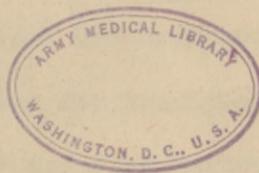


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**SURGEON GENERAL'S
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MAIN NAVY BUILDING
WASHINGTON, D. C.
5-12 NOVEMBER 1949

U.S. Surgeon-General's Office

CONFERENCE OF THE SURGEON GENERAL
WITH

COMMANDERS OF MEDICAL CENTERS AND GENERAL HOSPITALS AND ARMY SURGEONS

8-12 November 1949

Colonel Tynes - Conference is now in session. Ladies and Gentlemen,
The Surgeon General.

Major General R. W. Bliss, The Surgeon General, Department of the
Army, opened the conference with an address of welcome.

Colonel Tynes - Our first speaker will be Lt. Colonel McGibony, Chief of
the Hospitalization and Operations Branch, whose subject is a "Brief Resume
of the Current Hospitalization Picture."

Lt. Colonel McGibony - Lt. Colonel McGibony briefly discussed the present
patient loads in the station and general hospital systems. His discussion
was illustrated by graphs showing patient loads in each general hospital
with comparison of beds occupied to authorized beds. Similar charts were
used to show the occupied bed load to authorized beds in station hospitals
of each Army area. A final chart illustrated that of the patient load at
the present time. General and orthopedic surgery accounted for forty-six
percent; general medicine for twenty-six percent; tuberculosis for six
percent; closed ward NP for five percent; open ward NP for six percent; and
all others eleven percent. Additional charts were used to show the com-
parison of 1949 and 1943 patient load and authorized beds in each of the
general hospitals and each Army area.

Colonel Tynes - All of you have been hearing vague rumors the last several
months of radical changes at Valley Forge. We purposely delayed sending you
any description of this experiment so we could have an opportunity first to

see for ourselves how it was going to work and later to present it to you in some such discussion as we have here today. I am going to ask Colonel Gibbs, Executive Officer of the Medical Plans and Operations Division, to give you a brief statement as to what led up to this experiment. After that, Colonel Brewer will give you a brief talk on how he worked that experiment in his hospital.

Colonel Gibbs - Gentlemen, the principal story will be told by Colonel Brewer.

I would like to give you a picture of how we came to have such a plan and why we felt it necessary to test it. I think all of you will remember that at the beginning of World War II we had a type of hospital administration which was out of date. In recognition of these inadequacies the first significant steps were taken to realign the administrative setup of our hospitals; however, it was not until late in 1945 that these steps were published in a manual, TM 8-262, to the Medical Department. By that time active combat was over and some of the administrative organization in this manual did not fit the new problems we had in our hospitals. In 1948 we were confronted by curious contrast. The practice of medicine in the Army and the training of professional personnel was in every way at least equal to that found in civil medicine; however, hospital administration remained in the doldrums; in other words, in many respects it harked back to the horse-and-buggy days. Yet in modern business the United States had found by application of scientific principles of management in their business that they could save enormous sums of money and improve the efficiency of their organization. Then administration and management in the United States had made tremendous strides whereas in the Army it was not kept up to date; in other words, administration and management had not kept up with the development of our own medical service. In November 1948, The Surgeon

General set up in his office here, a group known as the Management Research Group. It was given the task of developing a plan of implementation by which our hospital administration could be streamlined and improved. Certain facts were recognized, that there was an acute shortage of doctors; that the doctors we had, had to be freed from administrative detail so that they might concentrate the maximum amount of their time on professional practice. We needed to train additional able lay administrators who could relieve professional personnel of this administrative load. We needed to develop a rating system for administrative officers which would assist in selection for chief positions. We needed an administrative system which would enable the medical service to operate economically. A procedure and reporting system was needed to give us exact data on which to base our statement of requirements. It was not until the spring of 1949 that this plan was developed. This plan was developed through the help of the best ideas and some of the most talented personnel that could be brought in from the field. These ideas that were developed did not originate in the Surgeon General's Office. I think whenever you are confronted with them, they will be very familiar to many of you. The plan, as it was developed, called for the development of a standard organizational form for all medical facilities, for like medical facilities; standardization of procedures; development of aids to management, such as manning guides, work measurement standards, and cost accounting. Early in the game we felt that we had to head up this management research group with a well-trained management engineer; a man who had a formal education in management engineering and a man who had a practical experience in both business life and in the Army. We were fortunate at this stage to secure the services of Colonel George Schunior from the Logistics Division, who met all of these qualifi-

cations. He now heads up our Management Research Group. Later in this program he will tell you something of the medium through which we hope to introduce these new systems into your hospitals. We felt that this plan should be tested in one of our General Hospitals before it was issued to field commanders. To this end we confronted Colonel Brewer at Valley Forge General Hospital with a proposition and he agreed to take over this test. He now will tell you about the plan which we presented, the many changes that he has found necessary to make and some of the problems that he has had in developing this test.

Colonel Brewer - I was called down here about the middle of June this year, this problem was presented, and I was asked to take it on at Valley Forge. We agreed. On 10 July we started the test and you will see many of your own ideas in this plan. There has been a lot of discussion about it. We realized from the beginning that we must have individuals who were alert, young in mind, and interested in progress. They had to be individuals who would not stand up and say, "We can't do it," but who would say, "How can we do it?" With the help of Colonel Schunior we started out. We looked over our old organization plan and charts with its various divisions and individuals. Our main problem was how to consolidate like functions. We looked at responsibility and activities. We decided that to begin with we would create a Deputy Commanding Officer, a professional man upon whom the Commanding Officer could rely to help him and take over his job if necessary. Looking into the career guidance plan we felt that we should put in an LSC or Administrative officer in this group and give those people something to plan for, so we created the job of Executive Officer. From some 22 divisions or sections we were able to cut down to 6 divisions. That is a big change. To do this we had to have The Surgeon General's

Office cooperate with us to the fullest extent, and obtain for us the permission to deviate from all regulations, directives and what have you.

As I said, the professional part that the Executive Officer used to have, we placed on our Deputy Commanding Officer. He now heads up our Education Committee and took over a lot of the work that the Commanding Officer himself would do. The Executive Officer or the Administrative Officer then took over the responsibility or activity of hospital inspector, public information, the portion of the Adjutant's job which had to do with strict administration. The Judge Advocate now reports to him, security and Inspector General functions are under him. You can see how that relieves the Commanding Officer. The Commanding Officer is only called upon then for decisions - high level decisions you might say - for the post, and has time to actually get out and see what is going on.

In order to run this thing we created a management office which is made up of 5 people. We have a management officer, manpower officer, fiscal officer, a secretary and one other individual. By creating these divisions we started with about 8 on the line and then we found out we could come down to 6. This chart was essentially correct by 3:00 p.m. on Friday and what has happened since then I don't know. When I get back it may not be the same. That's how fast things move.

The Welfare Division, we decided should take over all that has to do with the welfare of the troops and the patients in the hospital. Your chaplain, exchange service, Red Cross, a portion of the convalescent services, and special services were all put in the welfare division and headed by one officer. We had a little trouble there.- the Chaplain did not like it, the Red Cross bucked a little - but we convinced those people. I say "we," Colonel Schunior at this level and I had the Army there. We have those

people with us now. They looked it over, they are convinced it can be run. We are having no trouble whatsoever, I can assure you, and it is a coordinating agency whereby one individual now can take care of your entire welfare activities.

