Well, we haven't done a thing about it so far. I recommend that it be done but nobody will act.

GEN. LULL: I think that that is being corrected at the present time.

COL. TURNER: We hope so, sir; we're absolutely against the present practice and believe it's in violation of AR 40-210.

GEN. LULL: We'll hear from that later.

COL. WALSON: Is it desired that the Second Service Command Laboratory continue to submit monthly report of the actual number of each type of test or examination performed? On several occasions inquiry has been made in the transmitting indorsement to these reports relative to the foregoing without reply thereto.

GEN. LULL: I take it this refers to the monthly report of laboratory work done, submitted by the Second Service Command. How about that Major French?

MAJOR FRENCH: Yes, sir, that's what we inferred -- that it was the question of a monthly report, and we felt, as the answer indicated, that it should be continued because that is the only manner in which we are able to judge the volume of work from the laboratory and the personnel, supply, and equipment needs. We keep fairly close touch with those laboratories, and that's our best method for so doing.

GENERAL LULL: I will introduce into the records at this time a memorandum signed by Major French, directed to Colonel Bayne-Jones, relative to this report. I won't read it, but it's to the effect that they desire the report. That will clarify the answer.

SPMCE AJF/le

14 June 1943

MEMORANDUM FOR: Colonel S. Bayne-Jones

SUBJECT: Question for Service Command Surgeons Meeting.

1. The above should be continued to enable this office to intelligently comply with requests for personnel, supplies, and equipment.

2. As directed in AR 40-305, Service Command and Department Laboratories, "Special reports regarding the investigation of grave sanitary defects, epidemics, or other conditions that are seriously affecting or may immediately affect the health of troops, and monthly reports of work performed, will be forwarded to The Surgeon General through proper channels." No report other than a monthly report of the actual number of different tests performed is received from the Second Service Command Laboratory. This is therefore the only way in which this office is informed of the activities of this installation.

3. This report should be continued and simplified to include other activities as directed in AR 40-305.

A. JAMES FRENCH,
Major, Medical Corps,
Assistant.

GENERAL LULL: The next question from the Fourth Service Command, question number 117:

Question: What is to be the extent of the Industrial Hygiene Medical Service as to medical care for civilian employees and their families, both at Government-owned and operated plants and at plants operated under contract?

Answer: With respect to employees in Army-operated industrial plants,

it is the responsibility of the Army as an employer to provide the following:

a. Emergency relief and after-care for service-connected injuries, the latter through the U. S. Employee Compensation Commission.
b. Emergency relief for illness or distressing symptoms occurring during the work period. Temporary or emergency care is given for the purpose of avoiding loss of man-hours of production.
c. Safe and healthful working conditions.

The Army has no responsibility for the medical care of families of employees, except in those few instances where the War Department policy concerning "remote" places is in effect. It must be recognized, however, that inasmuch as industrial employees and their families are frequently domiciled upon the military reservation that situations occur from time to time that have to be dealt with as they arise. Problems concerned with sanitation, water supply, waste disposal, and the control of communicable disease present themselves and occasionally severe illness, which must be dealt with at least on an emergency basis. It is believed that there is sufficient provision in the regulations to cover these situations, but it is inevitable that with the rapid expanse of these plants and the new conditions which prevail, conditions will arise which cannot always be foreseen and have to be dealt with on the basis of necessity and common sense. With the respect to contractor-operated plants, the Army has no responsibility other than to see that the contractor satisfies his obligations in a reasonable manner with regard to providing safe and healthy working conditions and adequate medical service in the plant.

Comment: That's the point. Some of our installations are remote, and a great many of the families of the employees are domiciled right on the reservation. We don't have the doctors. We can't get it done fast enough.

Comment: This thing has come up, especially with reference to one or two industrial plants. Colonel Lanza will confirm this. We have the families and no medical treatment available, and we've just got to do something about it to protect ourselves. However, most of these plants are in industrial areas where the families can get some treatment locally, but there are some where they cannot get treatment locally.

GENERAL LULL: Yes, I think the answer is not clear about after care. Isn't that turned over to the Employees' Compensation?

COL. LANZA: Yes, sir.

GENERAL LULL: It calls for what local facilities after?

COL. LANZA: We try and send them, as you know, to Marine hospitals or other designated places, but at some of the places you've been talking about we have to give them after care locally. There is no place to send them. Ordinarily, after the first-aid treatment, so-called, is given, they become wards of the Employees' Compensation.

GENERAL LULL: I think that should be corrected because if it remains as being answered it shows after care.

COL. FRENCH: What is the policy with respect to medical inspectors? Are they to be Medical Corps officers or Sanitary Corps?

Answer: It is the unqualified opinion of the Preventative Medicine Division that the post of medical inspector is a professional activity and that the medical inspector should be a Medical Corps officer. In addition to general medical training the medical inspector should be specifically trained in the knowledge and control of communicable diseases, medical and technical aspects of sanitation, and in all phases of preventative medicine. Sanitary Corps officers do not have the basic training requisite for medical inspectors. They should be used in the fields of their special technical competence.

GENERAL LULL: I think that has the backing of all of us -- that a medical inspector is a medical man. Now, we have a lot of valuable assistants and specific inspections which should be done properly by Sanitary Corps officers who are well trained for it, but the medical inspector should be a medical man.

GEN. SIMMONS: I'd like to emphasize what you have just said and to ask this conference if it would not be advisable to formally set down minimum qualifications for medical inspectors. Just as we have in your headquarters at the present time, consultants on medicine and surgery and various other specialties who are from the nature of their jobs picked as outstanding, highly qualified men in their specialties, I feel that the medical inspector should be a highly qualified, well-trained man not only in epidemiology but in sanitation and all other branches of preventative medicine. I believe that if we could formulate minimum requirements for medical inspectors, and, if we are not able to obtain men with these qualifications, to take steps to train them, we could raise the level of health in our Army. The only thing that I would like to add is that we think this problem extends beyond the medical inspectors' position at the headquarters of the surgeon of the service command. It includes medical inspectors of posts and camps, which we feel is also a professional, medical job. There were two directives issued from service command during the year to the effect that to save professional manpower those medical

inspectors jobs would be listed as nonprofessional. I feel that that ought to be changed.

COL. FRENCH: The usual custom is to take some old fossil that doesn't know anything about surgery and medicine and make him your sanitary inspector on the post. Now, I agree with everybody that the sanitary inspector should be qualified as such, and that he should be a medical officer, but the way we're being cut down now, we've got to utilize doctors for taking care of the sick, or I'm afraid that we're just not going to have enough, especially well-qualified men to do much extensive inspection of the post and installations.

GENERAL LULL: I think that we could work out a compromise. The ideal situation is to have a medical officer who is qualified in sanitation, and epidemiology, but, in lieu of not having him, we ought to use whatever we can get, and I know that there's many posts where we do not have trained medical inspectors, large posts. We do not have enough trained men. That category is very short. Now we have tried. We have set up a training course at the Medical Field Service School for sanitary inspectors, but the most of these men are divisional Sanitary Corps inspectors or men from the tactical units, and here again the choice of selection in sending men corresponds to what Colonel French says about putting the old fossil on as the sanitary inspector. Some of them have been sent up to take this course, and have benefitted much by it.

COL. JONES: If you'll get out a directive, it will help the service commands, saying that medical inspectors should be medical officers. That's what we are up against.

Comment: All right, Colonel Jones, I'll make a note of that. We might get something out from this office.

COL. STONE: I'd just like to make a few comments on the relative importance of the job of medical inspector in some of the other professional jobs as far as it affects the whole command. Now, it is true that we have to take care of our work from day to day and ward patients, and the like, but there are certain conditions particularly in training units and in units where the housing isn't too good and during certain phases of the year when epidemic disease is present that unless the medical inspector is a medical man and can realize the potentialities of the situation, he won't be able to give proper advice or to take proper action. The surgeon himself will then have to carry the burden. Now, if the surgeon's job is such that he can carry the burden all the way on it, that's well and good, but if he can't, it's dangerous to have the responsibilities rest on a Sanitary Corps man who has no medical background. For instance, in our tactical units, you will recall last year, well, number one, in the First Division we had a situation that didn't work

so very well. Our personnel weren't well trained in medical inspection, and we didn't get the thing under control until they were practically overseas. Number two, the Second Armored Division at Fort Bragg had a dentist for a medical inspector, with three weeks' service, and we had over three thousand cases of bacillary dysentery. The organization was alerted for overseas duty and were actually held up because they were so poor in their housekeeping that they couldn't get by in this country let alone in North Africa or other places. Now, it is not only the handling of the specific situation, but it is to see that the organization takes on enough training so that they can take care of themselves. If they cannot carry out proper sanitation within this country, they will certainly be unable to in the theater of operations. Now in the South Pacific, the first word we get back from Australia is that our personnel don't know anything about sanitation, and for God's sake to give them adequate instruction in this field. We won't do that if we put in Sanitary Corps men as medical inspectors. It would be decidedly undesirable policy to put sanitation and preventative medicine in a subsidiary position in terms of personnel and to say that we can't supply these places because they have got to have internists and surgeons. I think one of the most important duties we all have is to protect the health of the troops as well as to treat the sick. There is one point about that - we have the interns and surgeons available, and we do not have men trained in public health. I think that the answer to that is that we should train them. Well, that's very true, but we haven't been very successful so far. We have made certain progress, but the interns and surgeons are already trained, and men in preventative medicine are not. I might add that the committee for General Simmons's information in drawing up the new recommendations as to the formation of the organization of the service command surgeon's office is taking into consideration the preventative medicine situation.

COL. WALSON: The only alternative under the circumstances it appears to me is to delegate either the surgeon or some other medical officer as a medical inspector in addition to his other duties in the smaller posts and assign as an assistant to the inspector, a Sanitary Corps officer. The medical officer in that instance would have to train his sanitary officer to do all the work that he is capable of doing.

COL. BURNETT: From the standpoint of the camp surgeon and the service command surgeon I think this is essential, that in dealing with matters of hygiene and sanitation and preventative medicine that we have in standing operating procedure of every camp and large station a medical section which covers all points concerned with the enforcement of sanitation and hygiene and preventative medicine.

I have seen that work very well when a commanding officer in

several camps stood back of that and everybody knew what was expected and the camp surgeon and medical inspector and one or two Sanitary Corps assistants were checking every week the details of this standing operating procedure to see if these points were carried out in the camps of that particular service command, and with very gratifying results. That's the only systematic way of handling it in camps and large stations and it can be done successfully, as has been demonstrated in several of our larger camps. The standing operating procedure of each camp, post, and station under regulations is required. That's gotten out by the commanding officer and there is a section in that standing operating procedure for the Medical Section. There should be, and that should deal with the details of preventative medical procedures in that camp; should outline the responsibility of each officer concerned, and the commanding officer's responsibility; should stress coordination, cooperation, and instructions of unit commanders and should allow the procedure of camp surgeons of that particular camp to have jurisdiction to go into the areas occupied by troop units, by field course units and cooperate with their inspectors to get results, formally or informally, and I have never seen it fail where it has been put on that basis. There has been no objection on the part of the division commander. But you've got maybe a dozen different types of units to deal with in a camp. You've got to coordinate it from headquarters under the camp commander and, if you have it in your standing operating procedure, you will have no confusion as to authority or method of procedure, and, if you don't have it, you will have everybody trying to do something in a different way. Now that can be done, is being done in a number of camps, was done very successfully to my knowledge at Camp Pickett, Virginia, with a great deal of wholesome enthusiatic cooperation on the part of all officers and commanding officers concerned. And then they know what it is, and you must explain these things in your camp newspapers, you must have methods of education as well as enforcement of regulations. That applies to your venereal disease control, too, and everything in your extracantonment sanitation of towns and villages; where the responsibility begins in the hands of the civil authorities; where the camp is responsible; where the civil authorities are responsible, and in that way you can get enthusiatic cooperation. It takes speeches, newspaper articles, personal conferences, inspections, and a standing operating procedure for the Medical Service for that particular camp or locality.

GEN. SIMMONS: I'm glad to hear you say that, especially your application of the necessity of an educational campaign, because after all, all we can do is to provide the facilities for sanitation, and the actual carrying it out is up to every individual in the Army, and I think all of us could profit by stressing this educational end of our jobs. Could I bring up at this time, General Lull, the point which was mentioned just now? And that

is the question as to the value of our arrangements with the public health service for extra military sanitation and for liaison officers. Is this the wrong time to bring it up?

GENERAL LULL: No, no.

GEN. SIMMONS: As you all know, this thing had its inception in what I think is a very sound policy. That is to supplement the sanitation and the disease control activities on our military reservations by the activities of civilian health agencies working through the Public Health Service and the work being done by State and local health departments, for certain reasonable distances around our military reservations. As a part of that scheme, we arranged for the Public Health Service to put in the headquarters of the Corps Area (now Service Command) surgeon an officer known as the liaison officer through which you are to channel your activities with the civil health agencies. So far, I haven't heard any definate complaints, but I have heard questions on both sides, both military and from the Public Health Service, as to whether this scheme was working a hundred percent. I'd like to throw that out for discussion. I feel that theoretically it should be the ideal set-up. I'd like to know if there is anything we can do to improve it, if it is not working.

COL. GIBNER: The liaison officer of the Public Health Service has his office within our group of offices, not ten steps away from my own. He furnishes us with a carbon copy of every report he makes on his trips to the various areas. We have a dividing line that everything that has to do with extra-cantonment sanitation we refer to him. Anything that has to do with the sanitation work in the station which comes to his attention he refers to us. There is very close liaison, a great many visits and discussions back and forth and we believe he has been of a great deal of value to us.

COL. BURNETT: The Public Health Service officer attached to our headquarters has done invaluable work, and he keeps the Third Service Command fully informed of the conditions generally, and we feel we couldn't get along without him.

COL. MOORE: We haven't done so well. The critical situation that we are having is with this. The South Pacific malaria is coming in. They are going on furlough, treatment was incomplete, and we found as awful lot of mosquitoes breeding down there in those irrigation canals in great numbers. I tried to see if we could get funds through Dr. Williams in Atlanta to combat it. I got nowhere and finally am going personally through Fifth District in San Francisco, and telling them that I had seen them in great numbers at Modesto, right in the back door of Hammond General Hospital. We finally persuaded somebody to get interested and the campaign has at last gotten underway, fully a year and

a half after it was first brought to their attention. We've had a great deal of difficulty in getting any Public Health Service funds for extra-cantonment combating of communicable diseases. I think each man that you have -- Public Health Service man that you draw -- makes a great deal of difference. We had a Dr. Harrison and he was top-notch.

COL. FRENCH: In the Fourth Service Command the cooperation is excellent. However, there are just two Public Health liaison officers there and they cannot cover the seven states to what I believe is 100 percent, as General Simmons stated. This service command operates practically the same as the Seventh Service Command. The cooperation has been excellent, and we send out with their liaison officer the medical inspector from my office. He usually accompanies him on his trips and by coordination between the medical inspector from my office and the liaison officer and then the local people, it is working very satisfactorily except in some of the smaller communities where they don't have health officers for the little towns. That is gradually being worked out though.

COL. WALSON: The Second Service Command is receiving hearty cooperation by the liaison officer, U. S. Public Health Service. Frequently either the sanitary engineer or the medical inspector makes surveys with him of local problems. I think it is very important that the liaison officers, U. S. Public Health Service, continue on duty in the service command surgeon's office.

COL. HART: In the Eighth Service Command the work is excellent. We have an excellent liaison officer. He and I visit periodically the State Health officers of the five states in the service command. He works in close liaison with the medical section in the office. I think we could not well do without him. He also is the head of the Ninth District, which coincides with the service command, which makes it much better for us as far as funds are concerned.

COL. REDDY: The First Service Command has had excellent cooperation from liaison officers and from the Public Health Service as a whole. Anything we have requested from the Public Health Service through our liaison officer we have always received very promptly. We have been very fortunate in having several excellent men assigned to us, and we now have a third man. I fear that the first two men we had really worked too hard -- they were on the road too much -- both of them broke down physically -- both were excellent men. The man we have now I think is a very fine man. I understand he is quite an authority on occupational hygiene in the industrial plants. He came from your laboratory out here, so I expect he will be a very excellent man too.

GENERAL LULL: Well, gentlemen, that seems to be an expression of opinion. How about the Sixth Service Command?

COL. HILLDRUP: I have been in this position for less than a month, and I haven't had time to evaluate the situation there. I have heard no objections, however.

LT. COL. TURNER: The main question has arisen, General Lull, over whether or not there is duplication of effort between the liaison officer and the man in charge of the Public Health Service district. This is very valuable information to us, and we are glad to have the expression of opinion.

GENERAL LULL: Could I ask you once more if anyone has any suggestion for improving this service that we might pass on to the Public Health Service by either the type of personnel or the channels to be followed. Well, now, for example, the Ninth Service Command has had trouble with this present incumbent -- do I get it -- is there anything about that which could be changed in the procedure that might help the situation? Except the individual of course.

Comment: I would suggest that this be given consideration by the service command surgeons and that a letter be written in to General Simmons if you have any suggestions. I believe that would be getting it down to a more concrete basis.

Comment: In this connection, would it be out of order to ask if this is a representative opinion of the group, if we could let the Public Health Service know that we are glad to have this service and that it is appreciated?

Comment: I think from the opinions expressed you can already notify the Public Health Service to that effect.

Comment: Because, as all of you know, we have had our periods of antagonism with the Public Health Service, but I think for the last six to nine months we have been getting wonderful cooperation on all levels with them. I think we ought to nourish that and cherish it.

LT. COL. TURNER: This question was discussed at a conference of Public Health Service officers, and they too were not sure of the value of this service, and I think they would be very pleased to have the expression of this conference group.

GENERAL LULL: I think it would be well, General Simmons, if, when the notes are written up on this meeting, you abstract the notes briefly and send General Parran the abstract.

GEN. SIMMONS: Could I delay you one more moment to ask you a little more about the trouble you had in the Ninth Corps Area. You said you were unable to get funds from Williams. Was that because it is out of their jurisdiction as far as the Budget is concerned, do you think?

COL. MOORE: Oh, no, I think it is throughout the entire United States, isn't it?

GEN. SIMMONS: Well, you know the budget cut them down to a certain arbitrary line beyond which they had to have special requests of some sort in order to get authority to work -- it wasn't the Mason-Dixon Line, but it was something corresponding to that -- see what I mean? But Williams has been cramped because of this arbitrary decision that he couldn't work without special request outside of a certain area in the South. Now I wondered whether that had something to do with your trouble there?

COL. MOORE: I don't believe so.

GENERAL LULL: All right, gentlemen, we can go on to the next question -- a question submitted by the 4th Service Command: Is the venereal disease program to continue as at present; that is, are specially trained venereal disease control officers to be assigned to each of the major stations?

Answer: Insofar as possible the venereal disease control program will be continued as at present. However, demands for venereal disease control officers in theaters of operations may necessitate the reassignment of specially qualified officers now assigned to service commands or larger stations. The time may come when suitable replacements cannot be made. In this event the promotion of venereal disease control activities will become a responsibility of medical inspectors.

I think that answer is clear enough. You will be furnished the men just as long as we have them and there are calls to send these men out to theaters of operations. And we have to pick good men to go to theaters of operations. In that case you will have to reshuffle the men in the service command if we take a man out of a big station or out of the service command, and it's just the same old story with the personnel -- we'll have to spread them a little thinner.

COL. FRENCH: Did that question come from the Fourth Service Command?

GENERAL LULL: Yes.

COL. FRENCH: I'll tell you why that was done. We had information that we were going to have eight medical officers. Well, we have three consultants and three medical officers in the headquarters, and there was a question as to just where we would use the other two -- whether the VD would have to go or the nutritionist or who.

GENERAL LULL: Well, that is a problem that I think will have to be thrashed out in every service command. They allow you only eight Medical Corps officers.

Question: Recommend approval of a policy requiring pelvic examination of all enrolled members for the particular purpose of detecting venereal diseases, upon arriving at duty stations from training centers, and such periodical examinations every six months thereafter. Special care should be given to make this examination rectally when indicated. This in addition to the monthly physical inspection required under section 3, WAAC Circular No. 1.

Answer: It is believed that such an examination would result in a great number of needless procedures and that the current regulations contained in WAAC Circular No. 1, sec. III, paragraph 2a, enables the local medical officers to order any type of physical inspection including a visualization of the cervix when indicated. In view of present regulations, it is thought inadvisable that an over-all order should be issued requiring a pelvic examination other than already provided for in regulations.