We created a Personnel Division. Look at what we knocked out of the organization chart: We took our Retiring Board, we took the Special Orders section of the Adjutant's office and gave them to Personnel (all your orders essentially are Personnel functions, movement of personnel or doing something with them); we took a portion of Convalescent Services, part of the Registrar's section which had to do with records, and split the Personnel Division into 3 parts, similarly as shown on here; we took a portion of Troop Command and Finance and put them all under Personnel. This resulted in a saving by consolidation of these divisions. We have already saved about 32 people, including several officers. It is operating more efficiently in many respects. It is brand new. This Division is just coming into play at the present time.

Our Accounting and Statistical Division is made up of a portion of the old organization that had to do with funds, including appropriated funds, record keeping, supply, etc. This division is set up under one officer and various other individuals necessary to run it. We took our Fiscal and moved it there. We left budgets and budget preparation in Management.

Here is the Food Service Division which is not hard to understand. We took what was our old food service and mess administrator and made them into one food service division. It worked out very easily with no problem and again we made a saving.

We took our Supply Division then and said, "What can we do to consolidate supplies?" We took the post engineer, the portion of his job that

pertained to supplies and put him into the Supply Division. We took our old Supply Division which of course included Medical, Ordnance, Signal, and what have you, and moved that over into the Supply Division. We took the supply of our troops and we put it directly into the Supply Division. We have no unit supply anymore, clothing is issued direct from the Quartermaster. We took that portion of the Registrar that had to do with the supply of the patients in the hospital and we put it into the Supply Division. You can see this portion of the Supply Division that has had to do with your statistical and accounting section. The accounting goes over into the Accounting and Statistical Division. Then we took the Engineer, we left him feeling that he had a very definite staff level function and just relieved him of his statistical, accounting and supply, giving him time to really get out and get on the job on the post.

You can see there has been very little on the professional line as yet. Our post medical inspector, our outpatient service and our pharmacy service were put in the outpatient service. Some of you probably have that already. And then we took the tumor board, brought it down and made the laboratory service responsible for it. I think that works in several hospitals already.

I am not going to go into detail as I have some other charts explaining these various consolidations that we have effected or combined divisions I should say, but would like to show you what we have accomplished as far as Personnel savings go. In June when I was called down here we were running a ratio of operating personnel per 100 patients remaining of 160.6. At the end of July, we went down to 156.9. As of October, the last of October, we were 138.9. I think you can see that is a very definite saving. Our efficiency, I feel, has not fallen one bit. I feel in many instances it has

been very definitely improved; we have a happier group of people; we have given them something to shoot at; we have given them responsibilities and we have taken away a lot of the little detail work that the higher up people used to do. Through this thing, unfortunately, because I cannot take credit for it, we were able to absorb our cut with no difficulty. I think all you people got cut. We got an 85 space cut. We were about ready to declare those people surplus at the time but in addition to that 85 cut we have been able to get rid of 130 other people. Shortly we will declare 11 officers surplus. We have 6 or 7 now that we have already declared that we have no use for. And as I said, this is the plan and you are going to fuss about it, you are going to fight about it. I fussed. I felt bad when I saw the old DOP go out. I just couldn't imagine the DOP going out. Yet we have no DOP anymore. It's all part of the Personnel Division. Just one of the things I had neglected to mention to you, the Welfare Division took over all non-appropriated funds that pertain to the hospital and the post. Now one that we have left off of here is the American Red Cross in the Welfare Division but it goes under it at the present time in the new setup. But you remember your old funds you had, you had your Protestant Fund, your Catholic Fund, your Patients and Special Sundry Funds, you may have another name for it, Headquarters Fund, Post Trust Fund, Central Post Fund, all of your other type funds, we took all of these funds and we created, which has been done in a couple of other hospitals, the Post Treasurer. It means that we have one fund now under that man. He took the individuals that were working in the Hospital Fund; as a result of this consolidation of funds with theirs, approximately 4 people have been saved. See the Welfare Division? We should have on here really the Red Cross too. It is working well too. A couple of you people have seen it. He keeps one ledger

with a breakdown of the various funds; at the end of the day those things are totaled up and placed in the correct fund here and that is all there is to it. There is no trouble. We run up against no difficulty. Where we had all these large numbers of people, now we have one. We have 3 people in addition to him, they are going to take care of all these funds and comply with all the regulations. The Chaplain objected to the loss of his fund, until we showed him that he would still be represented on the Council.

Now we would like questions, any type of questions that you have.

We will try to answer them. We still have more ideas to apply.

General Cole - In your organization do you have control of your Post Engineer activities and Quartermaster, etc.? How would you break this down on those posts where all those activities are under post command and are only farmed out to the hospital itself? We have several situations like that.

Colonel Brewer - I won't say that it is going to depend on the Army, but when this is implemented at your hospital you will have people from the Surgeon General's Office who will come out and do their best to get it as near this standard chart as possible, but we will have to vary with the Armies.

General Cole - Practically all your utilities, your Engineer, Quartermaster, Finance and Signal, and now the Civilian Personnel are all handled through the Army, and that makes up a great part of your activities. Yet, you have a Signal Officer, is that right? Does he work out of the Army?

Colonel Brewer - No, we do not have a Signal Officer.

General Cole - You have no Signal Officer, Engineer or Quartermaster, the Finance Officer is loaned to you from the Army, and all your utilities work directly under the Army. The same thing is true at Brooke, and, of course, General Streit has the same with the Military District of Washington although you do have your own Engineer.

Colonel Brewer - This is the man with the ideas, General.

Lt. Colonel Schunior - Now you've put me on the spot. General, these procedures have been developed for internal use at the hospital. There are innumerable procedures that Colonel Brewer would not have time to mention here that the General Staff wants to implement at posts, camps and stations. Our supply procedure, for instance, is something that they have been looking to for years. It gives them answers that they have not been able to get before so what it looks like eventually will happen is that posts will adopt our supply procedure. However, whether they do or not, it will not affect your operation because we will just cut off wherever you picked up, in other words, entirely within hospitals. If you don't have Engineer personnel chargeable to you, then you are not directly concerned with that, so neither are we. This is the framework of an organization and cannot work under all conditions. It will have to be adjusted to suit the individual hospital. It can very well be applied to Army and Navy, and Fitzsimons where they are independent-type stations and where the commanding officer is also the post commander.

Colonel Liston - My comment, or my query rather, refers to the lowest horizontal group of services there and the vertical that extends above them. I am a little confused as to where that vertical line should end. It now ends below the responsibilities of the Executive Officer whereas it is my belief that it should extend through to the base of the green line. Am I correct in that?

Lt. Colonel Schunior - Yes, Colonel, it should go up through in showing your professional groups to the Deputy and Commanding Officer.

General Noyes - Where did you put Cost Accounting? In Management or down in Accounting and Statistical?

Lt. Colonel Schunior - In Accounting and Statistical. Your Fiscal Officers have retained the budget preparation in Management. Your manpower determinations and your specifications and workload studies are done in Management.

Colonel Liston - The Fiscal Officer in my headquarters is also the Cost Accounting Officer.

Lt. Colonel Schunior - That is the way it used to be here, but we have taken all of his people now and they go into the Accounting and Statistical Division.

Colonel Liston - Is this where the budget comes from?

Lt. Colonel Schunior - This will be supervised by another officer. The raw statistics are furnished by the Accounting and Statistical Division and the analysis and interpretation are made in the Management Office.

Colonel Liston - Where is your Hospital Fund?

Lt. Colonel Schunior - It comes under the Welfare Division and under the Post Treasurer. I know Army and Navy General Hospital has had a similar setup and I think that Percy Jones General Hospital has it. Fitzsimons General Hospital has one too, and it has worked very satisfactorily.

General Streit - Will you explain a little something more about the Management Office in its relation to the organization?

Colonel Brewer - Well, this Management Office is a group of people who study the problems that are presented to the hospital. They study workloads, ward personnel, where personnel can be most efficiently used and also the money that is necessary to adequately run your hospital and maintain the level that has to be set up, that is to say, within The Surgeon General's standards. As a group of individuals they do not make policies, they merely recommend to the Commanding Officer changes whereby the efficiency of your hospital

can be improved and your cost can be kept down to a minimum.

General Cole - What is the difference between the Management Office as you have it and the old Control Office?

Colonel Brewer - In some places the control officer did merely manpower studies, at other places he did have both the manpower studies and workload, that is, working efficiency setups, except here at Valley Forge. When we took it over he was merely an individual who went out and studied the personnel situation as it existed there and made recommendations as to what to do to utilize personnel. The Management Office is better than that in that it has to do also with your budget and personnel utilization.

General Streit - What has been required of a medical center? What duplication will be necessary in a medical center? Because a lot of these activities are in the center level rather than the hospital level.

Lt. Colonel Schunior - This will have to be modified and changed for a center level and I think that probably General Streit is going to have a few gray hairs on that. We realize that it does not apply to him on a center level.

General Streit - I would like to know a little something more about where these savings in personnel have been made. I would like to know just what people are being saved in this operation, because as it is we have the divisions of operation and administration that we formerly had, only juggled together in a little different style.

Colonel Brewer - By combining these various divisions and sections we have been able to keep people comfortably busy for eight hours a day now, assuming sometimes some people were busy and sometimes other people were not busy. But in the Accounting and Statistical Division, by combining the various people in the post engineer's, those in supply, those in the

fiscal and personnel divisions that had to do with statistics, medical records, etc., we have saved three enlisted and 9 civilians. The organization of the Welfare Division has resulted in the saving of three enlisted and one civilian. In the NP Service we have been able to get rid of one officer, 25 enlisted and 44 civilians and that included part of our cut of 85, so I would like to say again, that instead of 195, we can only take actual credit for about 125 of these people. In our Supply Division we are saving 2 officers, 5 enlisted and 3 civilians so far. There are a couple of minor reductions, one here and one there, but I think that you can see that question right there. The cut will be a part of the cut in our NP Section where we had to cut down admittance back in the early part of the year.

General Streit - I understand you are using IBM machines in this operation. Would you give us a little explanation as to how much of this saving is due to machines and how much to the organization?

Colonel Brewer - Well, I would say it is about fifty-fifty. Maybe 60-40. You have to give the machines credit, there is no doubt about it. But I think that when we first started out we gave more credit to the machines than is actually due because this combining people to take over the similar-type jobs has very definitely resulted in savings where the machines are not applicable. For instance, in the Post Treasury he does not use the machines. But the machines are a very definite element and with these machines you can do just unheard of things.

General Gaines - I believe your cost went pretty high for the last quarter of the last fiscal year. Is that in connection with this study or are you going to show any money as well as personnel savings here?

Colonel Brewer - There will be a money and a personnel saving. I do not have the money saving as yet. This section is relatively new right here. This has been changed twice in its development, as I told you, in combining these various jobs and we cannot say definitely that everything is going to work in this division at the present time.

General Roberts - I don't see a Registrar, where is he?

Colonel Brewer - There is no Registrar, Sir. He comes under Unit Personnel. Here is one thing that is progressing ahead very nicely. The Supply Division, where we have changed our requisitioning procedure. We are working out a punchcard system now whereby we probably will be able to eliminate requisitions, in that cards will go to the depots instead of our people having to prepare long requisitions. A card can go right into the depot, it can be put on an issue slip and then issued right from the card. Think of the time that is spent every year in the preparation of requisitions. Your keeping your card on each item up daily, you know what you have, you set up your stock levels, 90 day, 120 day, or what have you. When you reach a certain place you can send your cards on to the depot and they in turn can put them on their IBM machine and the machine will know what is necessary to bring them back to your level and then can be put on an issue slip which comes back to you.

Colonel Liston - Is this Armed Forces Radio that you have on the chart of the new organization of the Welfare Division your hospital programing system?

Colonel Brewer - Yes.

Colonel Liston - There are no other elements in there?

Colonel Brewer - None that I can think of.

Colonel Haff - General Cole, has the setup in your hospital of a Chief of Professional Services resulted in any savings in your individual offices?

General Cole - I don't think you can cite any particular personnel, but it has done this: It keeps all professional activities under one head so that the person who is responsible for the professional service and the conduct of that service in the hospital is cognizant at all times of what is going on, on all the professional services. In other words, he is the coordinator of all the professional services: medical, laboratory, X-ray, surgical, orthopedic, and any other services which might be established in the hospital. He coordinates those and coordinates meetings so that if one service calls for a meeting of a certain type, why, he perhaps is having a meeting of that type in another service and he can coordinate this so that they are not jumping off at tangents all the time. As far as any actual saving of personnel is concerned, I don't think there is any.

Colonel Liston - Colonel Brewer, does that responsibility of Chief of Professional Service rest with your Deputy Commander in your setup?

Colonel Brewer - We cut it out. I will not say it is not practicable, but we have not applied ourselves very much to the professional services. Whether this man will eventually be the Chief of Professional Services we don't know.

Colonel Liston - Do you have a separate Office of Chief of Professional Service?

Colonel Brewer - We have not bothered with the professional services other than to consolidate pharmacy, the Post Medical Inspector and the Tumor Board under the various services.

Colonel Liston - General Cole, is the Deputy Commander a professional officer?

General Cole - He is.

Colonel Liston - Does he have any other duties to perform other than being assistant commandant?

General Cole - He has the entire professional training program.

Colonel Welch - Colonel Brewer, will you clarify the relationship between the Fiscal Section of the Management Division and the Accounting and Statistical Division and the Disbursing activities?

Colonel Brewer - The Finance Officer is under the Personnel Section. He is part of the Personnel Division. Your Fiscal Officer is part of the Management Office, has to do with your budget preparation and the maintaining, as Colonel Schunior said, of the information necessary for your cost accounting reports from the Statistical and Accounting Division. They are two separate people.

Colonel Welch - Does the Fiscal Officer prepare the cost accounting reports?

Colonel Brewer - All of the necessary data that he wants for any of his reports are obtained from this section through the machine.

Colonel Welch - Isn't it anticipated that the cost accounting system of the hospital will be merged with that of the engineer service for the post, which are quite different?

Colonel Brewer - It is all merged.

Colonel Welch - But they will still have to keep their various required records for engineer activities, for medical supply activities, and the various others. May I ask also whether the Post Treasurer is responsible to one council?

Colonel Brewer - No, sir. That is a disputed question and nothing has been done about it at the present time.