GENERAL LULL: Major Craighill will discuss that a little longer.

MAJ. CRAIGHILL: I'm at a little disadvantage because I don't know who made that answer.

GEN. SIMMONS: The answer was made while she and Colonel Turner were away.

MAJ. CRAIGHILL: I was going to say that this thing came up yesterday and that in physical examinations for acceptance pelvic examinations are required. Am I not right?

Comment: It's not being done.

GENERAL LULL: Well, they're going to be. For all members of the WAAC and nurses. Physical examinations are going to require pelvic examinations, whether or not the instructions are out. That was indicated yesterday. Now, if Major Craighill will enlarge on this a little.

MAJ. CRAIGHILL: I believe they're all going to be required. To date, pelvic examinations have not been required and those that have been done in most instances have been rather inadequate, with certain outstanding exceptions. Examination on going to duty posts is something that I'm very interested in, and I hope that some method can be worked out for it. I think it's important to get an examination after the WAAC has been in a month or six weeks. I don't yet know whether it is practicable and can be carried out.

GENERAL LULL: Any further discussion?

That will be something that will have to be looked into.

COL. WILSON: The idea is excellent, but difficult to accomplish with medical personnel shortage. There's a tendency to put more obligations on the Medical Department, service command, and at the same time decrease the medical personnel.

GENERAL HULL: The next question has some bearing -- I might read it. Recommend that the requirement now in effect in this service command for vaginal inspection and/or pelvic examinations prior to enrollment be put into effect in every service command and strict compliance be required.

Answer: This recommendation has been covered in the following recommendation sent to WAAC Headquarters recently by The Surgeon General's Office.

GENERAL HULL: If it has some bearing I might read this:

1. It is recommended that par. 24, Women's Army Auxiliary Corps (Tentative) Regulations, 28 May 1942, be changed to read as follows.

a. Pelvic examination will be made on all applicants of the WAAC, care being taken to make such examination rectally when indicated.

b. In addition to the conditions common to both men and women which are listed as causes for rejection for general military service in MR 1-9, the following are additional causes for rejection for service in the WAAC:

1. Pregnancy.

2. Infections or new growth involving female organs (the breasts included).

3. Congenital abnormalities or lacerations of the birth canal which in the opinion of the medical examiners are of such a degree as to cause incapacity.

4. Incapacitating menstrual disorders. (Amenorrhea per se is not a cause for rejection when secondary to menopause or surgery which was performed for a benign condition.)

5. Other gynecologic conditions which in the opinion of the medical examiners are disqualifying for admission to the WAAC. Colonel Turner, have you anything to add?

LT. COL. TURNER: Major Craighill and I have just come from Daytona Beach where this problem was a very serious one. They've had to CDD over 400 WAACs out of about 1700 passing through the center. The main disabilities have been gynecologic and psychiatric. We feel that it's not practicable to give a satisfactory

pre-induction examination in the ordinary induction station and that some mechanism should be set up whereby there would be a screening examination as at present, and then the WAACs sent to a few centers in the country where adequate examinations could be done. This is obviously more expensive, but we believe it would be good economy in the long run.

GENERAL LULL: We have here another question 122 which has some bearing on this. This is:

Question: Of what does the monthly physical examination required under section 3, WAAC Circular No. 1, consist?

GENERAL LULL: And the answer: Is this your answer, Major Craighill? There may be some discussion of this.

Answer: On 7 January 1943, the Office of The Surgeon General forwarded to the Commanding General, A. S. F., the recommendation in reference to the physical inspection of WAACs. The recommendation was as follows:

1. It is not considered practicable, at this time, to conduct routine periodic physical inspections of enrolled members of the WAAC for the purpose of detecting venereal diseases. It is, therefore, recommended that the following modification of AR 615-250 be published as a War Department or WAAC circular:

Physical inspection of enrolled members of the WAAC will be in accordance with AR 615-250, 24 July 1942, but with the following changes and exceptions, substituting the words "enrolled members" for "enlisted men" and "newly enrolled members" for "recruits." Par. 1(2) to be changed to read as follows:

(2) A careful investigation for the detection of communicable diseases and vermin infestation.

Par. 2 to be changed to read as follows:

2. Special.--a. In addition to the monthly physical inspection required by paragraph 1, the commanding officer, upon recommendation of the surgeon, may, whenever conditions warrant, order a special physical inspection of any enlisted man for the particular purpose of detecting vermin and unreported cases of venereal and other communicable diseases.

Par. 4a(2) to be changed as follows:

Special attention will be given to the detection of vermin infestation and incipient cases and suspects of communicable diseases.

MAJ. CRAIGHILL: I think that some form of monthly examination should be done but there's no uniformity in the method at present. It seems to me that the main thing is to work out a simple technique which will give valuable information with the least difficulty. I'm working on that problem. I don't believe it's satisfactory at present. Some of the posts are giving regular monthly examinations and going to a lot of trouble about it and getting very little information that's of value. I think it's a waste of time the way it's being done in most places.

GEN. LULL: You gentlemen will be advised of any decisions made in this office as to routine examinations of WAAC personnel.

COL HILLDRUP: How about using especially well-trained nurses to make this inspection?

GEN. LULL: How about that?

MAJ. CRAIGHILL: I would rather see it done by medical officers, if you're going to do it all.

Comment: I agree fully with that.

COL HILLDRUP: Well, there again you run into adding a lot of work onto an already overworked outfit and you're coming up against a proposition of subjecting some young ladies to an embarassing procedure which I think could be eliminated by the use of especially well-trained nurses.

MAJ. CRAIGHILL: I hope that we can put in some women physicians in some of the bigger camps, who will be able to do this job. I think it would be a waste of time to have nurses do it. I'd rather see it dropped altogether.

We hope to get the women physicians to place especially in the camps where there are large concentrations of WAACs. So far we haven't been very successful, but I believe that we will be able to get some who are well trained to put in the large places especially.

GEN. LULL: Another question that arises: Should prophylactic stations for WAACs be established?

Answer: The answer is no.

GEN. LULL: I think that's final. It needs no discussion. I mean that's against the policy -- the carefully thought policy of this office.

COL. JONES: What is the policy as to furnishing quick freezing equipment in general hospitals?

Answer: (1) A freezing microtome for frozen histopathological sections is included in the basic equipment of general hospitals.

(2) Freezing equipment, such as Stokes' lyophile apparatus and quick-freezing food compartments have not been included in basic equipment lists for general hospitals.

This wasn't for laboratories, for your pathological specimen; this was only for food.

GEN. LULL: This has nothing to do with the laboratory at all; it was quick-freezing for food, but that is not included. As a matter of fact, that should not come up in Preventive Medicine Division at all.

GEN. LULL: Colonel Howe is here, if you want him to tell you.

COL. JONES: I know. This is purely a matter of supply.

GEN. LULL: What is the policy as to establishing prophylactic stations in cities where no troops are quartered, such as Cleveland, Charleston, Cincinnati, which are junction points, and a large number of men may be passing through or on leave?

Answer: AR 40-210, paragraph 23b(2) states that prophylactic stations will be established in locations which will permit of their maximum availability, whether this be on posts or in civilian communities visited by large numbers of troops on leave.

I can see that there's going to be some difficulty in regard to personnel. If it's in a city where recreational facilities are utilized by a given camp or post, you could use personnel from that camp or station, but I don't know what you are going to do about these stations.

COL. HILLDRUP: I'd like to ask a question at this point. What is the consensus as to the value of prophylactic stations off the post? I recently asked for a report on the prophylactic stations operating outside of camps in the Sixth Service Command, and I found that the average number of prophylactics given was less than 20 a month. Now, if we've got to maintain them for numbers like these, it's a loss of time and money and effort, and manpower. Now, I, for one, don't believe that they're worth maintaining except in special instances. We have found in certain areas that prophylactic stations for colored troops are fairly well patronized, but we have them adjacent to stations in the larger cities of the area, and they are not patronized, and the amount of work done doesn't justify their maintenance.

COL. BURNETT: In 12 or 13 localities where there are no camps, posts, or stations, and where we have prophylactic stations, we have made arrangements to distribute individual prophylactic packets to fire stations and accident wards of hospitals and police stations, etc. The locations are being published so that troops in these localities where there are no prophylactic stations established will know where to go to get these, and the Provost Marshal in these areas is acquainted with and distributes that information. We bought 10,000 packets recently. They were bought and paid for through arrangements by the commanding general of the service command. The company commanders always buy them for the use of their own men. The commanding officers of the post usually have a small discretionary fund they can use for that purpose.

GEN. LULL: Company funds are used for it all the time now.

Comment: Well, that's at camps, posts, and stations.

GEN. LULL: Yes, that's right.

COL. BURNETT: Any place where you have a Provost Marshal or a Military Police company, of course this situation can be handled all right. It's just in the place where you don't have them.

LT. COL. TURNER: I'd like to comment here, General Lull. We feel that perhaps two-thirds of the prophylactic stations could be closed up without affecting the venereal disease rate. We do believe they should be continued in large centers and cities near large camps and particularly for Negro troops. We believe the mechanical prophylactics, the condoms, are really playing a much larger role in cutting down the rate. We're also hoping to get a more satisfactory packet -- a one tube packet. We are very much interested in the experiment that Colonel Burnett is carrying out in Baltimore. It may prove to be the best solution to the problem.

COL. BURNETT: Might I say, from observation and study of this question in camps and stations, not only as service command surgeon but as camp surgeon, that I believe the immediate use of this Wyeth Packet is a far safer and a far more effective method than the old administration of solutions with its questionable technique. I feel that a good soap and water scrub plus the use of a packet is of very much more value than the administration of some of our standard prophylactic procedures. It is without danger, without risk, and without the effects of trauma and mistakes of solutions which you not infrequently see.

GEN. LULL: I think we all realize the shortcomings of it, but we're simply doing the best we can. The next question:

COL. JONES: How soon will form 140 be available?

Answer: When an additional supply is received from the Government Printing Office. Requests for supplies of this form should be sent to the St. Louis Medical Supply Depot.

COL. JONES: That doesn't tell us when, though, does it? Have you any idea?

LT. COL. TURNER: They have ordered from the GPO. They should be available very soon.

GENERAL LULL: They're on order; they've been approved and on order.

COL. JONES: How far should we go in approving projects for treatment camps established by states? That is venereal treatment camps, I take it.

Answer: The determining factor should be the demonstrated need for such facilities is the answer given.

LT. COL. TURNER: We feel that it's a sound program to establish isolation hospitals, provided they're medical installations and not punitive installations. We feel that they should be backed up by the Army, but I'm not sure that that's going to do a whole lot of good. Their establishment depends upon getting priorities for materials.

COL. JONES: That came up in our service command, especially in Kentucky. We approved it down there, but before we approve one of those things the commanding general insists that we've got to say that it's for the benefit of the Army. He's right on that because we shouldn't approve something calling for the expenditure of Government funds when we don't know whether it will be a benefit to the Army. That's coming up in West Virginia right now, and they've been after me -- the liaison officer has been after me and the State Health officer has been after me -- and say they can't do anything unless we approve the thing. Well, I can't approve it. We haven't any troops in West Virginia. Now, the same thing is under foot for Colombus, Ohio. We might stretch our conscience a little there and approve it because we have troops in Colombus, but we can't do it for West Virginia. Now, they say they can't get it. The Public Health Officer was down here at the meeting last week or the week before; says we're blocking it. Well, we are blocking it if that's what they require. I don't see why they have to have it. If it's a thing that's needed for the public health, why does the Army have to come in there and approve it, before they can get the money for it? Now, what'll I tell him unless we do? What will I tell him there at Colombus when it comes up?

COL. HART: We are very much interested in having the medical facilities made available to states to incarcerate, not for a punitive measure but for treatment, those who are affected. We approved, over the signature of the service commander, their request for priorities and so forth. I think that those places that do not have troops, are important so long as your contact history shows a number of venereal disease contacts at a place. We are interested in getting affected prostitutes or non-prostitutes, or whatever you call them, treated and we do not agree that they should be put in jail. We think that way priority orders are given out now it is necessary for the service commander wholeheartedly to go along with the states in our service command in order to obtain priorities to build these hospitals or segregation camps, etc. We take it to be a direct furtherance of the war effort. The funds are given to them by the Public Health liaison officer and we have no trouble in getting the funds allotted. The only obstacle we have ever met has been the priorities to get the materials to build them. We have two or three. The money is there and has been allotted, the plans are drawn, and we are struggling now with the priority boards to get the priorities to build them. We have no trouble in getting public funds for the constructions of these institutions.

COL. JONES: The commanding general of the Fifth Service Command has been a little hesitant on it. This is a little different than many projects that were brought up early last year. Practically every little community that had anything connected with the Army within miles of it came in for increased hospitalization, increased water systems, sewerage systems. We just had to put our foot down on it. The commanding general just couldn't do it, and now this comes along the same line, and he is very leery of approving anything where Government funds are concerned when it is put in on his say-so as a benefit to the Army.

GEN. LULL: I think this is just one thing you have to evaluate. We have people come in or write in every week to me about getting personnel deferred to do research work for some project that is supposed to do the Army some good. I know that there are 4,421 young men working on the question of shock alone in the United States. They come here wanting to know about getting these men deferred because they are working on shock which will do the Army a lot of good when they find out all about it, and we just have to say we can't do it. We hope something will be worked out, but we can't defer the young men. Then there are projects, which Colonel Bayne-Jones for instance has approved under the National Research Council. We do cooperate in getting these men deferred. Every case has to be judged on its own merit, I think.

COL. WALSON: The Commanding General of the Second Service Command requires careful analysis of the project under consideration and the chief of the Medical Branch is very careful that he can support the project in question when he is asked to approve same.

GENERAL LULL: I think that is the way it'll have to stand. The project will have to be judged on its merits, and if it is of any military value he can put the stamp of approval on it.

The next question is 129: What is the responsibility of service command in Air Corps A.S.T.P. units? That question is brought up by the Fifth Service Command and I believe was answered the other day in that all Army Specialized Training Projects will be under one heading. Now Colonel Fitts is coming over here this morning and that will be taken up when Colonel Fitts gets here. Here is another one that I don't understand. Have each representative state tell how he is complying with the provisions of War Department Circular No. 59, 1943. I don't even know what that War Department Circular is.

COL. LANZA: That is one on industrial medicine.

COL. JONES: I wanted to see how the different service commands are complying with that. I wondered how you fellows were doing. We've got a War Department Circular out that is impossible to comply with and the general is on my back all the time. It had provisions in that Circular which are impossible to carry out, and I wanted to see if we were the only ones up against that kind of thing. How about it, gentlemen?

COL. BURNETT: In the Third Service Command we have some 24 Army Industrial Plants. We have an officer in the Third Division of our Third Service Headquarters and in my section and branch that does very little except check these plants. The people employed there number 107,000. We have contract surgeons and a few medical officers and Civil Service medical men on duty and nurses. Now, that Circular required pre-employment examinations which we are trying to do and which we are doing in most places carefully, and periodic checks which we are doing. It takes the time of 97 civilian nurses and 8 Civil Service physicians and 24 contract surgeons and 12 medical officers to keep track of these 107,00 and with them 843 military. It's a separate set-up really, and it requires an awful lot of work and continuous checks on the work that these contract surgeons do, and Major Schrader of my office does very little except continuously check all those plants and see that these examinations are carried out and the routine dispensary care is given and the proper medical attention is given, but it takes a lot of people to do it. Now the question brought in connection with this, as to whether this should be done in civilian-operated plants and the answer, I believe, the Colonel gave was no. It's

only Army-owned industrial plants that this work is done in. The service command has got a responsibility towards the Army-owned contractor-operated plants in that the service command satisfies itself that the medical service and its control of occupational diseases in the contractor-operated plants are being properly handled. It doesn't supply personnel to do this work, but it does check these plants at intervals of two or three months in order to satisfy the responsibility of the Army for a plant which is Army owned and which is a military reservation and which the War Department has held as responsibility of The Surgeon General's Office.

COL. GIBNER: The wording of Circular 59 in some places doesn't give us authority. As I remember it says that at exempted stations the service command will give advice on the request of the commanding officer thereof and we have been thrown out of one station. A representative of my office went down there and they said, "All right, we'll let you go around, but you can't make an official inspection."

COL. LANZA: Was that in a contractor-operated Army-owned plant?

COL. GIBNER: Yes.

COL. LANZA: Well, in writing up Circular 59 that point was discussed very thoroughly with General Hillman, and it was General Hillman who pointed out that the responsibility lay with the service commands and that the service command had the right to go into and inspect any military reservation within the geographical limits of the command any time it felt like it. That was their privilege and they could not be kept out. The wording of Circular 59 in that particular sentence refers to the asking for advice and does not refer to service command responsibility for inspections.

COL. JONES: One trouble the Fifth Service Command is having: We haven't done anything on Government-owned civilian-operated plants. You have a provision in there that we will make those inspections when requested. You also have in the Ordnance Article an inspection organization set up in Chicago. They go down there and inspect. We don't know when they are going or anything about it. If we go to butting into it, we are just tying things up. I don't think we have any business in civilian-owned plants. In fact, I wouldn't let our men go because I know what will happen to them. It's none of their business.

LT. COL. LANZA: I might say that actually for practical purposes the responsibility of the service command on contractor-operated plants is a very small one. It doesn't entail any great burden of supplying any of the personnel or of frequent inspections.

COL. JONES: What is the responsibility?

COL. LANZA: If I got one thing clear from General Hillman in the discussions occasioned by writing up this circular, it was that, in the last analysis, the service command has the responsibility inasmuch as they are military reservations within the geographical limits of the service command.

COL. JONES: The circular doesn't read that way.

COL. LANZA: Well, I don't doubt that the circular is full of imperfections or not full of them but has a good many imperfections that are more or less inevitable on the first writing of so complex a subject, and even within a reasonable length of time that the Circular 59 needs to be re-written or reviewed with certain alterations and corrections.

COL. JONES: When will that be done? That stands and that's what governs what the service commander works under, and you're giving us an impossible thing that he can't work under, and he wants it settled. That's what he wants. He told me that you don't go under those plans regardless of what this says. You also provide in there that you'll get contract surgeons. We tried to get out of this office more than once, the contract surgeons for these plants. Right down here, you say to get them from Civil Service. We have written to Civil Service, and Civil Service comes back and wants to know how many we want. We, advised them as to that, and also asked the salaries which should be paid. We have heard no reply to that, and that has been over a month. Now, we just can't get the contract surgeons to go in there. Then, what are you going to pay the contract surgeons when you put them in there?

GENERAL LULL: That question is coming up in a minute. I might answer it right now. I might insert here in the record the next question. Regulations authorize pay of full-time contract surgeons at the rate of $3404 per year, if married, and $1800, if part time. Letter from The Surgeon General's Office, dated 12 January 1943, states that Civil Service regulations provide pay for associate professional grade $3200, to $3800; full professional grade to $4600, according to the type of work. It would appear only P-3 (starting at $3200) or P-4 (starting at $3800) can be paid.

What schedule of prices should be paid?

Answer: This matter has been thoroughly discussed with Civil Service authorities and with the Civilian Personnel Division of The Surgeon General's Office. It is the understanding that these civilian physicians will be employed on the status of P-4, -5, and -6. However there are localities where the local Civil

Service office is using a manual published 23 years ago, and apparently do not pay sufficient attention to letters of instruction issued by their own department. In any instance that a local Civil Service office states medical officers cannot be hired on a status of P-4, -5, and -6, if the service command will communicate with The Surgeon General's Office, Attention: Occupational Hygiene Branch, this office will see to it that the Civil Service office in question gets correct instructions from Civil Service Headquarters in Washington.

COL. JONES: It isn't the local Civil Service that we are talking about, it is the Civil Service here in Washington that we've written to and asked, and these jobs are not equivalent to what those higher grades pay. They can't pay them those high prices for the amount of work they have to do under Civil Service regulations.

LT. COL. LANZA: May I comment on that, General Lull? We had a telephone conversation yesterday with the office of the Medical Director of the Civil Service Commission, who called up to say that they were issuing a letter again, a Circular Letter to all of their branches in the United States, calling their attention to the fact that for the purpose of supplying Army-owned and Army-operated plants with positions that these could be hired on a P-4, -5, and -6 basis. They also reiterated what I mentioned in the answer that a lot of these local places were using a manual that was written 23 years ago, and they've been told more than once that that has been corrected since. There's no question. We have gone to the top with the Civil Service people, and there's no question but that you can hire them for that because other service commands are doing it.