Lt. Colonel Schunior - General Streit brought up a point here which I think we should emphasize at this time, and that is - how much are we able to do by machine? There are two very important factors in this re-organization. One is the training of officers and people. The other is the proper utilization of these machines. I wish that it could have been possible to have given you a demonstration, but I think you are going to be extended invitations to Valley Forge so that you can see the rapidity with which medical statistics, civilian payrolls, supply accounting, and cost accounting are now compiled. I think you are trying to visualize the operation as you have seen it. Also there is some doubt in your minds as to why you should have a personnel authorization officer, a fiscal officer, and a management officer. In some of your hospitals that will not be necessary. One officer can perform the three functions, provided that officer is trained in the three functions. If he has had personnel work, if he has had fiscal work, if he has had methods work, then you can use only one. Here we are having to use three because the previous training program of the Medical Service Corps officers was such that we did not have the right individual for the job. The machines definitely make it possible for us to have this kind of an organization. There are many things that we have done which do not involve saving of personnel, but it involves added service to the hospital. For instance, we do not let ward attendants go on any messenger errands of any type. The Supply Division instead of maintaining supply records now delivers supplies to the wards. The linen people deliver linens. Food carts are delivered. Everything that the ward requires is delivered right to the door, so that your ward attendants are within the ward at all times. Those are some of the things that will not reflect themselves in a statement of savings, and in most

cases they have been made possible by the machines and by this Accounting Division which you see here. This Accounting Division will be concerned with anything that has to do with mechanics of accounting - keeping books - no policy. They will prepare civilian payrolls. You will be astounded when you see what a simple proposition it is for you to get not only supplies, but studies on the utilization of supplies - the usage, demand, and cost of supplies. As I told you before, there are many things over which we have no control in the Surgeon General's Office, which are directed, and we have to do. We would have to go through a very laborious process if you had to submit a monthly report on the value of your inventory which now will be done mechanically at any time and you can come up with both answers. How much in quantity; how much in dollars. Maybe those remarks will have explained the function of this division a little better, and your question, General Streit.

Colonel Brewer - About the Personnel Division. It has taken over in the civilian branches; it remains the civilian branch under the new setup. The military branch takes up your Finance Division, pay of troops, patients, the special orders section that came out of the Adjutant's Office, the A & D office, the Medical Records Section, the old military branch, and your patient personnel section - all went in under the Military Branch. They are in the Finance Branch now, created within the Personnel Division. Your Troop Command Branch took over the job of your old Detachment Commander, your CO, DOP, and the clothing and baggage section of your DOP. Your Training Branch, which has to handle enlisted personnel only. I & E goes over into the Training Branch of the Personnel Section.

General Gaines - How much physical change did you make in the hospital, for instance, your patients' clothing, your other supply, Unit Supply, and so on?

Colonel Brewer - Unit Supply we don't have any more. Patients and enlisted people draw direct from Quartermaster. The Detachment submits what they want to the Quartermaster - they go over there and obtain their supplies right there; their uniforms, or whatever they happen to have. We had to build a new fitting room over the Quartermaster section. Our patients' clothing room stays in the same room as the A & D Office.

General Gaines - So this is a paper consolidation.

Colonel Brewer - Some places we are going to be able to adapt this better than others. But we have in this Personnel Division, we have civilian branch, military branch, the Troop Command, and the Training, all in one section - in one building now. Finance is definitely separated.

General Offutt - The Troop Command Branch is within the Personnel Division. Does that mean you have separated your actual commanding officer of the troops from the troops?

Colonel Brewer - No, sir. He is not separated from the troops at all. But it so happens that all of ours are. Our Personnel Division sits right next to our Detachment. So he is there, except that he has assumed the responsibility of the old DOP command. He has all troops, whether it be detachment, patients, or medical detachment.

General Offutt - The physical setup is not questioned. The Troop Commander could sit in with the Personnel Office.

Colonel Brewer - Even mine does not sit in my Personnel Office, sir. Except now, all of the work that he used to do that pertains to records, and otherwise, is all handled in this division. He is with his troops. He comes in constant contact with them out of the hospital, in the hospital and can see his people, and all the paper work he used to have to do - his Morning Reports, and the rest of those things are done here.

Colonel Lehman - Colonel, I don't see any brackets for Military Police and Provost Marshal. Explain that, please.

Colonel Brewer - The security as you noticed up here, which has to do with your Military Police section, goes under the administration of the Executive Officer.

Colonel Lehman - Have you abolished the position of Adjutant?

Colonel Brewer - Yes and no. The Adjutant came down and is to become the Assistant Director of Personnel. But we have to maintain that will be his primary duty; the secondary duty will be Adjutant. Only for the reason that Army Regulations are so cluttered with the fact that the Adjutant this, and the Adjutant that, and the Adjutant has to authenticate orders - we cannot do away with the Adjutant until we can get that changed, and I doubt if we can ever go that far.

Colonel Lehman - One more question. I see the Personnel Division is built up until it is going to take a good man to handle it.

Colonel Brewer - Right. You've got to have a very alert, active individual who really is a fire-ball. He really has to be a fire-ball.

Lt. Colonel Schunior - We left out one point there. We have tried to organize the services as a team. Each chief of professional services has an administrative assistant, who is the Administrative Officer. That officer is primarily three things. He is an Assistant Detachment of Patients Commander, so that you can take the service closer to the patient. He sees about passes and minor disciplinary problems and things like that. He is an assistant property officer to assist him with property; he has charge of all the property on the service. He is an assistant station complement commander, so that you haven't actually removed the station complement from the individual soldier; you have taken it a little closer

to him. The nurses and these administrative assistants work out the assignment of personnel between the wards. The Management Office makes any adjustments between services as are indicated.

General Cole - What have you done with the Custodial Branch?

Colonel Brewer - The Custodial Branch comes under the Supply Service. We have under the Supply Division created a service branch, and that branch, as Colonel Schunior mentioned a little while ago, your laundry delivery and pick-up, your custodial service, and picking up drugs at your pharmacy - all those things that are delivered to the ward - ice delivery to the ward, all of these come under this one section - the Service Section of the Supply Branch. All of your medical supplies are delivered. On the delivery of the laundry alone, we figure we have saved a minimum of 95 man-hours per week.

General Gaines - Who heads up your food service? What type of officer do you plan to use there?

Colonel Brewer - Dietitian. She will be in charge of the entire food service program.

Lt. Colonel McGibony - One point there, General Gaines. When I came back originally, that point was brought up. I was wondering what would happen to the MSC officer we had who was filling the jobs. Personnel people state that that has been taken out of the career pattern of MSC officers, so they will gradually fade out of the picture and Warrant Officers will go in as Assistant to the Dietitian.

Colonel Liston - Under Circular 64, certain responsibilities of the Class II installations are the responsibilities of Army and others are the responsibility of Tech Service. Does this new setup which mixes those rather freely in any way interfere with the wording of Circular 64? I ask this question

because in our office we are presently working over that circular.

Lt. Colonel Schunior - I think it does to some extent. There is a new circular being written now.

Colonel Liston - Yes, I have it on my desk at the present time.

Lt. Colonel Schunior - We'll have to back-track wherever that interferes until such time as those things can be coordinated on a Logistics Division level - such as your motor pool. We will not be able to touch that. A while ago, Colonel Welch brought up another point on the Engineers cost accounting. We are not changing that system of cost accounting at all. It stays as is. The thing we are trying to change is the means by which we compile the data which the Engineers give. Colonel Brewer has at Valley Forge about 4 or 5 people under the old system who were doing nothing but compiling statistics for the Chief of Engineers. Now that personnel is chargeable to your hospital operation, but what we would like to do is to eliminate the cost work to the Engineers for maintaining a separate payroll from what the fiscal officer maintained. What we are trying to maintain is one payroll and from that one make the proper distributions. We will not conflict with Circular 64. Whatever we do, we will have to back up until the Logistics Division can have its say either way. However, for the period of this test, we do have the authority to deviate from these things to see if they are practical and will result in something better than what we have at the present time.

Colonel Liston - Has any attempt been made to coordinate the Engineers cost accounting system with the hospital cost accounting system?

Lt. Colonel Schunior - Now they are so far apart that you cannot get them together. We have just put them all in this one statistical accounting section. The 2d Army Engineers were up here last week going over this

entire problem with us and will be back this next week to show how they can be worked into the overall statistical accounting for the whole hospital. As it now stands the Engineers have to work two sets of accounting system. We have said time and time again we still have had to keep our records and physical data as per regulations but in addition they have had to keep another system which we have got to convince the other people is just as good and can take over and replace the old type.

General Streit - There is one difficulty with this system that has not been brought out which seems to me a major one in Walter Reed for example, and that is lack of space to make the necessary changes. If I wanted to move my Detachment of Patients to the Personnel Office, no one could find a place to put it. There isn't any place to accommodate those two sections and to find an office for any of these activities that you want to combine is an extremely difficult thing to do. Recently, I had to find some space for the Vet Division to get one little office for them. He didn't have one little office. The only thing I could do was to eliminate the linen exchange, which I understand the SG was in favor of, so we eliminated that operation and made an office out of it. I see great difficulties with a system of this sort in hospitals because of physical facilities and space.

Colonel Brewer - That is true; however, the combining, the taking of portions of the various sections out to make another section results in some space in the Personnel Division, or in the other division or DOP or Registrar Section, because you are going to lose all that portion of the personnel and the Registrar section that deals with statistics. There is going to be created a smaller staff, there will be some saving. That was one of our problems - you said last night we had a lot of empty buildings. We have looked, hunted and torn ourselves apart trying to get these people together

to eventually establish one of these divisions. Afterwards you will find that it creates space for something else.

General Streit - To illustrate a point, when you brought the Personnel Division together you had a completely empty building. If you didn't have one you could have, and you picked a building adjacent to the troop command so you could bring these two commands up to your Personnel Division where there was sufficient space in that building to move your detachment of patients and your sick and wounded. In my wildest imagination, I cannot visualize General Cole being able to, at Letterman, or I being able to do it at Walter Reed.

Lt. Colonel Schunior - Here's just an example. We created this statistical accounting division. Then we looked over the post Engineer. We took away his supply setup of 3 or 4 people who did his supply work and put them over in the supply section where they could be absorbed, with the result of a saving of two people. We took those individuals that had to do with his statistical accounting and left them. We moved his small supply section that he had, of all his spare parts, nuts, and bolts, electrical appliances and put them over in the stock section of the supply. As a result we have left in the Engineer Section, the Engineer and his assistant, so that is where the statistical and accounting division is moving in. With the post engineer it was rather simple or we never would have been able to find an office. It has been by shifting of people and bringing them into the other places that we have been able to obtain most of our vacant space.

Colonel Lehman - One of the most difficult minor questions that I have to answer is whether I have a bed for someone who is applying for admission. Under this new organization, do I have to call up the personnel officer and have him contact someone?

Colonel Brewer - Well, we haven't run into that difficulty as yet but the chief of Personnel is the man to go to if you want to know anything about the status of your patients. He is responsible for the military branch of the Personnel Section.

Colonel Lehman - I do not believe you have amplified that point. It seems to me that that would complicate things. That is a question that does arise particularly in a hospital as small as the Army and Navy is. The urgent request may come along: "Do you have a bed? I'm seriously in need of hospitalization."

Lt. Colonel Schunior - You have to answer that reasonably, promptly. Colonel, there is an A & D Office as such and we do not attempt to go through all the laborious procedures of trying to get the last bit of detailed information out of the patient when he comes in. Instead of having the ward morning report, the accounting section now prepares a ward roster every night which goes to the ward. If the ward has made a mistake in the personnel that they have there by transfer and have not reported it, then the Chief of Service comes in and he gets on that ward for not reporting it. We had trouble initially but now these rosters have become almost perfect; they don't make mistakes. If they transfer patients from one ward to another the nurse calls in and that change is made; if she fails to call in, she is caught the next morning. So you have control over it, so that you do know in the Admission Office where you have beds. We tested these procedures out on a convey of 38 patients and we had them out of the Admission Office and some of them never did come through, within 26 minutes. We have stressed that a great deal.

Colonel Tynes - Colonel Schunior is going to talk with us now for a few minutes on plans for phasing in our other hospitals.

Lt. Colonel Schunior - First, I would like to emphasize very much from our standpoint here in the Surgeon General's Office that your suggestions are welcome. As Colonel Gibbs told you, no one has tried to master-mind this thing. You have sent representatives in here and we have gleaned from them what ideas we possibly could and then Colonel Brewer has tried them out in his hospital. We certainly would appreciate it if you have any suggestions to offer or want to discuss any immediate problems that are bothering you about this organization. I think you could understand it a lot better if you could see some of the procedures that have been installed so as to make this organization possible. Now unfortunately, on some of these procedures we are going to have to go through the red tape of having the Logistics Division get all the technical services together, the Army Comptroller and various other people involved, to pass on them before we are able to put them in effect in our other hospitals. However, we have kept the Logistics Division and the Army Comptroller very close to it. We have taken their representatives up there and they have assisted us in finding the answers to some of the problems so that from their reactions to the whole thing, I do not think it will take us very long. But we have set up a tentative program for working with you in the reorganization of the hospitals because there are certain things that we can do without the staff coordination that I have just mentioned. There is the matter of procurement of these machines which we have already initiated; the various people who manufacture them have told us that they could meet the schedule that we gave them. There is the matter of training people to operate these new office machines. We have started action in that direction. We feel, for instance, that we do not have, at the moment, the trained officers to take over this Accounting and Statistics Division so we are asking for an extra

civilian slot in the appropriate grade to assist with the implementing of the procedures of that division. Tentatively we have set up this schedule.

We would like to work with Walter Reed and Murphy during the first quarter of this coming calendar year; we would like to work with Brooke during the second quarter; we would like to work with Letterman, Fitzsimons and Madigan during the third quarter, and with the others during the fourth quarter, and that is assuming that all these things are approved by you and by the various divisions of the Surgeon General's Office. It has been presented to them; it has been presented to General Bliss and, I think, to everyone else that is involved. If that schedule does not fit in with your plans, we would certainly like to get your reactions so we can adjust it accordingly. The assistance that we will give will consist of probably just a fresh viewpoint on some of these things. General Streit, I want to mention one big problem, and that is the matter of space. I am sure that in some cases we will not be able to do some of these things because of space, but I think we should make an effort to find the space and if that is not possible we should adjust the plan to fit your requirement. I do not think there will be any money available to construct too many buildings around our hospitals so that we might as well forget about that.

General Streit - You mentioned Brooke in the second quarter. Do you mean including the Medical Center?

Lt. Colonel Schunior - Yes, sir.

General Streit - Do you have plans for the consolidation of centers, activities, etc.?

Lt. Colonel Schunior - We have a lot of plans, General, but I would rather wait until we start working with your own organization.

General Noyes - Couldn't you send us advanced plans down there so we can study them?

Lt. Colonel Schunior - Yes, sir.

General Noyes - I think that would be best. At least you know we would have some thoughts by the time you get down there.

Lt. Colonel Schunior - That will be done. We wanted to work with General Streit because it would be convenient. As I mentioned before, and as I mentioned to General Bliss, I had not had any contact with Medical Service Corps officers but it strikes me that they require a great deal of training and they certainly require a new type of training to fit this thing. We have had an Adjutant who traveled from hospital to hospital being an adjutant; at one place he was an aide, somewhere else he was file clerk, somewhere else he was a messenger boy, somewhere else he was a valuable staff officer. So you look on the cards and you see someone that was an Adjutant and you don't know what kind of an individual you have. Or you have some that have traveled in the Supply circle. They don't know anything about Personnel. You have registrars who know all about medical statistics but they don't know anything about Supply. So, we have a considerable training program on our hands. That is the more long range. The shorter range is that we need to train individuals quickly by gathering together the best brains in the hospital administration business from our own office and from your hospitals to give them a six-week course at Valley Forge to be your Management Officers. We would like to do that some time during the first quarter of next year. Personally, I cannot impress you too much with not only the desirability but the necessity of the selection of someone who is able to learn and who has the desire to learn. If you pick out someone who is too set in his ways, along in his forties, it is going to be

difficult to give him anything that will be very valuable in the long run. The selection of your Management Officer, I think, is very important; if he does not do his job, he can ruin the whole program by being the type of individual that we knew in the control setup before, where you try to master-mind the thing without giving due regard to the people who are actually responsible for the operation. We will send you more specific details as to when the school will start. We also hope to bring in your executive officers and other key individuals that you may want to send to Valley Forge for a shorter period of training, possibly a week. That will be phased in with the plan of working with our hospitals.