GEN. LULL: I think that one thing that probably can be done here is write a job sheet for P-4, -5, and -6, specific job sheet, because they pay a lot of attention to job sheets in the Civil Service. If a job sheet can be written defining his work and get the Civil Service up here to say that this is a P-4, -5, or -6, depending on the size of his job, and then send them out to the service commands, I think that we would probably get some results.

LT. COL. LANZA: Just three days ago, for instance, we had the same thing come up in Colonel Burnett's Service Command in connection with a Quartermaster plant in Philadelphia, and the local Civil Service people refused to employ the doctor on the basis that they had no authority. We called up the Civil Srrvice headquarters on the telephone, and they on the telephone issued instructions to the local people in Philadelphia to quit obstructing us.

COL. JONES: Local people said that they had nobody on the list.

LT. COL. LANZA: Well, that's true in a great many localities.

COL. BURNETT: In the Third Service Command, we've been able to employ three times as many contract surgeons as we have Civil Service, and they're hard enough to get.

COL. JONES: We haven't gotten any Civil Service, and we can't get full-time contract surgeons. We've got a number of part-time.

LT. COL. LANZA: The situation there, of course, is in the different situations in different parts of the country. I think in the Seventh Service Command they've been able to get sufficient doctors.

Comment: We have received a list of Civil Service physicians practically over the entire United States. The personnel officer at my office has gone over those records, and very few of them were acceptable in our opinion. It is difficult to get doctors on a contract surgeon basis, full-time, part-time, or on a Civil Service status, and a lot of them that are, if you get down and investigate, you will find that they have characteristics that makes them not eligible for service. I can speak very freely because I had at one time here to select Civil Service positions for the Panama Canal Zone, and in order to get two positions we had to go through 60 applicants, and we were forced to turn them down; we were supposed to take them from the top, and we had to have an excuse to turn them down, but they were undesirable, and many of them graduates of sub-standard schools, and drug addicts, just worthless individuals so we had a great deal of trouble. The Civil Service list is about exhausted as far as these professional categories are concerned.

Getting back to the inspections that the service command and industrial plants, that we spoke of a moment ago, we make an inspection of those plants at the present time. We haven't been thrown out of any of them. However, there is a phase in connection with all industrial plant inspections that I think should receive careful consideration. I refer to an inspection made by the service command, by the Chief of the Ordnance Branch in Chicago and by this office, The Surgeon General's Office. There have been instances where as many as three different offices inspected in one week, and the inspections in some instances conflicted. Now that's going to leave a bad impression of the commanding officer of that station. It seems to me that it ought to be correlated and headed up somewhere so that there's not a duplication or triplication of these instructions in the field.

LT. COL. LANZA: I want to make clear certain distinctions. We through our Army industrial hygiene laboratory in Baltimore make surveys of the Army-operated plants on an average of once a year or

maybe longer. The service command makes inspections in some service commands as often as once every three months. They like to keep in touch with their plants. The Ordnance makes frequent checks for a variety of reasons that have nothing to do with us -- mostly on the basis of safety and explosive hazards, and they have a large force of auditors who are traveling continually, spending days and days in all these Ordnance Plants. Now these auditors have caused some confusion themselves, for they sometimes get out of their own field and make recommendations respecting industrial hygiene and medical service. Strictly speaking, it is none of their business. Now that problem the Ordnance is trying to cure itself. Then on plants other than Ordnance we have the somewhat new activities of the Provost Marshal General, and we are trying to prevent undue duplication there. The PMG have asked me to be a member of several of their committees here in Washington. They themselves realize that there is a lot of confusion and a lot of reduplication, because they have thrown hundreds of men into the field as inspectors who have no background of Army experience. The other day I had a conference with Colonel Field and Colonel Miles at the Ordnance Safety and Security Branch in Chicago and made this suggestion that Colonel McConnell of the Medical Corps who is our liaison man in Chicago visit some of the service commands. He has already, I believe, been to the Second Service Command, and he was intending then to visit the Fifth, I believe, and the Eighth, and after he has visited the service commands, we would have a meeting of his office, our office, the office of the Director of Field Ammunition, and the representatives of service commands to control this matter of frequent inspections. On the other hand it must be recognized that speaking from the point of both the Ordnance authorities and the Chemical Warfare authorities, they would much rather see their plants inspected over frequently than under frequently. They are dealing with all kinds of hazards; they are continually confronted by the menace of catastrophe, and I don't doubt that they visit their plants continuously, and it's probably an irritation, but they probably think it is the safe thing to do.

GEN. LULL: Well, probably this thing will be straightened out. Yes, sir. One more question, by the Fifth Service Command.

COL. JONES: What price will we pay contractor for full-time contract surgeons when we know we aren't going to get them for Civil Service? What price can we pay full-time contract Surgeons?

GEN. LULL: Full-time contract surgeons can be paid the same as a first lieutenant.

COL. JONES: Well, you won't get them. That's a maximum of $284, isn't it?

GEN. LULL: Yes. I know that is a handicap. That's the reason we went into the professional group.

COL. JONES: Another question has to do with the employment of enlisted men at these plants. War Department letter states it is not contemplated furnishing enlisted men, Medical Department, for these stations, but civilians should be furnished. What are you going to do if you cannot get civilians?

Answer: In emergencies it is not probable that serious objections would be taken to the utilization of enlisted men until such time as civilian personnel can be supplied. That is provided that enlisted men are available.

GEN. LULL: When you get home you will find the famous circular that was put out by the Control Division that Colonel Rogers spoke about yesterday. After I left the meeting, I got ours. That ties you down to an over-all figure of so many people in the service command. Of this number, not over so many will be officers. The service commander can divide them up any way he wants. We just got ours yesterday.

COL. LANZA: The Civil Service Commission says that they are about to issue you authority to raise the starting salary for civilian nurses to $1800. Headquarters Army Nurse Corps furnishes us from time to time lists of available nurses. If nurses are needed in an epidemic locality and cannot be obtained, this office will endeavor to procure them elsewhere, if notified. We always have some who are rejected for some reason here, and if they haven't been utilized in industry you can make your initial employment wherever you want to.

COL. JONES: This is for the plants.

COL. LANZA: Yes, this is for plants. We can supply you with lists of rejected nurses whose defects probably will not cause their rejection for work in plants.

COL. JONES: Well we're doing that. But what we run into is the manpower question. I wonder why that couldn't be taken up with the representative of the War Department?

GEN. LULL: It could be. We ought to have a ruling on it. Get a ruling on it.

COL. JONES: Some ordnance depot infirmaries provide for large sterilizers and complete x-ray equipment. We have not installed equipment because some of them do not require it, and the ones that do will not have the personnel to operate them. Commanding Officers insist on the installation. What is the answer?

Answer: All requisitions for equipment on new installations, or unusual equipment, are referred to The Surgeon General's Office for approval and are routed to this office. Unless it is evident on the face of the requisition that the supplies are absolutely necessary or if there is any question that the requisition may be over ample. The matter is referred back to the service command for a detailed statement of justification. It is evident, however, from approval of industrial equipment requisitions that come from service commands from time to time, that the approving officer had no first-hand knowledge of the needs.

COL. JONES: They probably never go to the Chief of the Medical Branch -- that's the trouble, they never go to the Chief of the Medical Branch. I think that we can set up the machinery here to refer those things to the Chief of the Medical Branch.

LT. COL. LANZA: That's what we do.

GEN. LULL: In that way you get a crack at it.

COL. JONES: Well, the point I was trying to make on that is -- here is a depot that is set up in Louisville. It has all provision for all kinds of expensive equipment and there is no need for it there. We can't get anybody to operate it so what is the use to put it in. We build those infirmaries and equip them and can't get the personnel. You can't put in contract surgeons who are qualified to run your x-ray outfit. You can't get the civilian employees to go in there to do your developing and so on. And we are tied down on putting enlisted men in there.

GEN. LULL: This next question has some bearing on that. A letter, S.G.O., dated 7 May, states it is desirable to do complete x-ray chest examinations of all civilian industrial employees and that arrangement can be made with the Public Health Service to make the surveys. What is the policy when diagnosis of t.b. is made? Is there any follow up, and who makes it? What is the disposition of the films?

Answer: The answer in par. 6 of the letter referred to states that prior to the survey the medical officer in charge of the team making the survey will make a preliminary visit to the plant to make the necessary arrangements and determine how such cases of t.b. as may have to be removed from their job are to be handled. This is generally done through cooperation with the local or county health authorities. Tuberculosis surveys so far conducted appear to be very successful and have provoked only favorable comment. That is the survey team goes in and makes a survey. The follow-up is supposed to be arranged for before the survey is taken.

LT. COL. LANZA: May I make a comment there, General Lull? It came to our attention that these t.b. surveys were being made in our Army-operated plants not through any medical approach. The approach was made directly from the Division of Tuberculosis in Bethesda and to the commanding officer of the plant, who then went ahead and authorized these t.b. surveys without the acknowledgment of the post surgeon or the service command or ourselves, and, on finding that out, we got in touch with Dr. Draper, the deputy surgeon of the Public Health Service, and had a conference, and arranged to have these surveys routed through The Surgeon General's Office, the service command, and the post surgeon so that they would be kept on a medical basis and so that reports of these surveys would be made first to The Surgeon General's Office and then the service command. They agreed to all that, and they also agreed to make these surveys only on a pre-arranged schedule and that is in operation now, and we checked with them last week and there seems to be no hitch on it. We have a very large number of requests. More requests listed now than the Health Service can take care of, I should say, in the next two years.

COL. WALSON: A county tuberculosis association in New Jersey wanted to make a tuberculosis survey of one of our industrial plants. They were told that The Surgeon General's Office had committed themselves to having this type of survey be made by the U. S. Public Health Service.

GEN. LULL: The next question is -- it's an old question that I think we can pass over fairly well -- What supervision as to sanitation, epidemiology, and venereal disease control should the service command surgeon exercise over Army Air Forces stations? I think that is going to be thrashed out and a policy announced. I don't think we need discuss it. From what General Kirk said the other day, I don't think so.

The next question I think has already been covered. What is the opinion of the service command surgeons as to the value of a nutrition officer in his office? Colonel Howe appeared the other day and I think you all expressed an opinion. Colonel Howe states the following: The above question is directed to service command surgeons. The opinion of the Nutrition Branch, Surgeon General's Office, is that a nutrition officer on the command's staff is highly desirable and such an officer can perform the following functions:

a. Act as nutrition consultant advising the commanding officer and chief of Medical Branch, the surgeon, and supply officer at Quartermaster on matters relating to nutrition and nutritional adequacy of the ration.

b. Review and coordinate the activities of nutrition officers within the commands.

c. Review the prescribed ration adequacies of rations consumed at stations where suitable nutrition officers have not been assigned.

Well, we all went into that the other day, and I think we are all satisfied with the concensus which was that he rendered valuable service which we had difficulty in utilizing in some of the smaller service commands without assigning him to a station and that can be worked out with the station. Furthermore the new allotment doesn't provide us with enough Sanitary Corps officers for that purpose. I think under this new allotment Medical Department officers. They allotted them to us in our allotment, I noticed and are Medical Department Immaterial.

COL. WALSON: Will these Medical Department, Branch Immaterial Officers, be assigned to the Medical Branch, service command?

Answer: The service command, or some other branch, like the Internal Security Division.

LT. COL. LANZA: General Lull, is there still this discussion on nutrition?

GEN. LULL: If there is anything you would like to bring up.

LT. COL. LANZA: There is a nutrition officer in most of the service command headquarters. The matter of nutrition program for industrial installations owned and operated by the Army has been discussed with Colonel Howe of The Surgeon General's Office, who agreed that it would be advantageous to formulate such a program. Would an officer attached to the Occupational Hygiene Branch in The Surgeon General's Office for the purpose of assisting service commands in carrying out a nutrition program in Army-owned and operated installations be of value of the service commands? That has certain angles; for instance I recall one industrial plant in which the personnel officer purchases a lot of vitamins and he just spent thousands of dollars for vitamins and was going to give them to every employee at that post, not consulting the surgeon about it at all. The surgeon recommended that it be given to only those that were working in connection with the handling toxic material. The commanding officer finally rectified the matter and carried out the surgeon's recommendations. But there may be, if they were available, a need for a nutrition officer to go around to those places, occasionally.

What we had in mind were two things -- not only the control of the vitamin abuse which is a very real one, and issuing of special milk allowances to many of these people but the

possibility that with the rationing of food and the general situation throughout the country in many places there is an actual diet deficiency. And, just a couple of days ago I attended the meeting of the Medical Committee on Nutrition of the NRC and that matter came up. They felt very strongly that there was a need for some first-hand investigation on the matter of dietary insufficiency which of course would apply to our Army-operated plants. That prompted the question. If such is the case it would be of assistance for us to have somebody to handle that phase of it through the service commands.

GEN. LULL: I might say that if there is going to be someone -- you've got to fire someone to get him in. We're up to our ceiling now. I mean I think the service commanders don't doubt but what the idea is excellent, but I just don't see how we can get the personnel to do it.

LT. COL. LANZA: Of course we would establish a man in the industrial hygiene laboratory in Baltimore.

Comment: They would still be charged against the service commands, wouldn't they?

COL. HILLDRUP: What is the method of obtaining quickly the services of members of The Surgeon General's advisory board of civilian specialists.

Answer: The Board for the Investigation and Control of Influenza and Other Epidemic Diseases in the Army is administered through the Preventive Medicine Division, Office of The Surgeon General. Requests for services of members of the board or commissions may be made by telephone, telegram, or letter to Brigadier General James S. Simmons or Colonel S. Bayne-Jones. These consultants travel under orders originating in the S.G.O. There has been little or no delay in getting approval for projects by the president of the board and other authorities concerned in various situations. On their side surgeons of service commands have cooperated cordially and effectively with Epidemiological Board Projects submitted to them for approval. So far as is known the present system is working smoothly and expeditiously. Most of the arrangements are initiated by telephone within the shortest possible time.

GEN. LULL: That is, if you telephone to this office when you need him, Colonel Bayne-Jones or General Simmons will send a memorandum over to the Civilian Personnel Division right here where they get out the order for the man. Usually I think arrangements are by telephone or telegraph with the individual to go.

GEN. SIMMONS: We start them before their orders are out.

COL. BAYNE-JONES: If you need them, why we can get them to you in a hurry.

COL. HILDRUP: I never did get mine I asked for down at Scott Field. I wrote a long letter about it.

COL. BAYNE-JONES: Since Colonel Hilldrup has brought up that question, I would like to speak frankly about the way we administer the board. Colonel Hilldrup's problem is to find out why at Scott and Chanute there was more scarlet fever and rheumatic fever than he thought should be there, and his letter to General Simmons suggests that the board be directed to go into that post, because there was a conflict between the authority of the Air Surgeon and the authority of the surgeon, service command. Is that right?

COL. HILLDRUP: Yes, but I got that straightened out.

COL. BAYNE-JONES: Now, we have never sent this board into any camp or post without thorough understanding on all sides. We have never used it as an inspection board without the inspection being requested and the whole of the cooperative enterprise has been on a good basis of understanding on all sides. I hesitated to write you all that until I had looked it up a little more. I have the figures on the scarlet fever and rheumatic fever at Scott Field and Chanute. We have had a commission studying respiratory disease and streptococcal infection at Chanute since 1941, and one of their troubles is they haven't had enough material to work with at that place. So there was a little discrepancy in the reports. As you say, the diagnosis might have been wrong.

COL. HILDRUP: That is what I was afraid of.

COL. BAYNE-JONES: They also sent the head of the service command laboratory in there, who looked over and reported on some of those cases. I have our usual "advertisement" of the board -- I sent these all to you -- but I would like to pass them around again and call your attention to the fact that the question is already answered on page 5, which, as General Lull says, tells you how you can get the services of these men, and they do travel under order, but they are on the move usually before any orders are issued.

GEN. LULL: All right. You know how to get them because I know from personal experience that there are times when you've got to get them out; they've gotten out in a hurry.

COL. BAYNE-JONES: We should like to ask the surgeons of the service commands to deal with us about this board rather than to try to employ it on the authority of the service command. It is only a matter of control -- there is no delay. In some cases as in the Ninth Service Command, Colonel Moore has an extraordinary arrangement with Dr. Eaton. He has given him permission to cover many posts and have reports go directly in to Dr. Eaton

because we are on the watch for influenza out there, and he has an excellent laboratory to study that. I think it is working all right with you now.

GEN. LULL: All right, next question: Should Air Force stations route their sanitary reports through the service command?

Answer: The Air Force stations should furnish copies of the sanitary reports to the service command for information of the surgeon. The report itself is to be forwarded to The Surgeon General through command channels. Now that was taken up before and we can't very well change it at the present time.

Comment: The objection is that the service commands do not see the intervening action.

GEN. LULL: That is perfectly true, and that thing should be straightened out.

COL. FRENCH: On that form, Circular 59, is a footnote which requires the indorsement of the commanding officer on that copy.

GEN. LULL: How about that, Stone? Who handles it? Long?

GEN. SIMMONS: Colonel Long has taken that over.

LT. COL. LONG: What was that question?

COL. FRENCH: There is a footnote on -- I think it is Circular 59 -- and the form -- well, it's one of the forms you got where they showed the name of report and by whom it was to be made out, and distribution, and I think you will find that at the bottom of that table a footnote -- my interpretation of which is that the commanding officer's indorsement should be on that copy of the sanitary report.

GEN. LULL: It is the report on the elimination of unnecessary reports.

LT. COL. LONG: I'm not awfully familiar with this thing. I have talked with Colonel Stone about it. This business of sending a carbon copy to the service command, as I understand, originates from the fact that in these Air Force stations the service command has no direct operative function to an Air Force station per se. The carbon copy is sent only for his information. You are quite right that you do not see the interim indorsements. I believe that that can be worked out later so that you can have complete information.

GEN. LULL: I think that that was one of the things General Kirk wants to work out in this handling of Air Force stations. I don't know where we are going to get, but I think that that is

another reason why service commands should have more responsibility relative to Air Force stations.

COL. FRENCH: We have the responsibility now but not the authority.

COL. HILDRUP: While we are on this subject, it has occurred to me frequently that Army Regulations 40-275, which governs the sanitary report, is due for a revision. These reports come in -- and they are voluminous -- they report month after month the same data, all of which you can get off the 86ab, and they go on in detail telling you stuff that you already know and has been on the previous month, etc. Now why can't this thing be arranged or rearranged so that they give this data once, put in a full report every three months, or six months, or whatever it seems -- and then on the monthly reports just put in that data which is pertinent.

GEN. LULL: In 1933 I tried to have that corrected -- when I was here in the office -- in 1933 -- and the argument then was that all vital statistics went to The Surgeon General direct and this was one of the times when they wanted the statistical data to go to the post commander -- and some of the other material in there -- to go to the post commander.

COL. HILDRUP: I don't think it does any good at all -- I never have thought so. I think the vital statistics -- if there is any upswing in rates of communicable diseases, the surgeon is going to bring it to the attention of the commanding officer without waiting for the monthly sanitary report, and I think it probably could be revised.

COL. GIBNER: At the opposite end of the scale from the type of report that Colonel Hilldrup mentioned is the other equally objectionable one with the entry "Satisfactory" under all headings, and nothing else said.

GEN. LULL: That's true. I think we might look into some revision of that Army Regulation. Next question: Current regulations require the discharge of enrollees who show positive spinal fluid findings. In view of the fact that many of these individuals are asymptomatic and remain so for years, would it not be in the best interests of the service to classify them for limited service and utilize them?

Answer: Regardless of the fact that any enrollees who have positive spinal fluid findings and are asymptomatic, it is not thought to be of the best interest to the Government or to the Army to retain these individuals on active duty. This includes general and limited military service. The potentiality of future danger, hospitalization, and necessity of specialized treatment of these individuals does not warrant their being retained in the service. That seems to be answered. There

is another question here from the Seventh Service Command, Colonel Gibner, that reiterates the status of Army-owned arsenals, depots, and industrial plants, and I don't think it is necessary to answer that in view of the fact that this conference is coming up and it will be answered.

COL. GIBNER: That's the same thing -- it will be finally ironed out, we hope.

Comment: Another one -- Question No. 146 -- to the same effect. All these of yours, Colonel Gibner, bring up very important ones about the employment of personnel, which have already been answered.