Colonel Gibbs - The first point is that the aim of this new administrative setup, this test, is to make it possible to have a better medical service. The primary aim is to assist the professional officer so that he has the maximum amount of time for the care of patients. Point No. 2 is, as Colonel Schunior has already covered this in part, we have a terrific training program ahead of us. Through this training program we must utilize every means possible. In the initial phases and during the time when we were determining precisely what we need in personnel, we were doing some training down at Valley Forge in preparation for the phase out of this plan. But we have already undertaken certain talks with the Training Division and we foresee that we cannot make this program a success until certain courses are introduced into the Medical Field Service School which will assist them in training our administrative officers to accept these new responsibilities. The aim, of course, is to make every administrative officer who is in the hospital service a competent manager. To that end we need every training resource at our disposal.

Colonel Tynes - We will adjourn and reconvene in this room at 1300 this afternoon.

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Colonel Tynes - The conference is now in session. Our first speaker this afternoon is Colonel Bruce, Chief of Mobilization Planning Branch, Medical Plans and Operations Division, who will speak on "Mobilization Planning."

Colonel Bruce - My talk is SECRET, therefore it will not be recorded.

Colonel Tynes - There is a change in the agenda. Colonel Phillips, Chief, Nursing Division, will now speak on "Army Nurse Corps Activities."

Colonel Phillips - I am pleased to have the opportunity to participate in this meeting so as to present to you some of the projects involving the Army Nurse Corps, and to discuss briefly some of our projects and problems in which you can be of great assistance to us in making our Corps operate more efficiently as a member of the medical team.

We have distributed to you a copy of the proposed Special Regulation on the Army Health Nursing Service which has recently been established at one or two of our installations, and which The Surgeon General hopes will be set up in other medical installations where the commanding officer of the post, camp, or station deems such action advisable. The Nursing Division, with members of the Medical Plans and Operations, Personnel, Preventive Medicine and Resources Analysis Divisions, have spent a great deal of time in discussing this program, its objectives, the manner in which it should be set up, and have finally concurred in the Special Regulation which you have before you. It was unfortunate from our standpoint that such a regulation was not published prior to the establishment of such programs, but the one or two programs that are under way are pretty much in line with the guides proposed in this regulation.

The first thing that I want to mention about this program is that it is not set up with any idea that nurses can replace medical officers. Its organization, however, was suggested in order to assist the medical

officer in caring for outpatients at our installations with the hope that the nursing service could supplement his work and through the initiation of teaching programs, the establishment of a school program, all of course, under the immediate direction of a doctor, effect a decrease in the daily workload in the outpatient service, and assist in keeping down the rate of hospitalization of dependent personnel.

In the establishment of any program where nursing personnel is utilized, we are desirous of keeping our requirements in the selection of personnel on a par with similar programs in civilian or other federal agencies. The success of this program and its effectiveness to the Medical Department will be in a great measure dependent upon the type of nurse selected to organize or to participate in the program. It is necessary that the individual selected have preparation and experience in Public Health nursing. We have several nurses, at the present time, who can qualify under the requirements set forth in this proposed Special Regulation, and the Preventive Medicine Division of this office is desirous of and will assist in reviewing the professional records of the nurses selected for these programs so as to insure the assignment of the more experienced person to the larger programs.

This program is not designed to provide nursing care in the home. Of course, there are times when the doctor may want certain medications given or dressings changed, but the assignment of nurses to do visiting nursing on the same scale as is provided by Visiting Nurse Societies in civilian organizations is not contemplated. We do not have sufficient nurses for such assignment and you know as well as I that were such a program set up it could snowball to such a portion that unreasonable demands would be made upon the Medical Department for personnel to care for the outpatients in their homes.

An MOS description for the nurse qualified for assignment to this program has been submitted for approval and publication, and will be circulated to the field as soon as it is published. In speaking of the newly proposed MOS, there are one or two comments I should like to make regarding MOS numbers for nurse personnel. We have frequent requests for the establishment of additional MOS numbers, and while we recognize the value of such classification, we also recognize the dangers which can develop. Basically, our personnel have a general nursing preparation. We do need, however, to have some nurses receive further preparation in certain specialties, and the indication of this special preparation by numbers helps us to better assign nurses and meet our requirements in staffing. However, it has at times prevented us from assigning personnel who may not carry the particular MOS desired but who could function under the supervision of a well-prepared supervisor in that field. I am thinking particularly of operating room nurses. We also have the problem of certain of our nurse officers feeling that the assignment of a specialty number should preclude their assignment to other services even though a need exists for assistance in areas where the workload has increased and their temporary assignment is needed.

We have had requests for the establishment of a course which would result in the classification of nurses in ophthalmological nursing, plastic surgery nursing, etc. Should we concur in such recommendations, we could tie our service into such knots that we would not be able to adequately cover our nursing needs.

One of the classification numbers desired by many nurses is that of 3430, the Administrative Nurse. There seems to exist an erroneous opinion that promotion will be based on the assignment of such a classification and

that unless nurses carry such a number they will not be considered for promotions to higher grades. Such is not the case. An administrative nurse must not only be well qualified in nursing administration as well as in nursing, but must have the qualities necessary for good personnel management and qualities of good leadership. A degree in nursing education alone is not sufficient to qualify her. TM 12-406, Officer Classification Guide, must be carefully followed in order to insure that we get our personnel properly classified. If our administrative personnel is not carefully chosen, the nursing service in our installations is going to suffer.

Requests submitted to this office for changes of MOS on nurse officers must be accompanied by an evaluation of performance of duty in the specialty classification requested, length of time the nurse has been assigned to the specialty duties, as well as a general evaluation of the individual by her supervisor and/or chief nurse.

Some of our nurses who meet the qualifications for the MOS in obstetrics and pediatric nursing but are not desirous of changing from the classification of "general duty" nurse to the specialty classification are not desirous of continuing in that type of nursing throughout their military career. It should be explained that an officer can be given a secondary MOS and may be utilized in either, depending on the urgency of the need. It is a distinct advantage to us to have nurses with preparation and experience in more than one specialty.

It is, of course, desired that nurses, insofar as possible, be utilized in their MOS, but the needs of the service and the desires of the individual should be determining factors in such an assignment. This decision should be made by the chief nurse and her supervisory staff.

May I enlist your cooperation in bringing to the attention of your personnel the importance of preparing fair, honest and objective efficiency reports on nurses. You all know the importance attached to these reports and the part they play in selection for promotions. We have occasional requests from commanding officers to make changes in their administrative personnel and still the efficiency reports coming in from their installations do not coincide with reports that are brought to us verbally. Our promotions to higher grades are limited. We must assign such personnel to administrative and supervisory positions. The selection board has nothing to go on but what is in the officer's record. The upgrading of an efficiency report so as to spare the feelings of the individual being rated or so as not to make necessary the discussion with the rated officer the shortcomings observed will not help us to maintain the type of Corps we want nor help us in the assignment of the type of personnel you want and need in your installations.

Our procurement program is not moving along as fast as we would like it nor quite as well as it did a few months ago. While we took on 360 nurses for extended active duty in the period from July to September in 1948, this year we took on only 138 during those months. We appreciate the assistance the Surgeons of the Armies have been giving us in the assignment of procurement nurses to assist in interpreting our program and needs to civilian nursing groups. The number of nurses on such duty, however, is limited and the territory we would like to and need to cover is very large. The Army chief nurses occasionally feel the necessity of calling on the commanding generals of hospitals requesting assignment of personnel as speakers who have either previously been assigned as procurement nurses or who they know are sufficiently acquainted with the various aspects of

both the Reserve and Regular Army program to speak effectively and convincingly at state nurses' meetings or before student groups. It would be most helpful to all of us concerned if all commanding officers would concur in the attendance, if possible, at such meetings of nurses who can effectively present our program to the public. We know many of our installations could use more nurse personnel, but we cannot get such personnel unless we make use of every opportunity to meet with civilian nursing groups to explain our program, the means of joining the Reserve and the method of requesting extended active duty to them. These requests are comparatively infrequent and the period of time the nurse would be away from your installation would be of short duration. We always try to select such personnel from installations near the area in which the meetings are to be held.

We in this office take every opportunity presented us to attend such meetings and the chief nurses in the Armies usually contact the state nursing organization to request an opportunity at their annual convention for an Army Nurse Corps representative to speak.

I recently attended a meeting of both the student nurse group and the graduate group in one of our large Midwestern States, and while we were most cordially received and every opportunity extended us to contact the nurse personnel and explain our program, there was very little interest evidenced in either the inactive or extended active duty status of our Reserve group. Civilian hospitals are still so in need of nurse personnel, and with the expansion of nursing service throughout the country there are so many opportunities for nurses in civilian positions that even the enactment of the Career Compensation Act did not stimulate much interest for extended active duty in either the Army or the Navy.

While the salaries in Federal services are much better than those in most areas in civilian life, that is not true of all sections of the country, and in addition to greatly improved salaries in certain areas, the more attractive working hours and living conditions, the ability to choose their place of employment without frequent transfers or necessity for overseas service makes civilian service more attractive than military service to many civilian nurses.

We all appreciate the efforts made to improve the hours of duty in the hospitals, but in a few installations just recently the cut back in personnel resulted immediately in the consideration by commanding officers in the hospitals of returning to the 12-hour night duty, and in some places the 12-hour day duty. Just as soon as we do that we can be assured that our procurement will drop even lower and we will gain very little by such practices. We should not be laggards in an effort to improve conditions under which our personnel must live and work, but rather should set the example so that other organizations will look to us when they wish to know how to improve their organizations. It may be of interest to you - it was quite a shock to me - to find out that in October we took in 16 nurses for extended active duty, and separated 32. That in one sentence gives you a pretty good picture of our procurement problem.

Just a year ago we asked I&E to make an attitude survey so as to obtain opinions of Army Nurse officers regarding matters affecting them and to obtain from them any suggestions and recommendations for changes in our policies which might result in making our service more attractive to them and aid in procurement. You may recall that a year ago procurement in all Corps in the Medical Department was a serious problem. We were enlisting the support of our state and national nursing organizations and

called representatives from all of the states and national headquarters into a conference here in Washington. It was the result of that conference together with the efforts that we made to correct some of the situations that the nurses in the opinionaires presented to us that our procurement during this year took an upward trend. We had hoped to circularize a group of nurses in civilian life who had been with us but did not seem to be interested in returning. Unfortunately, we were not permitted to include them. A study of the opinionaires regarding the relative advantages of nursing practice in military service and civilian life were briefly as follows:

More nurses stated they would choose military service over civilian from the standpoint of long-term security, pay and the opportunity for specialty training. More of them said they would choose civilian nursing over military from the standpoint of desirable living conditions, working hours, and opportunity to use their specialty training and skills.

When asked for suggestions which they felt would improve our procurement so as to assure the Army of having a sufficient number of well trained nurses, the most frequently mentioned suggestions were to improve living conditions, to offer more educational opportunities, and to provide shorter working hours. We have made progress in each of those areas within the past year and should endeavor to continue in that direction rather than revert to situations that caused the suggestions to be made in the first place.

There are to date 3,435 nurses on extended active duty, 2,443 of whom are Reserve nurses. We are approximately 500 short of our authorized strength and attrition continues at a rate of approximately 50 a month.

We have noted many instances in which requests for category changes are not submitted in compliance with SR 135-215-5, dated 27 May 1949. All nurse officers who are qualified under the provisions of SR 135-215-5, and who desire extended active duty beyond the expiration date of their current category should submit application for such change not later than six months prior to the expiration of their current category. Exceptions will be made to this regulation only when nurse officers desire to sign Category II or III.

We would like your assistance in advising personnel officers to remind those who are within six months of the date of expiration of their category that a request for an extension must be initiated if they are desirous of remaining on extended active duty. To prevent retention on active duty of ineffective personnel, requests for extension of category should be cleared with the chief nurses.

We were disappointed that the amendment to Public Law 36, which we had hoped would be enacted into law at the first session of the 81st Congress, received action only by the House. It passed the House and was referred to the Senate, but Senate action was not possible prior to adjournment. We have been assured that it will be given priority for consideration in the early session of the next Congress. Although much has been said about this legislation, there is still much misunderstanding as to what the amendment will do if enacted into law. Briefly, it will allow us for one year to give the opportunity for applying for a commission in the Regular Army to any nurse who reported for duty with the Army Nurse Corps in World War II before she reached the age of thirty-five. Upon the expiration of the year the age limit for commission in the Army Nurse Corps will revert to twenty-eight as established in Public Law 36. There will then be no further

opportunity for the nurse over twenty-eight to be commissioned in the Regular Army Nurse Corps. We have had many requests since the close of our previous integration to waive our age limit and can only explain to such individuals that while we can waive a regulation we cannot waive a law, and no nurse is presently eligible for appointment in the Regular Army Nurse Corps, if she has passed her twenty-eighth birthday.

We have a large number of nurses at the present time in our hospitals who have had the required six months of service prior to submitting an application for Regular Army. There is a regulation providing for the appointment at the present time of such nurses in the Regular Army Nurse Corps. It is included in the same regulation for the appointment of officers in the Regular Corps of the Medical Department, AR 605-20. We have been encouraging the chief nurses in our hospitals to interview those nurses who appear to be the type of individual we want in the Regular Army. From 393 such nurses, we have received approximately 90 applications.

On October 17th, we opened a Practical Nurse School at Walter Reed. The schoolroom facilities are provided at the Forest Glen Section and it is a physical setup of which the Army can be very proud. We have a very enthusiastic and well prepared group of instructors and the group of WAC enlisted personnel attending this course is a most enthusiastic and well selected group. We had hoped to have an enrollment of fifty; instead, this first group comprises thirty-two. Whether sufficient publication was given the course or whether sufficient time was not allowed for the submission and processing of applications, we do not know. It is a forty-eight weeks' course with one additional month provided for furlough. This first course is a trial course and plans for revision of the course content of the Medical and Surgical Technicians course is under consideration. Future

plans include making completion of one of those courses a prerequisite for application for the Practical Nurse course. The selection of WAC enlisted personnel was made from applications received from the WAC assigned to medical installations. Successful completion of this course will make the graduate eligible to apply for registration in states providing such in accordance with the standards of the National Association for Practical Nurse Education. We would like to see an additional group taken in February, but whether that is possible will depend upon the approval from O&T, GSUSA, and P&A, GSUSA, availability of housing at Walter Reed, and the interest displayed, not only by the WAC enlisted group, but by other Medical Department personnel.