COL. GIBNER: War Department Circular No. 59, 24 February 1943, "Industrial Medical Program of United States Army." In the case of contractor- operated plants which are manufacturing or assembling aircraft, are such plants under the jurisdiction of the service command, Army Service Forces, or of the Air Service Command insofar as the industrial hygiene program is concerned?

Answer: There is written into the contract of every privately operated Government-owned manufacturing plant specifications for the maintenance of adequate sanitary and healthful conditions. It is the responsibility of the Commanding General of the Service Command, Army Service Forces, to inspect such plants to see that such sanitary and healthful conditions are being maintained. That is the same thing as the other which will be threshed out. I maintain that is the same thing as the other which will be threshed out.

COL. GIBNER: Headquarters, Army Service Forces, Memorandum 850-20-43, dated 2 April 1943, "Accident Prevention Reporting Procedure," paragraphs 3 and 4 require "commanding officers of Government-owned, Government-operated facilities" to submit monthly Injury Summary Report (Form No. 502), to the Chief, Medical Branch. Does the word "facilities" refer to <u>all</u> Army installations within the service command, including industrial installations, or is it meant to refer only to industrial installations? (The Internal Security Division interprets the term to mean all Army installations.)

Answer: The wording of the above-mentioned memorandum is not clear. Those reports which according to par. 3 and 4 should be submitted to the chief, Medical Branch, and thence to The Surgeon General's Office, are to be submitted from only those industrial installations falling within the scope of the Army industrial medical program.

This is a combined form made up at the request of the Chief of Staff, Army Service Forces, in order to reduce the number of monthly reports to be submitted by Army-owned facilities.

COL. GIBNER: It was the interpretation of the word "facilities" -- our internal security office took the position that applies to everything run by the Army posts and everything else.

LT. COL. LANZA: May I comment on that?

GEN. LULL: Yes, Colonel Lanza.

COL. LANZA: We called up the PMG's office, and they said that it was their fault that that thing was loosely written, and that they acknowledged that the term "facilities" as they used it wasn't quite accurate and that they were getting out a circular letter to correct it.

COL. GIBNER: Are pre-employment physical examination reports of civilian industrial workers considered a confidential record, based on privileged communication between the examiner and examinee? If so, where should such reports be filed, in the plant or depot surgeon's office, or in the personnel office?

Answer: They should be filed with the medical officer of the depot surgeon. This matter has been discussed with the Medical Director of the Civil Service Commission who agrees that these records are privileged communications. Attached is a copy of a letter sent to the Army Service Forces, dated 25 May 1943, which will be placed in the record.

In case of separation of an industrial worker from employment for any reason, what disposition should be made of the individual medical records?

Under the present circumstances, the medical record of an industrial employee leaving an Army-owned and -operated installation should be kept by the Medical Department of that station. This matter was discussed with Mr. Jones, Civilian Personnel Division, S.G.O. who stated that there was agitation at present for the setting up of a central file for records of the War Department Civilian employees. If that goes into effect it will go into a central file.

COL. GIBNER: Is it intended that the provisions of paragraph 23, AR 40-210 will apply to the WAAC's? If so, what educational material is considered appropriate?

Answer: The provision of par. 23, AR 40-210, other than those applicable to prophylaxis and physical inspections, are applicable to the WAAC's. A qualified woman medical officer has been assigned to the Preventive Medicine Division to study the problems relating to the venereal diseases among the WAAC's, and to plan suitable preventive measures. It is expected that satisfactory control program will be forthcoming.

Major Craighill, do you wish to state anything further?

MAJ. CRAIGHILL: No sir, we are starting an educational program and are going to try to get that under way in July. I hope it will serve as a preventive measure.

GEN. LULL: And this next question which has to do with the physical examinations has already been answered. It was proposed by Colonel Gibner, of the Seventh Service Command and is a duplication of the previous question as to what kind of physical examinations will be given under the provisions of section III, WAAC Circular No. 1, and Major Craighill said that an attempt is being made to work out something of that sort.

Question: Is it contemplated that individual venereal disease prophylaxis material will be made an article issue? If so, when?

Answer: Although consideration has been given to making individual venereal disease prophylaxis material a matter of issue to soldiers in the Continental United States, no recommendation to that effect has been made. Individual prophylactic packets are issued to troops in theaters of operations.

COL. GIBNER: That question I think was already discussed. Is not the form used in consolidating station venereal reports unnecessarily elaborate?

The items included in the form for the consolidated venereal disease report are essential to a full understanding of the venereal disease control officer cannot develop an adequate program. Such information is also necessary to The Surgeon General in planning policies relative to venereal disease control. Any elaboration, Colonel Turner?

COL. TURNER: I believe it looks more elaborate than it really is.

COL. GIBNER: Quite a bunch of directions there that go with that. Do this and don't do that, include this and include that. You are going to have a lot of trouble educating many of our inexperienced station surgeons and their personnel to get those reports, in correctly.

COL. TURNER: Most of those directions were in reply to questions that have been submitted from the field. Most of them cover relatively minor points.

COL. HART: To reduce repetition of functions in Ordnance contractor-operated plants, request that the chief, Medical Branch, service command headquarters, be notified when any outside agency makes a sanitary industrial hygiene survey at these plants.

Comment: That already has been covered. That is the question, Colonel Hart, about so many people making an inspection. That has been covered.

COL. HART: The Third Air Force has issued a directive which is in conflict with Army Regulations 40-210, 15 September 1942, paragraph 24. This directive instructs all units on a post to send a copy of monthly venereal disease statistical report to service command headquarters instead of to the post surgeon for consolidation of venereal disease. Reports of all units on the post which are transmitted to the service command headquarters. Numerous unnecessary reports are sent to this headquarters which are time-consuming and expensive as all report must be sent "confidential."

Answer: This question will be taken up with the Air Surgeon and necessary corrections made.

COL. HART: Clarification is requested of AR 40-210, 15 September 1942, par. 24, which states that monthly venereal disease statistical reports will cover all units residing on the post on the last day of the reporting period for which report is rendered. This seems unfair in some instances as when a unit arrives on the post on the day before the reporting period ends, the strength is counted for one day only and the venereal disease cases are included on the post report for the entire period. This tends to give that particular post an abnormal rate, which occasionally requires explanation to higher authority. It is suggested that venereal disease cases and strength be counted by the station for the time that unit resides on the post.

Answer: The suggestion that venereal disease cases and strength be counted by the station for the time that unit resides on the post will require rather complicated bookkeeping, and occasionally results in the omission of data for transferred units. The procedure recommended in par. 24a overcomes this. There will be instances in which the venereal disease rates for a post will be affected by such units. An explanatory remark on the form should call attention to such situations.

GEN. LULL: It will of course throw out your rates if you have a unit, for one day only. But it does save bookkeeping, and it ought to even up all over the United States.

COL. HART: When troops go on maneuvers, the strength and venereal disease cases are not counted as their home station drops them from its report. They are in the field and do not reside on any post, camp, or station. Apparently, they are included in the field force report as rendered by AR 40-210, but are not included in the service command venereal disease statistical

report which is sent to The Surgeon General. It is suggested that these units report to their home station in the same manner as if they resided on that post.

Answer: Would suggest that maneuver troops submit reports to the headquarters of the service command in which maneuvers are being held, and that they be shown a sub-total on the service command venereal disease statistical report.

Comment: That suggestion satisfactory?

COL. HART: It is satisfactory to us. It is satisfactory to be shown on the report for the service command in which maneuvers are being held.

Question: Is further reduction in the allotment of Medical Corps officers for the industrial hygiene program anticipated? If so, what arrangements will be made for care of civilian employees in Army-operated plants? The use of civilian doctors has been unsatisfactory in the Eighth Service Command.

Answer: This office cannot anticipate War Department allotment of Medical Corps officers for the industrial hygiene program. Every effort is being made to adequately staff with competent physicians, preferably medical officers, every important industrial establishment owned and operated by the Army.

GEN. LULL: That was an argument we have with Military Personnel in which they said that we had only so many doctors and that the Army industrial medicine would have to get along with a minimum. They didn't want to tie us down to any minimum but they would leave it up to the service command as to how many of those men they could spare from other duties to put in the plants. And they objected to alloting officers -- as a matter of fact, you can't get them for these plants.

COL. HART: Reference is made to WAAC Circular No. 10, 1943, Section 36d and c regarding the discharge of WAAC enrollees not on active duty. What is the reason for the procedure outlined in par. 36d and c? She is not and has never been on duty. This has been a confusing procedure when put into practice. Recommend that procedure as outlined in paragraph 22, section V, AR 150-5, be followed in these cases.

Answer: The procedure outlined in WAAC Circular No. 10 is necessary to clear the files of individuals who have been enrolled but placed in the Enlisted Reserve Corps to await actual call to active duty. Some of these individuals develop intercurrent illness or physical defects and, therefore, must be discharged from the WAAC's rather than be left on the Enlisted Reserve Corps roster.

COL. JONES: If you carry out that Regulation as it is written, it causes trouble. These girls are scattered all over the service command. If one of them gets sick, we have to go out, pick her up, bring her in to a hospital and discharge her. You've got to put her on active duty. Why don't we discharge her just the same as we do an enlisted man who goes in the enlisted reserve. They are scattered all over the second command. We don't bring them in when they get anything the matter with them, unless it is something unusual. They come under that provision of Army Regulations. Now, we've written in twice about that, but we have never gotten any answer to it, and it is something that should be settled. We have three right now. As I just told the personnel officer, I would let them stay there. I am not going out and bring them in and put them on active duty and clutter up our hospitals with them.

GEN. SIMMONS: I think that might be coordinated with the WAAC Headquarters.

COL. JONES: We happened to have one in Cleveland the other day. The only way I could get rid of that one was that I happened to have an Induction Board up there and I appointed the Board to handle it. Another one happened way over in West Virginia some place.

GEN. LULL: I don't think WAAC Headquarters have any objection to it at all, if they understand.

COL. JONES: If they understand how we discharge enlisted men, they probably would agree.

GEN. SIMMONS: Major Craighill is our liaison with WAAC Headquarters.

GEN. LULL: All right. Suppose we have Major Craighill take it up with WAAC Headquarters. See if they can be discharged in the same manner as enlisted men under similar circumstances.

GEN. LULL: Can The Surgeon General give a clear-cut limitation to the degree of psychoneurosis which renders an officer unfit for duty with combat troops?

Now I know somebody answered that question and I won't read the answer, because I don't think that there's anybody here who can give a definite answer as to what degree of psychoneurosis. I don't. Do you agree with me? I don't see how you can give an answer on paper to what degree of psychoneurosis.

COL. MOORE: What is the source of typhus fever, cholera, or yellow fever, vaccine for stations directed to immunize personal proceeding overseas other than by air, both as to individuals and organizations?

Answer: Paragraph 6c(6), POM, "Vaccinations against typhus fever, cholera, or yellow fever, or other special immunizations will be effected only when specified in movement orders, and will be accomplished at the staging area or port unless otherwise directed."

COL. MOORE: I think the question here, hasn't been answered, is that when it is directed where do you get the vaccine. That's what they want to know.

COL. LUNDEBERG: This reference is to paragraph 6c(6) POM (Preparation for Overseas Movement). I am sure you are all acquainted with it. In the case of Camp Cook, we recommended to the supply service that they supply them directly. I think other stations with similar problems can be handled the same way, as individual supply problems. The reason for restricting the distribution of yellow fever vaccine and cholera and typhus vaccine to staging areas was that there just wasn't enough vaccine in the country, and you all know the importance of the distribution factor. Now, that we are coming out of the woods on yellow fever typhus and cholera vaccine, I think, that there is no reason why that restriction can't be let up a little. However, there still isn't enough of these special vaccines to distribute helter-skelter over the entire country as we do with typhoid vaccine.

That is a thing that has to be set up. In this case here it had to come through The Surgeon General's Office -- this Camp Cook, and it may be that we'll have to give the local supply people more authority for distributing the material. I thought the way it has been handled was quite satisfactory up to the present, but apparently it isn't, by the staging areas informally letting stations have what vaccine they need. They're glad to have some aid in the vaccination program of troops going through. I think up around New York that's a common practice. They'll call them up and give them a 1,000 cc. of typhus vaccine and vaccinate the troops before they get at the staging area.

COL. MOORE: That's all on storage -- I mean, they have adequate stocks on hand.

COL. LUNDEBERG: Yes, sir, in the staging areas.

COL. MOORE: I should think they could simply call on the staging area for it.

COL. LUNDEBERG: But it doesn't seem feasible yet to let every station have a complete stock of all these vaccines.

COL. MOORE: Are you the people who write into the directive that they will be immunized before they leave?

COL. LUNDEBERG: No. That's done by somebody over in the Operations Division, A.S.F. Well, I think, probably, we could clarify that a little, by stating that these vaccines could be obtained from the staging area or the port.

COL. LONG: Well, it's probably very doubtful that orders are written to immunize these people at their home stations. In this preparation for overseas movements, it is written in that these special immunizations will be administered at the port or staging area. Now, there's good reason for that. Typhus and cholera vaccination both give relative immunity only. This immunity is of short duration. It doesn't make very good sense to immunize them a long time ahead of time they go into these areas where they're coming in contact with disease, and all of these orders for overseas movements are written that these certain special immunizations will be administered at the port or staging area. If they want to be done back of that, I'm quite certain that the port surgeon will authorize the sending of material to the post, or if that cannot be done, it's relatively simple to handle it from this end through the regular supply channels. If it is indicated that these immunizations should be done early, in general we're very much in favor of doing these immunizations as late as possible before leaving.

Question: The fluid plasma reserve being wasted in military and civil hospitals especially the latter, totals many thousand units. Is it practical to salvage fluid plasma into dry plasma? When will dry plasma be available for issue in continental United States?

Answer: (1) Outdated liquid plasma cannot be salvaged by processing it into dried plasma. (2) In response to the question "when will dried plasma be available for use in the continental United States," it can be stated that some is now available for smaller installations. This is based upon the principle that small installations will have very little turnover and will keep that plasma on the shelf for longer periods of time. Accordingly, the liquid plasma, which cannot keep as long, would be better utilized in the larger installations where the turnover is more rapid. (3) As regards the waste of plasma, it may be stated that so far none has been wasted. When this liquid has been returned, it has been redated since its period of usefulness can be extended to a fifteen-month period.

Comment: That would appear to be an administrative procedure that is beating the devil around the bush.

Comment: Will the War Department get out a directive classifying the stations of such and such a size that will have dried plasma or is the program going to run that for us?

Comment: Request that Colonel Freer answer this question.

Question: Medical officers believe malaria is inadequately treated with atabrine. Is it contemplated increasing recommended dosage?

Answer: The usual routine method of giving atabrine, followed by plasmochin (as described in Circular Letter No. 33, 1943), is adequate for the majority of cases. It may be inadequate, however, for severe infections. Furthermore, a high percentage of patients with P. vivax infections undergo one or more relapses. It is doubtful that quinine by mouth gives significantly better results in general in a first attack. Evidence is accumulating that better results in general can be secured by giving a larger dose of atabrine in the first twenty-four hours and starting with intramuscular injection. Since the plasma concentration of atabrine is a determining factor in its effect (as with the sulfonamides), it would seem desirable to secure an efficient level early, rather than late in the treatment. Clinical studies of such a method are in progress and the results will be promptly reported.

GEN. LULL: So any change in this Circular Letter as soon as the evidence is accumulated, will be made if warranted. Is that right, Major McCoy?

MAJ. MCCOY: That is correct. Probably by fall.

GEN. LULL: Now, Colonel French, has a question to bring up from the Fourth Service Command which he would like to have answered.

COL. FRENCH: This is a question of danger of introducing malaria, yellow fever, sleeping sickness, and what have you, in seven states by the way of air. On 30 November 1942, the Army Air Force Headquarters at Washington got out a regulation No. 61-3 on warranting inspection and treatment of aircraft. Now we have found that the civilian aircrafts coming into the seven states on definite schedules are well disinsecticized by the Public Health Service. What we fear is the Army, Navy, Coast Guards, and perhaps any other ships that don't arrive on any regular schedules and do not announce their arrival until they start down on the field are not adequately disinsecticized. Now, we have here a report from the Public Health Service, United States Public Health Service, in certain parts of Florida, particularly with reference to Morrison Feild and 36th Street Airport of Miami and Homestead, Florida. They feel that they are not entirely satisfied that proper disinsectidation is taking place, and they believe that the danger of introducing yellow fever into this country is quite possible because of this. Now I told Colonel Souder that I didn't think we ought to bust down there and butt into this thing and make much of an

investigation without getting some real facts on it, and at least contacting the Air Corps Headquarters Office, but as long as the Public Health Service feel that it is inadequately done, I think it should be looked into.

GEN. SIMMONS: This is a thing in which we have been very much interested, of course, and Colonel Lundeberg is on a joint committee here which has to do with extending that action which we have already initiated some months back.

COL. LUNDEBERG: This directive 61-3 of the Air Corps is good. It's like Army Regulations, and should be complied with. It appears probable that there must be lots and lots of slip ups because we have independently received information that all pilots are not complying with the regulation as to disinsecticizing the air ships. We also have reports from travelers going across complaining that it is done in a very slip-shod manner, so in any procedure that has to be repeated hundreds of times, by hundreds of people, inefficiency is bound to creep into it. I think that is recognized by everybody. Public Health Service is going to investigate the matter formally. An Inter-Departmental Quarantine Commission is being established by the Army, Navy and Public Health Service. I think that the matter is going to be thoroughly surveyed very soon. I think those of you who know this regulation will all agree that from a scientific point of view it is well drawn up and if it is enforced, I think that the dangers mentioned will be minimized. It gets to be an administrative procedure, police procedure almost, to see that these people will comply. Materials are all available. We have improved sprays and all that sort of thing and now comes the question of securing the adequate use of the equipment.

COL. FRENCH: I'd like to ask is there any requirement that the pilot will make a certificate to the effect that he has sprayed after leaving an infected country and just before arriving in this country as required in this regulation?

COL. LUNDEBERG: I think that is the responsibility put upon the pilot.

COL. FRENCH: Is it just assumed that he has done it or does he have to sign a certificate to the effect that he has done it?

COL. LUNDEBERG: I don't know, I can't answer that.

MAJ. McCOY: I've had considerable experience with that. In fact, I handled that situation in Central Africa, set up the plans over there. All planes arriving from a malarious or yellow fever country are sprayed, and I recently came home that way, and when I got into each station, the man would come aboard and almost suffocate all of us with it. Except for isolated instances, I think

you will find that the regulation is well carried out.

COL. FRENCH: It really should be carried out before they land; otherwise, they might miss some insects. The men come aboard to do it. They don't carry that stuff on the plane. The crew objects to it very much, and they are the worst to howl about spraying it around.

MAJ. McCOY: Regulations require spraying a half an hour (I think it is) before landing. I don't have this regulation with me, but I am quite sure that it specifies spraying before landing.

COL. FRENCH: They don't do it, except in commercial airlines. Commercial Airlines do it, but the Army does not.

COL. LUNDEBERG: This regulation has been revised since November, I am quite sure, Colonel French.

COL. FRENCH: Has it?

COL. LUNDEBERG: Yes, sir.

GEN. LULL: All right, gentlemen, that's all for the Preventive Medicine Division, unless you have a few more things to discuss.

COL. MOORE: I can think of a few more things, I think.

GEN. LULL: All right, we are away behind schedules here, so I wonder if you can't make it snappy. By the way, I might make an announcement now that The Surgeon General is going to meet the group at 1:30.

COL. MOORE: I have two questions that just occurred to me. The question concerns individual prophylactic packets for Army Specialized Training Program where no company funds exist. On 21 May we submitted a memorandum to Headquarters, Army Specialized Training Program, which reads in part as follows: "It is the opinion of this office that individual prophylactic kits should be made available to A.S.T.P. students, since the establishment of prophylactic stations in colleges is considered unnecessary. It is believed that students should pay for such kits. It is recommended that the Specialized Training Division allocate funds for the purchase of initial supplies of individual kits wherever unit funds are not available, such funds to be reimbursed by the various training units." Now, I wonder whether Colonel Fitts could say whether any action has been taken on that?

COL. FITTS: If I remember correctly, that was an individual case and an individual inquiry made from a specific service command. The information that was sent back, forwarded, if I remember correctly, by the Operations Division was the fact that

efforts should be made for a revolving fund to be obtained by the Commandant, which would provide for the purchase of these kits, in order that they would be made available for purchase by the individual trainee. You remember that you and I agreed that it was unwise to consider the issue of them, and yet there has been no provision for post exchange facilities at the Army Specialized Training units. It would be necessary that the commandant obtain funds from some source, either from his own pocket, in order to arrange for the purchase and the sale of prophylactic kits.

GEN. LULL: Another from the surgeon, 9th Service Command, which I would like Colonel Hardenbergh to answer. Colonel Hardenbergh is Chief of the Sanitary Engineering Branch of the Preventive Medicine Service. The question is: "What is being done to check railroad watering points with reference to the technique of refilling? I saw some bad ones while coming East."

COL.HARDENBERGH: There are undoubtedly some bad ones. Their control is a responsibility of the United States Public Health Service, and we have had this particular matter up with them in connection with some other problems, including the one of locking toilet-room doors during prolonged stays in railroad yards. It is a very difficult problem to work out, and I don't know of any way except to keep closely in touch with them. Their inspection service, which is maintained through the states is stretched out about to the breaking point now because of the depletion of the personnel of the State Health Departments."

GEN. LULL: That is all covered in law as a matter of fact. Covered in law, but it's not in fact. No, it's just the enforcement of the law that is breaking down.

COL. WALSON: In the Second Service Command the medical officer or non-commissioned officer who accompanies troops on hospital train movements takes samples of the water on the train and returns them to the service command laboratory for examination. Where any descrepancies are found, it is taken up with the transportation officer who tries to correct the defect with the railroad company.

COL. MOORE: Did you notice any places where they didn't have these collars around the filling hoses? The collars should be 6" or 8" in diameter. Those I saw were not that large, nor were there any hose coils. The hose was lying right down between the platform and the railroad ties.

COL.HARDENBERGH: They usually place them between the double tracks, if they can, which keeps them away from the platform.

COL. MOORE: These were right along the platform, and the hose was being dragged; the end of it was not clear of the ground by any means.

GEN. LULL: Well, then, I've got to get through here. I want to introduce Colonel Anderson, who is Chief of the Medical Intelligence Branch of the Preventive Medicine Division.

COL. ANDERSON: We have received, in the last few days, in the Medical Intelligence Branch, a number of samples of captured enemy medical equipment. We have about 20 or 25 items now being catalogued. If any of the group would like to see them, I'd be glad to have them out on display, all properly labeled, at whatever hour would be convenient for the group. Now, the work of the Medical Intelligence Branch has been very largely that of assembling medical, health, and sanitary information about various parts of the world. It has been carried on, largely, through the preparation of surveys. I have brought with me a sample of one of the more recent surveys. Some of them have been published in the Army Medical Bulletin where you may have seen them. If any of the group are interested in receiving these surveys, which, incidentally, have not heretofore been routinely sent out to the service commands, we'd be very glad to arrange to have all surveys sent routinely to you. We have not sent them in the past as we were not certain as to how much interest there would be or how much value they would be to the service command headquarters. On the other hand, I think there are many persons who feel that they might be of very considerable value in the formulation of a training program. These that I am passing around happen to be surveys of China. We have prepared surveys for about 130 to 140 areas of the world. Some of them are rather old and are being brought up to date.

GEN. LULL: I'm sure that you gentlemen are not familiar with this very important section of the office. We'd be glad if you would go up and see what we're doing. This thing was started from scratch by General Simmons. Previously there had been no thought given to it, so he started out with this Medical Intelligence in order to find out conditions, disease conditions, in the various countries we might enter in order primarily to prevent the spread of communicable disease. However, the thing has grown beyond this and it has gotten to be a very big part of this office. For those of you who haven't seen it, it's well worth seeing. I would suggest that this afternoon, probably around 3 o'clock, would be a good time to go up there. It's right upstairs.

COL. ANDERSON: Room 1215, immediately above this room.

COL. HART: Can we be furnished with these surveys routinely without request? We are all anxious to get them.

GEN. LULL: Let it be entered in the record that the service commands desire to be furnished copies of these surveys as they are made.

GEN. SIMMONS: You want to show them how it is done, Colonel Anderson?

COL. ANDERSON: I have a map here showing these areas other than the Western Hemisphere that have been studied. You will note that it is a pretty complete coverage. A great many of these are being revised and those areas that have not been studied are under study at the present time.

COL. REDDY: How many surveys have been made?

COL. ANDERSON: We have made about 130 to 140 surveys. That list I showed you was simply some of those that are now available. Here also is the outline that we have used in connection with the surveys. It is being constantly modified. For example, we are beginning to add into the surveys material about pollens in these countries because of a question that came up not long ago as to the various pollens that might be encountered in a certain area. It was an omission -- an oversight on our part -- so we are trying to add it in at this time.

GEN. SIMMONS: I would like to add that the reason for starting Medical Intelligence, of course, was not just to get information but to have information that would be of value to the Army. With the planning for practically every group of troops that has gone away from this country these surveys have been used as a basis for specific recommendations for the preventive measures to be taken, depending on where the troops are going. For that reason I think it has been of great value.

And if Colonel Lanza will go down and state the question, we have to get out.

GEN. LULL: All right, Colonel.

COL. LANZA: For the past year there has been an increasing number of requests, from commanding officers of all types of Army facilities, that the civilian employees in these facilities, not now covered by the Army industrial medical program, be so included. We have had such requests, only yesterday for instance, from Colonel Clark, in command of the Fort Lewis Hospital, a few days before that from General Marks, in command of Fort Belvoir. We have had repeated requests for this from the A. S. F. and from the War Department. And we've had other requests from the service commands, the Ninth and notably, you remember Colonel Walson, the Second, where the matter of the Office of Dependency Benefits has come up.

GEN. LULL: Give us the answer.

COL. LANZA: My answer is, that it should be so included because you are dividing the employees of the War Department into two groups, industrial and non-industrial, for the former we do something and for the latter we don't. Except this, that in a number of places they have been doing something, that is they have set up a legitimate first-aid emergency service, which is all that is contemplated in this proposed amendment to No. 59. It has been stated by the various offices in the War Department that all these services should be consolidated under The Surgeon General, and not exist as extra medical services which have no relationship to The Surgeon General's Office.

GEN. LULL: Is that clear?

COL. LANZA: There are many installations where there are few civilians, maybe a hundred, maybe two hundred, very often women, where you want to set up a rest room and essential first-aid facilities, nothing more. But it should be coordinated, and the pressure to include these services in with what we do now is increasing from every angle of the Army throughout the whole country.

COL. BURNETT: Who will run these first-aid stations? Where will you get the personnel?

COL. LANZA: Well, many of them have personnel now, including nurses, and this we'll have to do just as we're doing now. You'll do the best that you can. You've got a very considerable medical set-up for instance in Washington, which has no relationship whatsoever to The Surgeon General's Office, and they wish to put it under The Surgeon General's Office.

COL. WALSON: May I ask would it be practicable for the War Department to issue a directive covering the medical service you want given to the civilian employees?

GEN. LULL: I think what Colonel Walson states if they can get much better headway in the service commands that the War Department will issue a directive to the effect, as to just what they will do. The Medical Department of the Army will establish and supervise first-aid rooms for the emergency treatment of casualties among civilian employees.

COL. MOORE: They ought to be able to do that.

COL. BURNETT: How are you going to do that? What numbers does that involve?

COL. LANZA: It involves roughly 600,000 people.

Comment: Well, we estimated employees in offices scattered in every

little town.

COL. LANZA: Well, in many of the places you can't do anything but provide a first-aid kit and somebody trained in first aid. About ten days ago I had a meeting with some representatives of the Director of Personnel for the War Department, and at the end of that I drew up a summary of that meeting and sent it to General Simmons and General Kirk. Mr. Macy, the representative of the Civilian Personnel, referred to the desirability of coordinating those various services for civilian employees, and it was pointed out that this was not the responsibility of The Surgeon General's Office. Also, that if the War Department decided to develop or extend its medical service for civilian employees outside of the District of Columbia it should adhere to the basic principals of the employer-employee relationship, that it was not a function of the employer to provide other than temporary emergency care as noted in the preceding paragraphs except under extraordinary circumstances. All that is contemplated in this is the providing of bare emergency care to our employees, but it is very difficult as General Marks points out and Colonel Clark points out, and as other people have pointed out to have 5,000 employees of the Army here and four or five thousand over here, and we don't do anything for them. It puts us in a very illogical position. Then when they set something in Colonel Walson's command as they did the Office of Dependency Benefits that is suspended between wind and water and it is nobody's business to do anything about it.

GEN. LULL: Well, a man from the Office of Dependency Benefits was in to see me the other day, and he wanted me to assign personnel up to his office, and his excuse was that he had 220 officers to take care of, and he said, of course, that they could look after the first-aid treatment of the 5,000 civil employees we have, but we haven't the personnel nor the authorization to look after them. Now it is true that in most of these places they have first-aid equipment and that's all, and maybe a rest room with a social worker, or a nurse sometimes, but they are loosely managed. As a matter of fact, I don't know who runs this one.

COL. WALSON: If the Medical Department employs a nurse, we are responsible for her services. There is a great deal of limitation to what she can do. When she goes beyond her field -- for example, prescribing treatment, we're going to get into trouble with the civilian physician.

GEN. LULL: Well, I think to clarify the record there should be some directive issued from the War Department or from this office as to uniform procedure. Now whether that uniform procedure is going to be practical in all service commands then the

clamors will come in that the directive cannot be carried out, but I think to start it there ought to be a directive if The Surgeon General wants to put this under one head the directive will have to come from the War Department.

COL. LANZA: Our office has persistently refused to have anything to do wiht it.

GEN. LULL: Yes, I don't mean that we won't touch it, but you're getting the increasing pressure from every direction, authorization for supplies and everything will have to be revised. My theory is this, that the employees are not part of the Army. That's been decided that the War Department employees are not part of the Army. Then there ought to be an obligation to Public Health Service to take care of them.

It's been passed on that the civilian employees of the War Department are not part of the Army. The Army consists of officers, enlisted men, and nurses, and so forth.

The whole thing was decided about ten years ago right here in this office.

Gentlemen, you have to be back at 1:30. The Surgeon General is going to talk.

GENERAL LULL: I'd like to introduce at this time, Colonel Wakeman, Director of the Training Division of this office.

I have some questions here that have been submitted by the various sections. I have one question left over, from the Personnel. Are all remaining general service technicians to be called out of service commands, and if so, is it assured that they will be assigned to numbered medical units? That came up yesterday, and he held it up for Colonel Wakeman. We thought, perhaps, you knew something about it.

COL. WAKEMAN: I'll give a little of the history of this limited service movement and the efforts we've made to control it. Over a year ago, the War Department issued directives that general service men would be replaced by limited service, in the fixed installations of the zone of the interior. Sometime after that was issued, in October or November, The Surgeon General wrote to the War Department requesting permission to receive and train limited service personnel to the extent of ten percent of capacity of medical replacement training centers. That request bounced back, disapproved. Later, G-3, super staff, ordered the Training Division, Army Service Forces, in May of this year, to set aside ten percent of the capacity of all replacement centers to train limited service personnel. We were told we would take two hundred a week, and we made plans to take two hundred a week at Camp Barkeley, Texas. The first week we received one hundred and sixty-eight, the next week we got none, and we didn't get anymore for about four weeks. Now they're starting in again. The directive specifies that general service personnel must be replaced by at least 5 percent limited service per month, until you have replaced 80 percent of your personnel in the fixed installations. A policy has been laid down by the War Department that you would replace general service personnel, yet at the same time, they do not give us the limited personnel to replace your general service people. One station sent in a request to find out whether he should transfer a proportionate share of his hospital fund, because he had been ordered to ship two hundred and fifteen of his detachment, station hospital. All two hundred and fifteen were distributed to four replacement centers, Infantry and Field Artillery replacement centers. I thought that of considerable importance and drafted a letter to the War Department inclosing copies of the orders so directing these 215 men to Infantry and Field Artillery replacement centers. I cited the case and made the following recommendations: (a) That the indiscriminate transfer of trained Medical Department personnel, trained as special technicians, to other branches be discontinued immediately. (b) That, if it is necessary to transfer general service trained enlisted personnel from fixed

installations of the service commands, any transfer of technicians peculiar to the Medical Department be limited to medical field units, and that if (a) and (b) above were approved, the memorandum cited in paragraph 1 of their letter on "Utilization of Limited Service Personnel" be amended in accordance with the attached tentative draft. We even wrote an amendment to the War Department directive, "Utilization of Limited Service Personnel," which would have prevented this indiscriminate transfer by adding one sentence as follows: "graded technicians peculiar to a branch will be transferred without reduction and to a field force unit of the same branch only." Well, that went over to the Director of Training, ASF, and the Director of Military Personnel, ASF. The Director of Military Personnel, ASF, returned it to the Director of Military Training, ASF, stating no action was necessary. I went over personally and saw the Director of Training and produced documentary evidence that people were being transferred from the Medical Department to line units and not to Medical Department units. They have put on a very strong indorsement and it has gone back to Military Personnel. Military Personnel states that these men are going to Infantry and Field Artillery replacement training centers for reprocessing and that they will eventually be assigned to medical units. The mere fact that Military Personnel, ASF, do not desire to change that directive is evidence that they do not intend to transfer the trained Medical Department technicians to medical field units. I have tried to provide facilities in the schools for the service command to train any limited service people they may have. I intend to take limited service personnel, if we ever do get them in replacement centers, send them to our enlisted technician schools and then redistribute them to your service commands. However, if we can't get limited service personnel to train, I don't know how we can replace general service men only to have them thrown away to line units. If you know that trained technicians have been transferred to other than Medical Department field units, I would like to have specific cases and orders. I have here a letter from an individual who seeks transfer back to the Medical Department. He has been in the Medical Department since 31 July 1941. He went through the 13 weeks' basic training, medical replacement training center, and a three months' course as an x-ray technician. He worked as an x-ray technician from October 1941 until 1 June of this year, and was a good one. On 29 May, he received his orders from the Second Service Command, transferring him to a Provost Marshal General's unit training center, Fort Custer, Michigan, and he is now serving as a prison chaser in the 459th Military Police Escort Company.

COL. HILLDRUP: Colonel, he is in what?

COL. WAKEMAN: He is in the 459th Military Police Escort Company.

COL. HILLDRUP: Will you give me that man's name? I will get him back to the Medical Department.

COL. WAKEMAN: Yes. I want to make an issue with the War Department on this case. I want to get more cases. I hear stories, but I want to get the actual orders. Colonel McCaw was in here and he said that he knew of cases that had actually been transferred from the Medical Department to line organization.

Chorus: It is common.

COL. WAKEMAN: They say it is common, but we haven't been able to get copies of the actual orders, that is what we need to prove to the Military Personnel of the War Department that this malicious practice is going on. It is believed that there was a promise made by one of the echelons to furnish to another a certain number of thousand men.

COL. FRENCH: The Medical Department having about 30 percent personnel in the 4th Service Command, that meant that we would lose several hundred men. These fellows got hysterical giving up the only well-qualified men they had, I mean physically qualified, but most of them were technicians. Several called me up and said, "What the hell do we do?" "Well," I said, "it looks to me as though you would have to meet skullduggery with skullduggery." I said, "If I were in your place, I would take my key technicians, put them up before the reclassification board and have them marked limited service." That is the way we had to do with a lot of these stations, but two or three of them we didn't contact soon enough, and they did transfer a number of technicians.

COL. WAKEMAN: Two hundred and fifteen from Fort Benning?

COL. FRENCH: Yes, that's right.

COL. WAKEMAN: The only reason I saw that order from Benning was because the question was raised concerning the transfer of a proportionate share of the hospital fund, and we made a recommendation that no transfer of the hospital fund should be made unless the men were transferred to a unit that was taking care of sick and wounded. Transferred to an Infantry center does not encompass that.

COL. FRENCH: Well, I think in this instance they caught old Bill Benson sound asleep because I raised hell after this instance. The things happened so fast that he was dizzy. He didn't know what they were doing.

COL. WAKEMAN: Now in some service commands this situation is not as critical as in others. I know in the one service command, the commanding general of that service command has set a rigid limit for

limited service personnel within the station complement of all stations, to the extent even that one commander received a letter stating his ability to command would be judged by the rapidity with which he got rid of general service personnel, and that happened to be in a station in which there is a replacement training center in which limited service personnel must be used to train general service personnel.

GENERAL LULL: I think Col. Moore said yesterday that he had it straightened out in the 9th Service Command. Did you not, Colonel?

COL. MOORE: That is correct, General. It would not happen in the 9th.

COL. JONES: You can hold your 20 percent general service, if that is what they allow you to do.

COL. WAKEMAN: Yes, in one service command they said that they want 100 percent displacement.

COL. JONES: I know, but if you hold your 20 percent that comes near caring for your technicians.

COL. WAKEMAN: Yes, but you can't get rid of such people as your graded technicians or your noncoms and people of that type. You must hold key noncoms. Your old noncoms are the most important to you. You may be able to reclassify them, however.

COL. JONES: We figured it out where if we hold our 20 percent that is the station hospital would hold on to their 20 percent in the grade of technician, noncommissioned officers, they could get by with it. But our trouble was that we didn't do that. In some of the places they let them go.

COL. WAKEMAN: Many of the stations cannot get limited personnel to train anyhow, and they are forced to displace the general service men before they have had a chance to get limited service personnel and adequately train them.

COL. JONES: Our personnel officer is just raising the devil all of the time because he is loaded up with limited service, and he doesn't know what to do with them. He is overstrength.

COL. WAKEMAN: Well, that may be true in some stations, but as a general rule there is a very serious shortage of qualified people that you can train as limited service personnel.

COL. FRENCH: Another thing, I suppose all service commands have this on induction. You can only induct 5 percent of limited service personnel on any one day. That cuts down the supply, too.

As I understand it, the commanding general of a service command has a very definite directive that he has to comply with.

He gets his orders and he has to comply with that directive, and furthermore about 40 percent of the personnel in the station complement are Medical Department. Well now, he has to get rid of all but 20 percent of his people and a large number of that personnel must be checked up to the Medical Department and possibly some other branch besides the Medical Department has not been anticipating the situation we have to meet. Now, as executives of his command, we have known this was coming, and for a long time we had tried to anticipate it as far as possible, and in every way possible by getting it to the post surgeon that he is going to lose his general service personnel, and every effort possible has been made to replace them with limited service people. But now that a definite date is set when this must reduce to 20 percent, by 30 June, the Commanding General probably with the directive he has, is going to reduce it to 20 percent.

COL. WAKEMAN: There has been a marked reluctance on the part of replacement centers and schools to replace general service men with limited service men. There is a reason for that. They haven't received limited service personnel. They couldn't get their hands on limited personnel and it dates back to the historical fact that we were not permitted to train limited service personnel in our replacement centers. If we had been given 10 percent of our capacity when we asked for it, we could have had trained Medical Department limited service personnel--any quantity--trained as technicians, and trained as well as our general duty people. Now as to what action is going to come from our attempt to halt mass transfers to other branches, I am not too optimistic. The mere fact that they didn't want to take any action initially is quite evident to me that they know that this process is going on and they do not intend to stop it. There has been a commitment by very high authorities to furnish so many general service troops to the Ground Forces, and it is going to be done, I am sure.

GENERAL LULL: Well, gentlemen, let's get on to some other question that has a bearing on this, I believe.

Question: With the limited number of medical officers available, quotas cannot continue to be filled, except from units assigned to the service commands for training. Is this desirable? About the time they get started, their unit is placed in a high priority; then the officer has to be relieved or replaced.

Answer: The answer submitted is for school details. Service commands are responsible for the training of officer personnel of numbered units. Trained personnel must be available for units to be activated. The personnel for these units will of necessity come either from unassigned officers or from service command zone of interior installations. If units already activated and assigned to service commands do not have a

balanced staff of trained officers, personnel from these units should be sent to schools for training. It is realized that frequently officers will have to be ordered out of the course prior to completion but it is considered advisable that every effort should be made to give officers as much training as possible between procurement and functional employment.

That refers to school details from numbered units. Now these units, as you know, as far as the personnel are concerned, are set up with a skeletonized personnel to start with and then are filled up before functional employment. Many of them, however, are not filled up in sufficient time to give them courses of instruction between the time they join the unit and the time they are alerted for functional employment. Any discussion of that question?

COL. WAKEMAN: I have heard that if the service command sends an officer to the course of instruction he immediately expects him to become a loss to that service command, since he usually is ordered to some other duty, after completing the course. Unless we have faster officer procurement, I know of no other way that units are going to be provided with balanced staffs. The units will have to go adequately staffed.

GENERAL LULL: It all hinges on procurement, which we told you yesterday was in terrible shape. It all hinges on procurement of officers and we are not going to get better in the future. We are still going to be behind the eight ball as far as procurement of officers is concerned, and the service commands will have to suffer when units are sent out. The only place we can get officers to fill these units is from the service commands.

COL. WAKEMAN: The Inspector General will not let the unit go unless it has a balanced staff adequately qualified. We just had one turned back because of the fact that they did not have an officer who had attended the Tropical Medicine Course and some other course. He (the Inspector General) in that instance had made a slight error because the officer was attending a course of instruction at that time. But, that gives you an idea of their attitude. In other words, we have no choice and the Inspector General will inspect each unit prior to its functional employment and if it does not have a balanced staff, it will not be permitted to go and then somebody is on the griddle. We and the service command are both on the griddle.

COL. JONES: What do you call a balanced staff?

COL. WAKEMAN: In this case there was a question of judgment, and I don't think it was exercised too well by the Inspecting Officer.

COL. JONES: Well, that comes up with your field hospital now. The function of the field hospital, as we understood them out there and as we have tried to train these men, is an altogether different thing, than from the opinion of the Inspector General who inspected this unit.

COL. WAKEMAN: That's right; he was slightly in error and has been corrected on that, and there is a possibility, too, that the authorities in the unit may not have been too anxious to walk up a gang plank and did paint the picture as dark as possible. All those things have to be considered on the report which the Inspector General turns in.

COL. JONES: I think that was part of it.

COL. WAKEMAN: I do too. When we sent an Inspector out, the unit was satisfactory as far as we were concerned.

Question: To what extent is the surgeon of a service command responsible for the training of Medical Department units of the Army Ground Forces in his area?

Answer: Officially, there is no responsibility on the part of the surgeon of the service command for training of Army Ground Forces Medical Department units. The Ground Force surgeon has unofficially indicated a desire for cooperation on the part of service command surgeons and the various station surgeons in assisting in the parallel phase of technical training of Medical Department technicians in both divisional and nondivisional Army Ground Force Medical Department units.

COL. WAKEMAN: I talked to the Ground Force Surgeon, and other than the cooperation of the station surgeon in making available parallel training facilities they didn't seem to want any other supervision or control.

COL. GIBNER: Apropos of furnishing the facilities, some of our stations are so heavily loaded.

I have in mind Camp Carson, where there are several numbered medical units and, besides that, two evacuation hospitals, that it has been very difficult for the station surgeon to set up a schedule by which he can accord facilities in the hospital for this understudy type of training without falling all over each other. It is becoming quite a problem.

COL. WAKEMAN: We will increase the number of technician vacancies to service commands if they need more. If they will ask us for them, we will try to give them vacancies to relieve that type of a situation. We have already increased it just a few days ago to help you out on your limited service people that you need to send to get trained.

COL. JONES: I would like to ask about sanitary companies.

GENERAL LULL: That question, I believe has been submitted by the Eighth Service Command. That will be answered in just a few minutes.

Question: The interpretation of the commanding general, Fourth Service Command, is that all these numbered station and general hospital medical units sent in there for training comprise one of the duties of the service command. They claim they're sent in there for training in administration. These units are Ground Force units are they not?

COL. WAKEMAN: Now the distinction between the two: all general, all station, all field hospitals, are under the Army Service Forces for their training. The evacuation hospitals and medical battalions and units from the so-called tactical organizations are Army Ground Forces units. The activation orders show us whether they are Ground Force or ASF. The surgical hospital, the mobile evacuation hospital are also Army Ground Force units. Convalescent hospital. We have one. There is some overlapping; we do also have ambulance battalions and gas treatment battalions under Army Service Forces for training. So, also, we have medical depots. You can't always go by the so-called Army split.

Question: What do the surgical groups belong to?

COL. WAKEMAN: They are Army Service Forces units.

COL. WALSON: The organization manual, Army Service Forces, under training divisions, states that the training division established its policies with respect to, and inspects, service command training activities performed under the supervision of, the respective Branches of the Supply and Service Division. Under the directive Supply and Service Division; it reads that each of the branches of the Supply and Service Division supervises service command training activities relating to its respective supply service in accordance with the training policies of the Training Division. I'd like to know, just a little, how that is operating at other service commands.

COL. WAKEMAN: It's operating differently in different service commands. In other words, in some service commands the responsibility for training of medical units doesn't see the light of day in the surgeon's office. It's in the Training Division of the service command. In others the surgeon does have something to say. We have been at posts in which the post commander has never seen the training of medical units. His S-3 has nothing to do with the training of medical units. It's completely decentralized to the post surgeon. I doubt if I'll ever see any greater state of confusion with respect as to who is responsible for what in the way of training.

In one service command, here is what has happened at some posts. At one post in the 9th Service Command, the post surgeon has issued an order, and I have a copy of that order on my desk at the present time, detaching two hundred and fifteen men from a numbered general hospital and putting them on duty in the station hospital for administration and rations. I think he has exceeded his authority considerably, in taking the men from the numbered unit and putting them on duty in his hospital, since they are not in parallel type of training in any way whatsoever. That's a type of situation that's going on, and the morale of these numbered units is terrible. When a unit commander sees his men taken away from him, it is not unlike taking people out of a station hospital and having them serve over in a Field Artillery unit as stablemen.

COL. FRENCH: I'd like to explain the situation in the Fourth Service Command. We had a nice plan and training set-up. We had a youngster who had been through Carlisle, got him from the Third Army Corps. And he was doing beautifully under our supervision, working hard in my office and from my office. When these birds came down there and scared the pants off the clerks over in the service command headquarters, they moved the whole works right out of my office, and right now I have no more idea how these units are being trained. They don't consult me at all. I know, from what I hear, that some of it is pretty tough. Now, we are training in the hospitals a great many station and general hospital personnel, technical men. And some of those units have been there too long; for instance the 300th, that's a Vanderbilt unit up at Forrest. They've been there so long that they've worn out all their films showing them over and over, and they've worn out all their shoes doing the same hikes, and one thing and another. They were just about ready to go over the hill. They called me up and asked me to put them in a hospital somewhere. So I did break that up about the time the WAAC Training Center was starting at Oglethorpe. I sent 15 or 20 of their officers down to Oglethorpe to help out on examination of the WAACs. And we've been able to parcel them out to a great advantage. But it certainly is ruining the morale of those organizations to keep them so long in a camp and insist upon their going over and over those training schedules, six or eight times until they can recite it all backwards. But we have nothing to do with the actual plans and training, except in the hospitals.

COL. WAKEMAN: In that connection this office may recommend the unit or the priority in which units go. That move may not be made. It may not be the one that goes. They had a malicious practice in the past of either marking units for certain task forces, then the job or the task force was disbanded or was not going to be employed immediately; yet they would not release those units that had been earmarked and, consequently, the units

which came in first and were the best prepared, are still sitting there, waiting for some umpty-ump plan to go into effect. It hasn't gone into effect, and even yesterday I saw a general hospital that came in within the calendar year of 1943, going out while others as good or better have been in for over a year. Now, with reference to Personnel, in those units that have been full and sitting there waiting: I wrote a plan on the 1st of the year for the utilization of those officers, had it concurred in by Personnel Service, sent it over to the War Department, from whence it came back stating that, due to a plan that was now being worked up in the War Department, they were returning this plan of ours and that we would not resubmit it. That's a favorite phrase. In that plan, the service command was permitted to utilize the officers of the numbered units, at any place within the service command so long as they remain earmarked for that unit. It permitted the service commands to get them to work in the hospitals in the service command. But the War Department would not O.K. that plan. It has been beyond our power to do anything about this. We have tried to use the best trained units first, but we have been powerless to do so because of the malicious practice of earmarking units for particular task forces.

COL. BURNETT: General Lull, I have 15 or 20 officers from these units out in different hospitals in the 3d Service Command and they are tickled to death; they get wonderful work. As I understood you yesterday, that can be continued.

GENERAL LULL: That can be continued and you can take all of the officers out of these units except the overhead to run the detachment. I would recommend that if some of those officers are not too highly qualified and you cannot find any other use for them, send them to school; at least keep them from sitting there thinking of their ills.

COL. BURNETT: They write letters home about it.

GENERAL LULL: That's the dangerous part of it. Too many letters have been written about that. As we announced yesterday, we see that reflected in the procurement of officers. The officers say, why should I go in the Army to sit at a camp.

COL. GIBNER: We have the 46th General Hospital out at Fort Riley, one of those old units that has been in and been alerted over and over, I think three times. We have put officers from that one who want to go to these schools and three times the unit has been alerted and we have had to cancel the orders and then the alert has been called off.

GENERAL LULL: Well, gentlemen, we have to be getting on here. Here's another question.

Question: Letters dated 21 April and 31 May 1943 from the Central Committee for the War Time Graduate Medical Meetings were received by the surgeon, Seventh Service Command, detailing plans for proposed lectures, demonstrations and clinics dealing with professional subjects, to be held at the various station hospitals or other designated nearby meeting place upon the request of the station surgeon. Do these meetings have the sanction of The Surgeon General? Are these meetings to be under the supervision of the service command surgeon or the Training Division?

Answer: The general program of wartime graduate meetings has been approved by The Surgeon General and the Director of Military Training, ASF. On 4 June 1943, a draft of an informational announcement was sent by The Surgeon General to The Adjutant General for publication to the service commands. This announcement contains a detailed description of the facilities offered by the committee for meetings at various military installations; a list of chairmen of regional committees within each service command; a map of the regional organization; and a list of national consultants. This announcement states in part, "Commanding generals of service commands are authorized to contact the chairman of sectional committees within their service commands to procure the services as outlined above, which are without expense to the government." These meetings should be under the supervision of the service command surgeons.

COL. GIBNER: I have been getting a lot of literature from those people, but haven't had any directives.

COL. WAKEMAN: The directive is in the Administrative Division, ASF. When it will get out, I don't know.

COL. GIBNER: Has it been approved?

COL. WAKEMAN: I think you should sit tight until you get the authorization from the Administrative Branch, ASF.

GEN. RANKIN: May I say a word about this? I didn't know that it was held up administratively, but I do know that these programs have been put into effect in certain service commands already without any further waiting and I think you would be interested to know that they are under the auspices of the American Medical Association, the American College of Surgeons and the American College of Physicians. The expenses are paid out of a fund of $20,000-$10,000 subscribed by the A.M.A., $5,000 by each of the other organizations. Now in the places where these programs have been held, there has been great satisfaction on all sides and I am sure that all of you will like the programs and will profit by them once they are under way. I didn't know that they had still been held up administratively.

COL. WAKEMAN: The program has all been approved some time ago and then it was necessary for us to get 9 different copies of the map and 9 different lists of the secretaries and then they changed their list of consultants two or three times. That has all gone out now to be published to the service command and should be out right now; I don't know why it isn't.

COL. WALSON: It is my understanding that this was to be decentralized so far as practical in local communities and let the surgeon of the hospital run his own show, so to speak with certain exceptions.

COL. WAKEMAN: We have said in the directive that there could be no single pattern of employment, and certainly if there is any one thing over which the chief of the Medical Branch should have supervision, this is one, and not the Training Division or anyone else.

Question: Are WAACs to be trained in Medical Technicians' Schools, and if so, how soon, and where?

COL. WAKEMAN: Information from WAAC Headquarters indicates that it will be possible by 1 September 1943 to furnish approximately 150 to 170 basically trained, unassigned individuals to receive Medical Department technical training each month. It is planned that the current training facilities in the Enlisted Technician School, Army and Navy General Hospital, Hot Springs, Arkansas, will be utilized for the technical training of WAAC personnel as medical, surgical, laboratory, x-ray, and dental technicians on and after 1 September 1943. Requisitions requiring so-called Medical Department technicians will be short-shipped except for a few who are adequately qualified in civil life. I have urged the acceptance of the WAACs in our hospitals to get away from the acceptance of mentally and physically crippled males, and finally a board was appointed in this office. The board made a study and contacted each service command as to the number you wanted. We consolidated these reports which totaled 22,000, to be utilized in the Medical Department. We sent it to the War Department, and it came back stating that this was a matter for the service commands to handle. Nevertheless, WAAC Headquarters have accepted our figures as to what would be necessary. I have disregarded the fact that it was a matter for the service command and have tried to work on it from this end also. You may know that the WAACs are having some difficulty in recruitment at the present time, and they are over 3,000 short of their capacity there in the center in Des Moines alone. I have seen them, and from what I have seen, I wouldn't hesitate a minute in taking WAACs in any hospital in comparison with the mental and physical cripples that you are getting. We are going to train them as fast as WAAC Headquarters will give us people to train.

COL. GIBNER: In the 7th Service Command we received a tentative allotment by grades and ratings of the WAAC personnel authorized in the various hospitals. However, when we activated on the basis that we would have to replace a man with a woman, grade for grade, when we came to set it down against the allotment of that particular station hospital, in some instances, the numbers of a certain grade allotted the WAACs exceeded the numbers we had allotted for enlisted personnel. In other cases, they took up the entire allotment. For example, a hospital would have three technicians, third-grade. The WAACs would be allotted three technicians, third-grade, leaving none for the men, and the WAAC detachment in aggregate strength would not be 25 or 30 percent. Now, that rule will all have to be revised.

COL. WAKEMAN: I don't believe it's possible for any hospital to accept WAACs on the basis of T/Os. It must be on the Basis of Manning tables of what you can use. I think it's going to be a fatal mistake if we accept the WAAC dictum that we will accept them by units and let them determine the grades and ratings. You will not have grades and ratings for your enlisted men if you do. It should be on the basis of Manning tables and not on the basis of T/O. That is a point that we must stick to.

Question: What are you going to do when they send you in a company with no grades or ratings and they are assigned to the hospital?

COL. WAKEMAN: You can then make your own grades and ratings if they are qualified.

Comment: We have a hundred and fifty colored.

COL. WAKEMAN: They are going to be free with colored.

Comment: I've only got one company there of a hundred and fifty, none of them qualified for any particular thing. Now what are you going to do about it? And they are pushing us right now to release a hundred and fifty men. Just Saturday, I told them there is nothing doing; that we couldn't let a hundred and fifty men go until those people were trained.

COL. WAKEMAN: I'd use them in the kitchen or any other place. I saw them at Des Moines driving two and a half ton trucks. I saw them doing all the first and second echelon motor maintenance. There wasn't a single man in any mess hall, WAACs doing all of the KP and everything else that was necessary to be done. It's going to be difficult to get whites. I'll take all the qualified white WAACs they'll give me for training as technicians. Just as fast as they'll give them to me, I'll train them. But they wanted to hedge to not more than a hundred and seventy. I have a promise of approximately a hundred and seventy starting in September.

COL. FRENCH: There's a point came up the other day. Captain Boyce, who is the chief wicky-wack down in Atlanta, said it had been brought to her attention that there were a number of trained technicians in the WAACs who were pounding typewriters or one thing and another. She spoke of one particularly, a laboratory girl that seven years after her college degree she'd had actually seven years training in the laboratory, in a clinical laboratory. She's down now in Daytona punching a typewriter in a company office. Now that looks to me like a waste of material. So I suggested to her that she get a list of all of those girls that had these qualifications for x-ray or pharmacy, laboratory, any sort of medical technician and submit it to me and that I'd tell her where we could use them. Now if that exists at Daytona it probably exists in other places.

COL. WAKEMAN: Colonel, the first robin doesn't mean it's spring; when I was at Des Moines I went over their classification records to find out what the rate of occurrence was for Medical Department specialists. Some of them were six-tenths per thousand. That's practically nothing. The highest was medical technician. I think they meant medical laboratory technician. The laboratory technician, which was the highest, was five per thousand. And that is for over 20,000 admissions, so you will see there cannot be marked misassignment. There is no greater misassignment than the one that exists at Fort Des Moines in which the commanding officer of the detachment, station hospital, is a captain of WAACs and is an excellently trained registered nurse. She could not come into the Nursing Corps because of the rule that we had that as soon as a girl got married she became worthless. She was married, so she went into the WAACs, worked herself up to be a captain in the WAACs, and now she's not sure that she wants to come back to the Nurse Corps. There are misassignments, of course, and these are the two examples which stand out like sore thumbs; but the rate of occurrence of skilled technicians is not even as great as it is among males.

COL. GIBNER: One of our post commanders submitted what I thought was an excellent recommendation that we employ half a dozen or more, depending on the size of the hospital, WAACs as medical secretaries and train them to write up histories, thus relieving the time of our limited number of medical officers. I thought it was an excellent idea, and I put it up, but I said that we had not heretofore provided enlisted men as medical secretaries and therefore the rule that a replacement of a man by a woman wouldn't work in this case, and in order to supply them we should have an additional allotment of WAACs. But the WAAC office turned it down and said nothing doing--we would have to replace a man with a woman. So I put it back up again, and asked Personnel that it be recommended to the War Department and that an additional allotment be procured for that purpose. Now, I don't know whether we get it or not.

COL. WAKEMAN: I hesitate somewhat in training medical technicians. I'm not convinced that we should put women on men's wards to take care of men, outside of being assistants to the nurse--to spell her off when she's absent from the ward or duties of that type, but to displace our male medical technicians, I'm not so sure that should be done. However, there is not a question about their being able to work in laboratories, x-ray, clerical positions, messes, or even in your operating rooms as so-called nurse, male operating, they can certainly learn sterilization. I don't believe we should put them out on the wards.

COL. GIBNER: That's the difference--Medical Corps officers are faced with the burden of writing all these histories and it takes an awful lot of time.

COL. WAKEMAN: Many of the hospitals now do have civil service employees up there writing that stuff from dictaphone. I mean in the general hospitals particularly.

COL. JONES: What is the policy of assignment to the hospitals? Who sets the number that will go to the Medical Department?

COL. WAKEMAN: You mean the WAACs?

COL. JONES: The way it is in the 5th Service Command, the number is determined by the commanding general.

COL. WAKEMAN: That's right. I am seriously considering, if we can get enough WAACs, to locate a school right at Des Moines, or at the other WAAC training centers to train our proportional share of medical people. I lean very heavily towards this plan, after going to Des Moines. And the same thing should be true at Daytona and Camp Devens.

COL. GIBNER: If they have room.

COL. WAKEMAN: They have 3,000 vacancies standing idle there at the present time. They could train laboratory technicians, x-ray, and some of the others right there at Fort Des Moines or at Fort Oglethorpe or Devens.

COL. WALSON: Originally it was my understanding that WAACs would be the white collar class.

The chief WAAC officer of the Second Service Command, in conference, assured me that she could fill all the positions of a Manning Table. That was some time ago. I haven't discussed the matter with her recently because I realize that there is a shortage of WAACs.

COL. WAKEMAN: So far as I know they will now. There was a time they didn't want to furnish the help to run their own mess, but they are doing that now. They found that a rather bad policy.

COL. FRENCH: But the class of WAACs that we are getting, a great many of them will fall under the category of kitchen help, in my opinion. We are getting in a large number of colored WAACs.

COL. WAKEMAN: You're going to get colored WAACs because there's plenty of them and they're going to be free with them. We'll have to train them. Now at the present time WAACs accept people with minimum qualifications of second-year high school. That's a lot better than we accept. And I can train colored WAACs if they have had second-year high school.

Question: The next question coming up is the question of sanitary companies. The Eighth Service Command requests the policy as to the use of Sanitary companies while continuing advanced training in the service command. All of these companies in the Eighth Service Command have completed their basic and unit training.

COL. WAKEMAN: Sanitary Companies should be employed on duty assignment in accordance with letter AG 320.2 (2-26-42) MR-M-C, dated 28 March 1942, subject, "Sanitary companies." Reference is also made to paragraph 5g, S.G.O. Circular Letter 52, dated 12 March 1943, which states in part, "Additional training will be applicatory in nature. The time available should be divided between mosquito and other insect control projects, rodent control, waste disposal, and assistance in sanitary details in the local operating hospital. A minimum of twelve hours per week should be devoted to a continuation of basic military and disciplinary training, and six hours per week to progressive physical hardening." In the case of a unit to be used in malaria control work overseas the service command concerned will be notified in sufficient time to allow concentration on this phase of applicatory training. There's a five-letter word that explains applicatory training. That's l-a-b-o-r.

COL. JONES: One trouble with that is that on mosquito control we've had difficulty in getting the engineers to hire the people that they need for mosquito control. Now if you throw in your sanitary companies to do this labor you're going to have more of it too. They're just going to be working it off on you all the time.

COL. WAKEMAN: Cutting of weeds and grass and all that is not mosquito control work, yet the foliage hides the mosquitoes. Sanitary disposal, rodent control, and all like measures are of a sanitary nature.

COL. JONES: I know, but if you do any of it the engineers are going to come right back and say they can't get the labor for mosquito control. I haven't allowed them to do it yet, just for that very reason, because the engineers have been trying to shove more of it over all the time and the minute you put those outfits in there and do that labor your mosquito control will drop.

COL. WAKEMAN: I understand, the more you do of that work the first thing we know we'll be inheriting the execution of sanitary measures which is not a function of the Medical Department in any way. But I know you all realize that we have to take our percentage of colored and it's a question of where we're going to use them, whether we're going to use them in hospital detachments or in sanitary companies.

COL. JONES: You figure we should go ahead and use them for doing this engineer work?

COL. WAKEMAN: I figure we had better use the sanitary companies activated rather than have our hospital detachments part-white and part-colored. That's what we will get if we do not use our percentage of colored in sanitary companies. That's the one way we could dispose of our percentage. But that is small compared with the number we have activated, an enormous number of sanitary companies about a year ago. Last year, when we activated that bunch of sanitary companies we had no colored MAC officers we could assign to them, and they were activated with white officers. I don't know whether all your companies now have colored officers or not. I doubt whether they all have.

COL. FRENCH: That brings up something I wanted to ask. Will your office assign the commanding officer?

GENERAL LULL: On requisition we will furnish colored officers if available; we could have furnished plenty of colored medical officers, but we didn't want to put colored medical officers with sanitary companies unless we had to.

COL. FRENCH: Well, what I'm trying to get at is this. You organize sanitary companies. Will the commanding officer of that outfit be assigned by The Surgeon General's office or will the service command do the assigning?

GENERAL LULL: The service command.

COL. FRENCH: That answers my question. In one company it was my understanding that The Surgeon General's Office assigned the commanding officer, and then we'd furnish the balance.

GENERAL LULL: We did at one time. I think that when they were organized it was The Surgeon General's responsibility to designate the commanding officers but now that's all over.

COL. FRENCH: The reason I brought it up was because we had one company that had three officers; the senior was colored with two junior whites.

COL. WAKEMAN: We are still recommending that one sanitary company go overseas with each thousand-bed general hospital. And, even all plans that are worked on still recommend that one sanitary company go with each general hospital. We haven't been able to get one with each general hospital.

Question: What is the policy as to training and use of field hospitals and sanitary companies?

COL. WAKEMAN: Sanitary companies and field hospitals will be trained in accordance with M.T.P. 8-1 and M.T.P. 8-10.

Question: It is suggested that affiliated units (especially general hospitals) be transferred to some newly activated named station or general hospital for functional duty pending transfer to theater of operation.

COL. WAKEMAN: So far as possible, within the limitations of available housing, numbered general hospitals have been and will be transferred to named general hospitals for parallel training. It is not desirable that these units actually engage in the functional operation of the hospital nor is it desirable that a named general hospital become so dependent on a numbered unit that the movement overseas of this unit will jeopardize the functioning the named installation. This office has no control over the location of affiliated evacuation hospitals, few of which remain in the zone of interior. These organizations have been utilized to a great extent on maneuvers furnishing services similar to that which will be required in the combat zone.

GENERAL LULL: It has come up within the last few days that some of these newly-activated units, after the officers get their basic training, might be placed in a newly-opened general or station hospital, because there is a need for them there. For instance, the one up at New York where we took over the hospital is just ready to open by the time we get it. We hear of it one day and they say we want the commanding officer and the medical supply officer in there tomorrow, and next week we want the staff there to take patients. It may be possible to use some of them that way until we can gradually fill them up and replace them, but we never can allow the hospital to become totally dependent upon the affiliated unit as such so that when we pull out the affiliated unit, the

fixed hospital is without any personnel. You can now use the officers any place you want, to bolster up your staffs in general or station hospitals. The services of these officers should be limited to the contemplated duties within the numbered unit if possible.

COL. WAKEMAN: Now there has been a concerted effort on the part of certain individuals in the War Department to reduce the allotments in service commands to such an extent that you would be forced to staff the hospitals with personnel from numbered medical units. We have never accepted this theory unless they could assure us that there would be at least two of these units there at all times, so that if one moved out the other could take over. They have gone so far as to maintain that all some of these hospitals needed was an administrative staff. The professional service could be furnished by the numbered units. And in the first place there is no housing available adjacent to most of the hospitals to provide for two units. As soon as they can provide the Medical Department with a proportioned share of housing we will be willing to go in on the place provided there shall be no less than two units at each such station all the time. Until that time, we cannot accept a theory that you can move out a hospital this week and move in another one next week and have an adequate medical care. Medical care to the patient must be continuous. We have recommended consistently that numbered medical units be activated in unit training centers, where there is an overhead efficient to activate and get them started on basic training. After three months in the unit training center, medical units could be moved adjacent to operating hospitals wherever housing may be or become available, for their last three months or longer, depending on how long they stay. This is when the service command should use those officers in the fixed hospitals of service command and not let them sit around and think when or where they are going or why they haven't gone.

COL. BURNETT: Why have hospitals and camps been located in isolated regions?

COL. WAKEMAN: I remember one conference I attended over two years ago in General Marshall's office when the location of replacement centers was being discussed. The chief of Coast Artillery got up and objected to his site at Camp Wallace, Texas. General Marshall told him at that time that there were considerations in the location of camp sites and the location of installations that he wouldn't understand and that the replacement training center would be located at Wallace whether or no. That was in the early days and that situation hasn't changed as time has gone on. Probably it has gotten worse. We may condemn certain locations but we must remember this about that business. Most of those boards that located these camps were in the service command and they picked alternate sites in 1, 2, and 3 orders; 1 and 2 have been used and

those being accepted now are 3, 4, and 5 in matter of choice. If you will study where camps are being located at the present time, it will appear that there is a studied effort to remove troops from large cities. Sites have been picked without taking the requirements of the Medical Department into consideration. If we tell them we have got to have a city where we can have a market center around so that we may feed patients, have milk, and so forth, they go forty miles in the country and put the hospital there.

GENERAL KIRK: What we want to talk about first is the use of numbered units that are in training and have been in training too long. There are nurses and doctors sitting around waiting to know where to go. They use those in station and general hospitals, some of them, part of them, and relieve the other doctors and nurses that are in those hospitals. I think Colonel McDonald has something to offer.

COL. MCDONALD: One of the problems that I found was the training of numbered general and station hospitals. The Training Division, ASF, has a plan whereby we would take these units which have completed 26 weeks of training and been through their basic training and place them on duty in the general and station hospitals for a triple purpose. One of those would be to give them functional training so, when they get overseas they will know how to operate a hospital, and will begin functioning in a normal manner. The second would be that we would save personnel. In other words, the amount of personnel normally allotted a station or a general hospital could be reduced and you could use the personnel in other places or The Surgeon General could get that personnel to organize new units. And third, it would avoid the criticism of having units trained and sitting by complaining to their congressmen and others about having nothing to do when we have a shortage of personnel. The disadvantage brought out is that it would interrupt the standard care and treatment which the named station or general hospital is giving because it would have to release up to 50% of the strength (no percentage has been set, but it seems to me that they could relieve up to 50% and maybe more). It is maintained by the Professional Group that interruption of the care and treatment would result. That could be minimized by having at least two units at each post, camp, or station where this plan was put into effect so that when one unit had been in training 6 months, or 4 months, or 5 months, and is ready to go overseas, you could substitute another unit which had already completed its 26 weeks of training. That would minimize the difficulty, and the plan would not work unless that is carried out; that is to say, to make this second unit available, have it available and trained. The Surgeon General is going to be vulnerable when he asks for additional personnel as long as the Headquarters, ASF, believes that some medical personnel could be relieved in this way. What we would like to find out is just exactly what The Surgeon General would like to have done in this matter. That's what I want to do, whatever General Kirk decides on after you gentlemen discuss it here and indicate what can be done, that's what, it seems to me, we should do. Colonel Wakeman knows a lot about the history of that, and knows about the plans.

COL. WAKEMAN: I think Colonel Wickert knows more about the plans than I do. We have never opposed the functional employment of the numbered units provided there can be some assurance that we would always have two units at that hospital in order that medical care could be continuous. There have been many meetings over in the War Department, conferences in which nothing has developed, because they will not provide housing adjacent to those stations to provide for an adequate number - two units at each station. I would like to see some kind of plan developed whereby we could use these units. There is the further difficulty, however, that many of these training units, even after 26 weeks of training have but 2 Medical Corps officers with them.

COL. MCDONALD: That wouldn't help the hospital.

COL. WAKEMAN: Simply planning to move in units isn't the answer to the problem, because we have been training these medical units with 2 medical officers not more than 5 MACs. It would provide enlisted men to the hospital. But we are at the present time over 10,000 enlisted men short in these units.

COL. MCDONALD: The question of housing is an important one.

COL. WAKEMAN: It is the question. Housing has never been provided except by the grace of the Ground Forces. Where housing happened to exist they have thrown our units into that housing irrespective of whether they could be functionally employed or adequately trained.

COL. FRENCH: In some cases two or three miles away from the hospital.

COL. WAKEMAN: Good examples are Rucker, Camp Adair, and places like that. They have stacked in units which could not possibly be trained at the post.

COL. MCDONALD: About how many stations have beneficial housing construction?

COL. WAKEMAN: For one unit? 22 general hospitals and 33 stations. About 55. Some of them we have lost, to the Air Corps and to the Ground Forces. In fact, I know at Barkeley, for instance, they moved their station hospital detachment over in this beneficial housing and made bed expansion in the hospital. So we've lost that so-called beneficial housing.

COL. MCDONALD: Let's take Fort Meade. As I see it you don't necessarily need beneficial housing to house additional units adjacent to your hospital. At Fort Meade I believe there is beneficial housing for an evacuation hospital.

COL. BURNETT: We have seven training units there at the present time.

COL. MCDONALD: You have enough housing there. Take the beneficial housing plus the housing you would relieve if you should delete 50% of your personnel, and you wouldn't have any difficulty putting a general hospital in there to function. I'm sure you wouldn't. I know the situation and I know that you could put that unit in there using the beneficial housing right adjacent to the hospital plus what you would relieve by relieving some of your personnel who are on duty. Now the other hospital which has been in 26 weeks training doesn't have to be right in the same location. It can be in some other part of the camp if they have transportation. As a matter of fact that is the way it is right now. They may go 2 or 3 miles, but one of the hospitals, the one that is actually functioning in with the station hospital must be right there. Certainly that must be nearby; either occupying the housing at the hospital or the beneficial housing constructed adjacent to the hospital.

COL. BURNETT: We have an unfortunate situation there, a congestion. We have a 23d general, a 29th general, a 1st general, a 238th station, 239th, and now we're activating a 28th portable surgical hospital there. Now that makes 6 right there at that one station and yet we have none down at Pickett and we have room there for one.

COL. WICKERT: That is just the difficulty that we point out. We get this housing for all these units now by the grace of God and the Ground Forces and those facilities that are vacated we have no assurance that we can get again for other medical units. We have no control over transfer or what happens to space which the units vacated. We get the list from Ground Forces as to where we can put medical units and how much housing is available and we have to shove them in there, whether we want to or not. Another point about Colonel McDonald getting these people: In these affiliated units that we are activating this month, all of the Medical Corps officers were on active duty prior to the activation in the service command. So we have had the benefit of those officers being on duty in the various hospitals with service command, even before the units were activated. All the others had been on pre-activation duty at their own volition. So the activation of these units didn't help materially. The other difficulty is, as I see it, if we get the Z.I. installation so definitely involved and dependent upon the presence of these training units to function, there is going to be some awkward situations when some of these units that had been stacking up, suddenly go. As hospital requirements in the theaters more nearly approach what The Surgeon General has recommended be set up, these units will move much more rapidly and there might be some embarrassing situations in moving these people out. Going back to the other point until these units are put on a 6 months'

projection list or even a higher priority, they may be activated. They are so low in their priority that they do not get their personnel, either enlisted or commissioned. Personnel Division is having a great deal of difficulty of getting personnel now that we have activated the remnants of the remaining affiliated units and there is a difficulty, as a matter of fact, a representative, from your office over the other day, about reorganizing certain units into lower categories to relieve some officer so we could have some officers to activate similar units.

COL. MCDONALD: I firmly believe that if you can get crystalized the plan indicating just exactly how much housing you should have and where it should be that the Headquarters, ASF, wouldn't hesitate a minute about approving. What we want first is, do you approve the principle of this functional training of these units in the station Hospitals?

COL. WICKERT: Well, it all depends how definitely and how completely, as I see it, the service command is going to depend upon the habitual presence of training units in order to discharge their responsibilities on hospitalization. Because, if they become dependent to the tune of 50 percent that would be obligatory of the War Department to keep another unit there to immediately take over when they moved one out to the theater. Now, whether that is an economy in personnel I am not sure. It would be saving 50 percent of your allotment to the service command but you would have to have two complete units present habitually to let the fixed hospital run. I'm not enough of a mathematician to figure out how much saving of personnel that would be, because you're saving 50 percent, say, of the allotment to the service command. In order to let the service command function there must be the habitual presence of two numbered units all the time adequately staffed with officers.

COL. WAKEMAN: Which we haven't got at the present time.

As a substitute for that plan, because housing could not be made available I submitted on 30 January a plan to the Training Division, ASF, in which it was requested that a directive be written and published in which the service command would be permitted to use any or all officers of affiliated units any place within the service command, provided the officers were earmarked to rejoin that unit upon the call of the unit commander after the unit had been alerted. That was returned to us and we were told that we wouldn't resubmit it.

COL. BURNETT: As a matter of fact, we've been doing that considerably in the Third Service Command.

COL. WAKEMAN: Well, if you're using those officers to the fullest extent I don't see a thing that's going to be gained by this new plan.

COL. MCDONALD: Decrease in officer personnel isn't the only problem. You've got your units including all the enlisted men and nurses and the other people that are in the unit. All should have functional training. Not simply, the officers. I'll admit that the officers, if assigned to positions in a large station or general hospital that correspond to their assignment in their own unit is perfectly all right. They get their training and that is very important but training for the rest of the unit is needed.

COL. WICKERT: Well, that was the reason we have tried with the War Department and ASF Headquarters, due to the nonavailability of housing to scatter the group as we wanted to do when we initially activated. We have had to accept the grouping on the basis of the availability of housing, but as these units moved out, those units would move from those groupings to the housing that we had asked for. After a unit had had an opportunity to shake down as a unit then we desired to place them near one of these general hospitals or larger station hospitals where this beneficial housing had been provided, and they could polish off their training. However, we have never been able to get an adequate amount of housing to run that scheme through.

COL. WAKEMAN: If we could have any assurance that the hospital would be adequately staffed with enlisted men -- if we're not going to fill our units we wouldn't know if we're going to have enough there when this second unit moves in. Our ideal plan was to activate these units in a unit training center and after they had shaken down and had their basic training our plan was to move them to these hospitals for functional employment. Take the officers and distribute them if necessary, but use the enlisted men in that hospital and they could have a reduction in their alloted grades and ratings on the basis of it but it would seem that there must be two units there.

COL. MCDONALD: That's correct. You must have your housing; you must have at least two units; but if you do get these things, if you do get your housing, and if you do get your two units, can you do it then?

COL. WAKEMAN: Yes.

COL. MCDONALD: All right. I'm sure that they'll approve the housing and go ahead and build it for you, if you'll make the recommendations as to what housing you should have. Now the question of the two units: you can step up your activation of units -- we've already had to step that back. Step up that and get

more units. Now you say you can't get the enlisted men. Well, has anyone tried to change that priority on enlisted men for these units? If we indicate clearly how we intend to use these units don't you think we can get that priority stepped up? What is it --116?

COL. WAREMAN: I don't know. We've got to have something higher and particularly since the Training Division, ASF, insists upon the definite training of all individuals for a 26 week period. If they don't get the men early in activation they're not in training. If they get them in dribbles over a period of months you're going to add many months to the necessary training period for the unit. It must be 26 weeks after 90 percent of the men are present for training, we have units with about 6 levels of training because of this constant dribbling of men to units.

GENERAL KIRK: How many units have we, general hospitals, numbered general hospitals, which have completed twenty-six weeks of mobilization training?

COL. WAREMAN: I can't give you the exact figure, I know we have 486 different units at the present time. As to how many have completed 26 weeks I'll have to look that up.

COL. MCDONALD: Well, it seems to me that the subject should be carefully considered and it should be determined what we need to carry it out. Increase the priority so we can get the men to set up these units; get the housing and at least two units to each place; and perhaps make a try-out in Camp Meade or some other place before you attempt to put it in all over. Go slowly, I should think, because it is going to take time to put in housing. Maybe there are two or three places -- maybe there's one place in each service command right now where you might try out this plan. I think it could probably be tried out at Fort Meade or Pickett. Start it out at Meade with several units. The only trouble is with Meade the last few months there's been so many units, there wasn't room for them all.

COL. BURNETT: We've always kept the allotment at Meade away down, not much more than half of their requirements because we have had these other units there.

COL. MCDONALD: At one time we had only 125 nurses who were not alerted for overseas duty. I took it up with The Surgeon General's office and he said not to be worried about that because we are not going to take them all out at once. I said all right don't take them except when I say so and you can take all you want on that basis. But if you have the officers, the nurses, and the enlisted men at big hospitals the thing will work. In other words, plan the distribution of officers to assure

success of the plan. If there is good supervision it will work. But the housing has to be available as well as personnel. If you step up the priority will that furnish the officers to the unit?

COL. WICKERT: No. That will not help us a bit.

COL. MCDONALD: All right suppose we take Fort Meade as an example. We've got, say 50 medical officers in that place. We put a unit in. We put 25 of the station hospital officers right over in the numbered unit and build it up. That is one advantage of the whole plan, it will give you personnel to put into new units. You can relieve 50 percent of the officers from that station hospital. This plan may not work except at Meade.

COL. FRENCH: It would four months ago at Rucker, but we've been moving the units out, putting them in places where they didn't have any, so they could have a station. This plan would have to be arranged, have to be planned. You would have to carry out the plan from A to Z. You put two 250-bed hospitals, station hospitals, for instance the size of Blanding -- a 1,000-bed hospital. That wouldn't take care of the situation.

COL. MCDONALD: These are small units, why couldn't you house one or two general hospitals there? Let Blanding give up part of its personnel. Blanding probably has 75 medical officers. Now if the unit being trained is moved out, 50 percent of your personnel will remain. I wouldn't want to see personnel at a station hospital that had been trained as a team in laboratory, x-ray, surgical, and medical work taken away and given to a training unit just for the sake of the training units help at that hospital. I think that would be working backwards on your effort to train that unit to do its function overseas. You couldn't have any plan that would work if it takes your key personnel out of your station hospitals. The Surgeon General has attempted to supply high grade professional men for all these general hospitals.

COL. WAKEMAN: In the final analysis, aren't our units going overseas entitled to about as good as we have? I think General Snyder said they needed more training before they got over there. They need more training to take care of themselves in the field. I personally think they are entitled to the best overseas. When they are out on their own they don't know how to go about it. That is field training and not hospital. They haven't been out in camp, in other words, don't know how to take care of themselves. That is the complaint of the training over there.

COL. WICKERT: There is another angle. There is one other thing that will have to be done and that is The Surgeon General's Office or

the service command or somebody will have to have a little more to say to what units are put on 6 months' projection. At the present time this is done by a major and a captain, ASF, on the basis of training reports. If we had two of these units and the hospital at Meade, for example, depended upon at least one of them functioning. Somebody would have to control the movements over here to see that they don't pick those two units at one time.

COL. MCDONALD: That should be The Surgeon General's function.

COL. WICKERT: We have so contended right along but we haven't accomplished it.

COL. MCDONALD: Aren't you always informed before they take the unit?

COL. WICKERT: Just in the last 48 hours we had a fuss with them because they had put on 6 months' projection 5 general hospitals that were never affiliated and left 6 or 7 affiliated general hospitals that had been activated for a long time.

COL. BURNETT: Might I say that the 29th General hospital down there has been activated a long time. It is thoroughly trained -- its gone stale. We used all we're worth to keep them busy. And he has got an excellent outfit, now that outfit is still there. It has been activated for a long time, but hasn't gone anywhere.

COL. WAKEMAN: Effective the 1st of July we can't even get a training status report on these units.

COL. WICKERT: For instance you take a lot of these units that were alerted to be ready a certain day, have been made available to that theater section. They are very loathe to give them up although the projected movement may be indefinite. They still hang onto it as part of the force for that particular theater, but they are not considered available to a movement that is going to take place earlier. You are breaking your neck to get this unit ready when there are other units that have been ready for the last 6 months and it is not going. Of course, the best trained unit ready to go over there and function should be used.

COL. MCDONALD: Absolutely. Any system that doesn't give you that isn't working right. If we can get at the cause, we will try to correct it. I don't think General Sommervell would stand for that a minute, if he knew just exactly who is responsible. I certainly would like to have more information.

You know what the requirements are, and when you have those requirements, number of units, personnel for units, etc.,

the plan should work. I think the training of those hospitals is very important.

COL. FRENCH: We don't have one thing to do with it. I don't know, just heresay, any more about the hospital than you do, down in my service command that is some situation. A year ago I knew the status of every organization, just exactly how they were equipped. How they were personnel; but I haven't any knowledge of it now.

COL. WARREN: Unless things change The Surgeon General will not have any of that information either.

GENERAL KIRK: Who does that?

COL. WARREN: The Director of Training, ASF.

GENERAL KIRK: I think we are getting nowhere fast.

COL. WARREN: We are getting into the same position as far as ASF units are concerned as we are with Ground Force or Air Force medical units. Well, off the record I understand there is a movement on to put the Training Division of all branches in the Military Training Division, ASF. Training Status Reports, which The Surgeon General devised in the first place, and which were adopted for all other units, are to be discontinued as 1 July 1943. If we get the information from the reports we will have to get it through the Training Division. Their excuse is that it is a duplication of paper work.

It isn't any such thing because field units still have to make two for the Director of Military Training. Ours is the third copy that comes in. There isn't any duplication of paper work whatever, and in the second place it is absolutely in counter distinction to the provisions that The Surgeon General, an agent of the Commanding General, ASF, may issue directions to the service commander in his own name without invoking the authority of the Commanding General of the Army Service Forces.

COL. FRENCH: Well I hope the reorganization of the Medical Branch Headquarters will be put over and that will go a long way toward correcting the situation down there. I personally think that The Surgeon General's Office should have the information as to their training.

COL. WARREN: Certainly technical supervision should rest with The Surgeon General for all units whether they are ASF, Ground Force, or Air Force trained. The Surgeon General and his representative should be allowed to go and visit any of those units at any time he wants to look and evaluate their technical training

without getting permission from Director of Military Training, ASF. I must now submit an itinerary and get it approved to go and inspect the training of any ASF units, or one of my schools or replacement centers.

COL. PURNELL: You mean down at Pickett?

COL. WALEMAN: Yes, at Pickett, and to inspect that place I must get permission of ASF and send notice to the commanding general, 3d Service Command.

COL. PURNELL: There is a medical representative attached over there at the Training Section. He is part of the Training Division of the 3d Service Command Headquarters. Well, he checks all numbered units to see what their training is, if they have schedules and programs, and keeping them up, and he inspects those. Now the training is reported also to the training officer at Leade locally. He is the training officer there, but the actual training is done by the commanding officer of that unit and the hospital commander cooperating, of course I am speaking of after the base training is completed, and it is supervised and checked by the training section of our headquarters which is a subsection of the headquarters with which I have nothing to do except through courtesy. I go over there frequently to see them and they come to see me, but that Training Section is a separate section there.

COL. WALEMAN: When we go out and see a unit, which we did here a very short time ago, we went to the post headquarters and the post commanding officer said, "I don't have a thing to do with these units. I have never seen them, and I don't want to ever see them." It is the responsibility of the surgeon of the post, who in many cases is his station hospital commander. So there is no one who is giving a damn about it. There are at least 9 different solutions, one for each service command, as to how the training set-up actually functions. Theoretically they are all set up under S-3.

The best information we were able to get was from those training status reports. They were drawn up in such a manner that we could analyze them and tell just about what that unit was doing by comparing with previous ones.

But again in reference to the field training in North Africa, for many of these units that went over there there was no opportunity to have any field training because they were affiliated units that came in 30 days before the unit sailed, and enlisted men went out of here with 4 weeks' training or less. Now we have a policy where all new incoming officers go through Carlisle before they are assigned to a unit.

There have been surges in procurement and as a result it was impossible to adequately train all incoming officers. The Ground Forces and the Air Forces have insisted that Personnel be made available upon procurement and they took these officers before they had any training and that they would train them. The results are now to be seen. They didn't train them

COL. WICKERT: To go back to the problem of enlisted men - not giving him high priority. We had some units some time ago that had been activated and had been in existence for six to eight months and the policy then was that we would take cadres, take them from the service command because the service commands were rapidly losing all their general service people and getting them replaced with limited service and that was a poor cadre source for overseas units. We should take cadre from like units. So we started to look into it and found that some of these units had never been filled up, but actually had less people in them at that time than they got in their initial cadre. That is an indication of how low these units rate in getting personnel if they are not on a projection or a high priority.

COL. WAKEMAN: The only thing that has saved some of these units is the fact that they got their initial cadre plus 50 percent or more of their trained technicians, unassigned school graduates, pre-activatedly trained. It is the only way they even got started. As far as I have seen, housing has never been provided for medical units.

COL. MCDONALD: Has it ever been asked for?

COL. WICKERT: Yes, sir. There is a letter at the present time for sufficient funds to expand the original 22 general and 33 station hospitals, I think it a figure of 56 or 60 additional ones or something like that.

COL. MCDONALD: Has it been turned down?

COL. WICKERT: I don't know what finally happened to it. They seemed to think that construction of additional hospitalization were the two new things in the construction program that were not very much in question. They thought that there was a good chance of its getting through.

That was result of several meetings we had in which we finally went ahead and got all the post population and the hospital facilities.

Then on this basis we tried to work up the additional housing necessary. They worked on it for some time, and submitted the letter of what we wanted to implement this program.

COL. WAKEMAN: The thing that worries me now is the numbered hospital units that were deferred because of the lack of housing. All the information that I can get from the War Department is that we are almost at the bottom of the barrel as far as men are concerned. Everybody else has the men they need now except the Medical Department. We have several deferred units that were authorized in the troop unit basis. It is a serious question as to how they are going to even fill replacement centers at the present time. I know that all schools are going to be cut 33 1/3 percent. The Air Corps has received orders now to reduce their quotas by 50 percent, the Ground Forces by 25 percent and A.S.F. schools by 33 1/3 percent. How they are going to get men to even fill replacement centers or even to replace losses - that's the only thing they are estimating on at the present time. They are not even figuring on these hospital units that were deferred because of lack of housing.

GENERAL KIRK: Well, it looks like we've got to do a lot of work to beat it out to these people that it is not their job but our job.

COL WAKEMAN: Control over and authority for training has been taken from service command surgeons, the same as The Surgeon General - all the responsibility but no authority. I don't think the two can be separated. I think that a certain amount of authority must accompany responsibility and that responsibility should pass to those who take the authority.

GEN. KIRK: I think if they find out where the housing is and where the troops are. Let's find that out. Then we've got something to figure on and we will do what we can do about it.

Well, I guess you know we're going to be taking WACs pretty soon. I think you are going to have to plan on six to ten percent instead of four for hospitalization. Then when it comes to hospitalization it has to be made available for enlisted WACs and officer WACs and not a distinction of putting all women together as we did in peacetime.

Marietta, I know, out here, is planning on 10 percent additional WACs. There's a group coming in here to Washington. Somebody is going to have to hospitalize. In addition to that, you are going to have to get obstetrical and gynecological facilities in your hospitals at least for examination, if you don't have them. All your hospitals are going to have to be able at least to examine women. The request has come in from certain places to set up facilities to take care of obstetrical cases in personnel that belong to that station.

Comment: I don't see how we can do anything else except stick to that. I don't think we are going to have enough facilities to get the hospital beds for those that need them. We make arrangements whereby those people that belong to our own command be taken care of in civilian hospitals and so arrange to have our doctors look after them there. Those arrangements were made and we are doing it. Then we are also directed that those people couldn't meet the expense of hospitalization, that either by grant or loan that money be supplied out of this Emergency Army Relief. Apparently they have got a lot of it and want to spend it. Those primary jobs to look after emergency Army Relief funds. That would be his principal job. The Navy appropriation of $2,000,000 to provide hospitalization for dependents of Naval and Marine Corps personnel. Heretofore they usually depended on the Army. Apparently the thing became acute and it was brought to my attention about a week ago. I mentioned it to Colonel Offutt; I didn't know whether he had mentioned it to the general when he spoke to him. But they did attempt to do something through legislation. Public Law 51, 78th Congress, that is generally for Navy and Marine personnel.

COL. FRENCH: General, that would work all right in these northern states where they have some big towns and big hospitals, but some places with us where the stations are isolated, for instance Van Horn, Rucker, Blanding are so far away, the situations are acute down there, and we have had to take certain emergency cases in those hospitals. Just out of ordinary humanity.

GEN. KIRK: I guess that will have to be done, if it is going to be opened one place, it will have to be opened every place. Got to

stick to the guns on the initial setup. Now about nurses? I've seen in years past that there are at least a half dozen nurses around nurses' quarters looking after and counting linen, running messes, and doing this and that. And I thought they ought to be taking care of sick. I still think they should. Nurses are now officers, and they pay for the mess the same as other officers. It seems to me messes ought to be available and run for them the same as other officers' mess or hospital mess. If they have to run their own mess, let that be additional duty the same as it is for an officer. With the money they pay into that mess, they hire the civilians to take care of it and the housekeeper to run their quarters. I don't think a half dozen nurses ought to be assigned to nurses' quarters to count linen and do housekeeping. I think they ought to be nursing. I am not so sure of the whole nurse setup; maybe we ought to take and put another medical officer or some medical officer in charge of it rather than have the nurse try and run it. Same as the Army Service Forces taking it out of our laps. I question very much how much good your nurses are that are assigned to service commands. How much information do they give you? Do you need it?

Comment: You mean do we need more?

GEN. KIRK: No, do you need what you've got?

COL. FRENCH: I couldn't very well get along without the one I've got. She's invaluable to us. In the procurement of nurses, she has procured a lot of nurses. The Red Cross has to procure all the nurses now, I know, but she interviews them, helps pick them out, gives them all the forms to go through. Goes out to make speeches all over creation to get more nurses. Is interested. The Red Cross doesn't want to do it. They won't come in the Red Cross.

GEN. KIRK: All right, what do you think about the messes now? Need them in there?

COL. GIBNER: I think they ought to be out of there and civilian employees put in there, to be hired to run these things. Nurses and officer personnel with hospital messes. I think that was intended so that when there was a few of them you could just add them in there without any increase in overhead. But it works the other way. They want a whole lot of them there and then they want an excuse for hiring additional cooks and mess attendants to run the hospital mess. What are we going to do about that?

GEN. KIRK: Hire them and charge them a $1.00 a day for mess. They are entitled to it the same as a medical officer or any other

officer. I think all the messes on the post ought to be run under one head. They have to do with duty officers, nurses, and sick officers. All out of the hospital mess and one mess officer. We did it at Percy Jones all right and had no trouble with it. Of course, we had a big dining room. One half of the dining room was for ambulatory patients; came in cafeteria style; and the other half were the officers; the nurses, the sick officers, etc, and they paid their dollar a day the same as the officers did. Now if you can't put them in one room you can surely set your one mess officer over as many as you need up in all those departments. It is authorized. You will get more work out of your personnel, and take care of the sick. It worked very well out there. We had one officer who was responsible for all the help. Now here is some more construction. We have a scheme up, we talked about the other day. I would like to put 20 percent convalescent beds for 20 percent bed capacity for all these general hospitals--put convalescent patients in them. Get them ready to go back to duty. Put them in uniform, put them under their MAC officers. House them, have physical directors, if we can find them, there to recondition them for duty. It will save a lot of construction money for hospital beds. Built for a 3d as much, gymnasium in each unit for inside training in bad weather, save $1,000,000 worth of equipment that goes into a 1500 bed general hospital. Save all the personnel that's critical, doctors, nurses, and otherwise. Each of these units where we can, we can take over a school or what not if the unit is willing.

To have an infirmary established there for sick folks only. Have the doctors whose patients are out in these convalescent units getting training see these cases, go see them once a week to see if they need anything. They can be sent back to the parent hospital for treatment if they need hospitalization. We want to trade these beds for that many general hospital beds. I think we can save and get by with it. There are many general hospitals now. I have already talked with the engineers and they have agreed to give us the usual 2-story barracks. Also they agreed to give us steam heat instead of individual heating. They also agreed to put in each unit a gymnasium sufficiently large where inside training can go on. They are all for it up to now. Of course, it hasn't been OK'd by the top yet. In some places it might work, at some places there's land available and at other places there isn't.

Now, prisoners of war. There are going to be a lot of these taken care of. Now, there were some places, I think, where hospitals had been built within compounds, and others there haven't, and some places probably nothing has been built up. I don't know. It was proposed in the Sixth Service Command by the commanding general there, that instead of building

hospitals within compounds we should build the necessary wards adjacent to the station hospital.

Question: Could it mean, be responsible for the prisoner that was in the ward, in the barracks adjacent to a hospital facility, rather than put the hospital in the compound, if there was a hospital there, and to put a dispensary in the compound only?

GEN. KIRK: Now, that seems very reasonable, if we can get that going. You've got to build your hospital facilities right there then.

Question: In the compound?

GEN. KIRK: Oh yes. Well, that is a different situation. You've got the place warm. But, otherwise, you're in agreement with that, are you not?

Comment: Well, we were disappointed when we didn't get any prisoners in the command.

Comment: We've got in one camp 3,000. Most of them have 6,000 in there.

GEN. KIRK: Well, I've a note down here, to write--like to have any of you at any time write me directly about anything I can do to help things. I think supplies and everything else should come from here and anything we could give would be handed out to you instead of having you ask for it. I don't like this red and green on requisitions. The fellow out in the field knows more what he wants than the fellow at the desk. On promotions, I'm trying the best I can to see if we can't get all first lieutenants, Medical Corps and Dental Corps, with at least a year's service promoted if it is so recommended. I don't know whether we can do it or not. Another thing that the A.S.F. want cut down are the reports coming in to Washington. Now, if there's a report that you think we don't need here, let's know about it. The less paper work we can have, the better. Too much of it. No time for the commanding officer of the general hospital to read all the stuff that comes over his desk every day, let alone do anything else. We'll try to give you the best help we can. I know Gen. Rankin will as regards consultants. He'd like to have sent in here a copy of the report you make in your service command, so we'll know what's going on as well as you know. When that's done, I think we ought to pry into every thing and we ought to be able to see what's done in Training, Air Corps, Ground Forces, and everything in the service command. You are The Surgeon General's Office representative and we hope some day to have it so that you will be.

That you'll be able to go in there and get your nose into things and see whether or not they are being done properly from a technical standpoint. That's our ideal. That's what we should do. It looks like it's getting worse. Now there are certain directives and hospital policies as to what cases will go to general hospitals and what will stay at station hospitals. It's never had any teeth in it, it's been lackadaisical, and every surgeon could do as he damned pleased. If he wanted to treat a fracture, he could treat him, or otherwise. I just want the other way. That order is written with an idea. I expect to see it carried out. If a case is going to be in a hospital more than 90 days, that means the fracture of any long bone or a spine, that case goes to a general hospital. There's a reason for this. We want to get our occupational therapy set up in there as well as the physiotherapy, and we want to get a brace shop and everything in one place to handle it. Then we'll go after this recreational this reconditioning center and be ready to be sent on out, if it's advisable as CDB. I want that followed. Now, if there are some station hospitals that we believe are sufficiently large to warrant this extra expenditure of material to put in to properly take care of that type case, and there are doctors there capable of doing it, why we'll OK it in this office. And if the fellow is so good down there, he's such a good bone man, if he's so much better than they've got in the general hospital, let's know about it, and we'll transfer him to the general hospital and send you another one. This war is being run, we want to win it, and we want to take care of the sick. An individual and what he wants don't amount to a good God damn. He's expendable, and I think that's the attitude we want to take while we're on this job; that it's not the fellow, it's the job and the job's got to go and he has to go and go running and go fast. I know we've got a lot of excellent professional men and probably excellent men in camp and station hospitals, but there are just as good in general hospitals. But the general hospital is built for a certain job and the station hospital is built for a certain job. So, let's know about it and we'll switch them. I'd like to have that directive carried out. It outlines a policy, and if it isn't signed by the Secretary of War we're going to get it fixed so it will be signed by him. Certain amputation centers have been set up and we want all amputation cases sent to these centers as soon as they're transportable, to have their amputations done. There will be no more buying of artificial limbs at any station. These men will be fitted, as they were in the last war, with temporary prostheses at these amputation centers. If the ones set up aren't enough, we'll set up some more. We pay $150 to $200 for each leg that we buy, that we have fitted locally, and unless you've got a good man there, 90 percent of these legs don't properly fit. It's a waste of supplies; they are ready for fitting within six weeks if they

heal by primary union. And then they have to be refitted and then they are ready for discharge. It is going to save us a lot of time by following this procedure. You know what happened in the last war: we discharged 150 cases in December 1919 at Walter Reed on CDD - amputation - and it can be worked that way if you keep moving.

We have been criticized by the Inspector General's Department. Snyder stated that he thought there were still in our general hospitals and other hospitals 20 percent of patients that ought to be discharged, that are constantly taking up beds. Our turnover wants to be a little faster than we have been doing. If there is anything to get CDD's through faster, let's do it. General hospitals and large station hospitals have authority - and then they have some service commands doing it -- is that right? -- for approval?

Comment: Yes, sir, from the station hospitals themselves.

GEN. KIRK: Let them sign them themselves, because there is a lag. I've seen officers lie around general hospitals three and four months waiting for orders. We should get set up in each service command where we should send our casual patients until they are ready for duty -- not only officers but soldiers. There should be a place when that man is ready for duty -- an officer or a soldier -- in any outfit in any service command -- that they can put an order on that fellow to go to a replacement center and not have to find out or ask higher authority where to send him. It should be a standing order: it's all set, is it?

Comment: Yes.

Question: May I ask you a question about general hospitals? One thing is congesting our general hospitals, and that is the Reclassification and Retiring Board for Officers -- up until very recently we just had two general hospitals functioning -- and they would have a backlog of some two and three hundred officers just occupying beds.

Waiting for what?

Waiting to get up before the Retiring Board for reclassification

Disposition Board.

Disposition.

The Disposition Board is a local thing in a hospital itself.

If that could be done, if retiring boards could be dispersed more generally around at some of the larger station hospitals

and reclassification boards, we would save the congestion of these general hospitals -- the officers' boards of these general hospitals -- tremendously.

Most of all, the reclassifications.

You mean as to limited service and general service.

GEN. KIRK: Well, the Disposition Board, as I see it -- at Walter Reed and Percy Jones we had a Disposition Board that all officers came before and all enlisted men that weren't ready for full duty. At Percy Jones we turned out 130 of these a week before that Board -- 130 a week at the new hospital -- that's how many we turned out in a week.

Comment: We can't do that for reclassification. They have to go to a general hospital.

GEN. KIRK: I'm talking about in the general hospital. That's what I'm talking about.

Comment: We've got a million and a half people down there --

GEN. KIRK: You want that authority granted to station hospitals?

Comment: Yes, some of the larger ones.

GEN. KIRK: Well, send in the names that you want, and we will see if we can change it.

Comment: Isn't there an Army Regulation ---?

GEN. KIRK: We can check that up.

Many of our station hospitals that have 2000 or 1800 beds -- they are just as capable of doing that. They have to send these patients clear up to a general hospital. There is railroad fare and everything to be considered. It could all be done locally.

Pretty soon you will get back to this other directive on some of these other cases. Why should we worry so much about railroad fare?

Time consumed too and congestion in the general hospital. The ones you are speaking about that go to general hospitals are officers only.

I assumed that purposely The Surgeon General's Office put that proviso in there because a general hospital was presumably better staffed, because there were so many factors to consider there.