I want to take this opportunity to express our appreciation for the splendid cooperation received from all of you in making possible the attendance of nurse personnel at the Workshops conducted each year at the University of Pittsburgh. These Workshops which have been given in Ward Administration, Improving Patient Care, Nurse-Patient Relationship and Staff Education have proved most helpful. We, from this office, as well as the chief nurses in our Army areas have noted the effect of attendance at these courses, not only in nursing performance in our hospitals, but in enthusiasm of our nursing personnel for association with an organization which they feel is interested in helping them to keep alert to and abreast of latest developments in their field. I must confess we were a bit hesitant about the response we would get when it became necessary to ask how many Army areas and general hospitals could provide the transportation and per diem expenses for the last Workshop. Two Army areas sent representatives and all general hospitals were represented. That is a fine record and we are most appreciative of your cooperation.

A question came in regarding the possibility of utilizing West Coast universities for such Workshops so as to cut down on travel expenses of nurse personnel from those areas. Since the answer to that question will appear in papers distributed to you, I will not take time here to reply to it.

Now one final subject. The success of our Reserve program as is true of Reserve programs for all Corps in the Army, and the extent to which we can maintain an interested group of qualified nurses who will be willing to keep their reserve status active will be dependent on the effectiveness of our training programs. With nurses who have had no prior military service and who apply for extended active duty, we provide an eight weeks' orientation course at Medical Field Service School. Such an orientation has assisted greatly in making the transition from a civilian to military status smoother and more efficient.

We were pleased to know the extent to which the Army areas were able to provide an opportunity for short tours of duty for Reserve nurses this past summer. We would like, however, to see the plan which has been initiated in one Army area extended to the others, i.e., setting up a two weeks' orientation program for nurses who have had no previous military service, but who are applying for a short tour of duty. If a two weeks tour of duty is all the individual is applying for, she will derive more benefit from such orientation than she will from two weeks duty in the hospital, and next year she will be of more value in our hospitals. If she is asking for more than two weeks, she will be more valuable to your installation and will adjust more readily, if she first had a basic orientation. We will be glad to supply your Army chief nurses with the orientation program carried out by Fourth Army, if the rest of you feel you can provide similar opportunities next summer.

I hope the members at this conference will visit my office or that of the Chief of Nursing Personnel, if we can be of any assistance to you. Even though you have no problems or questions regarding your nursing service, we would be happy to have any of you stop by.

Colonel Liston - Will the Surgeon General's Office supply the nurses in this new setup?

Colonel Phillips - They will be over and above the present hospital personnel. You will have to request your personnel, and Resources Analysis Division I am sure will authorize it. You don't want them assigned for duty to the hospital. We are also asking for a report to be submitted each month that is going to give us the indication of the workload, so that if you should come in for more personnel we will see whether or not it is justified.

Colonel Liston - Because of the shortage of the doctors that we are all well acquainted with, we are using both MSC officers and nurses throughout the Fourth Army Area in screening patients, a job which is somewhat similar to that done everyday by hired civilian industrial nurses. Some of the doctors feel that this duty should be done by nurses and not done by MSC officers. Others feel, and I feel personally, that the MSC officer is doing an excellent job. In other instances, it is being done by Sergeants of the Medical Department. I would just like your expression of opinion in regard to using nurses for screening sick call.

Colonel Phillips - I think when I was asked about that program, I concurred reluctantly, but because I knew of the shortage, and thought it would be for a temporary period only. Whenever we take a nurse for other projects or to relieve the personnel situation in other Corps we are depleting our own service and taking nurses away from the care of patients, and I am very reluctant to do that.

Colonel Glattly - I wonder if there is any possibility of including certain of the scarce category nurses, such as nurse anesthetists under the so-called "Black Plan," or the "Short Tours of Active Duty." I have had opportunity in the past few months to get ahold of two or three of these nurses, but by reason of the shortage of training funds, was unable to utilize their services.

Colonel Phillips - I believe that too is answered in your book, Colonel Glattly. I know when that plan was set up, it was because of the real shortage of Medical Corps officers and although the General Staff did not want to go along with it they did because of that shortage. The shortage of nurse personnel was not as great and I believe the Medical Corps personnel felt that they would jeopardize the chances of getting it cleared through staff.

Colonel Glattly - I know I would trade a doctor for a nurse anesthetist any time, that's how scarce they are in Second Army.

Colonel Phillips - They are scarce all over the Army. We have a need for 202 anesthetists and we have 100 of them. We are training them in seven hospitals now.

Colonel Liston - What is the present attitude of the Surgeon General's Office in regard to hiring of male nurses?

Colonel Phillips - You doctors can answer that better than I can. I have no objection to male nurses, if they are well qualified.

Colonel Liston - That is in civilian capacity, is that correct?

Colonel Phillips - If you contemplate such action, Colonel Short should be allowed to clear the personnel. We would like the opportunity to check on the professional qualifications of civilian nurse personnel, just as we do military; otherwise, you may be getting some that do not meet our requirements.

Colonel Liston - We have quite a number of arsenals, small and large, throughout the Fourth Army Area where I think we might be able to employ a male nurse very effectively, and where only one nurse is on duty. We have had application, but we have not taken anyone on.

Colonel Tynes - Some months ago, The Surgeon General announced a new policy on the appointment of the position of Director of the Army Medical Library. Interested officers were advised that they could apply for the position on the basis of a lifetime appointment, if they met the proper qualifications. The first officer to receive this appointment was Major Frank P. Rogers, MC. Major Rogers has just completed 18 months special training, including a 12 months course at Columbia University, and extensive visits to the various medical and other leading libraries throughout the country. Several weeks ago, Major Rogers was installed as a new permanent Director of the Army Medical Library. Major Rogers will now speak on the subject of "Services Available from the Army Medical Library."

Major Rogers - Ladies and Gentlemen - The Army Medical Library is now 112 years old. It came into being during the presidency of Andrew Jackson. During most of its early years, it consisted of nothing except a shelf of a few books, but by the close of the Civil War it had a total of 1800 volumes. At that time, one of the foremost figures in American medicine, John Shaw Billings, became its Librarian and he held that position for 30 years. When he retired from the Army in 1895 to become the first Director of the New York Public Library, the Army Medical Library collection comprised over 300,000 titles as compared to the 1800 at the time when he became its Director. The Army Medical Library had become the world's greatest collection of medical literature. Today, the Library possesses over 1,000,000 titles, of which at least one half a million are bound volumes. We still

like to call it the greatest collection of medical literature in the world, but are not quite so sure that we can call ourselves the largest anymore. The latest statistics gathered by the Medical Library Association show two libraries that are larger than the Army Medical Library. Both of these are in Russia, one at Moscow and the other at Leningrad.

The Army Medical Library operates under a general directive to acquire the medical literature of the world regardless of language, form or date of publication. We add well over 75,000 pieces to our collection each year. We have some 18,000 files of periodical titles of which 6500 are current and increasing at the rate of 100 per month. By law, we serve the entire medical profession of this country, both military and civilian.

The library is not only a library in the ordinary sense, it is also a publication agency. Various indices have been published by the library in its history. First and foremost is the index catalog of the library of the Surgeon General's Office, which was started by Dr. Billings in 1880. It is now in its 57th volume and includes over five million references to the medical literature of the world. Another publication started at the Army Medical Library was the old Index Medicus. This was also begun by Billings in 1879 and continued until 1927, when it was combined with a publication of The American Medical Association which continues to this day as the Quarterly Cumulative Index Medicus. The third major publication of the library is a newcomer. It was started under private auspices in 1941 and was taken over by the Army Medical Library in 1945. We know it as the current list of medical literature. It is published weekly and is extremely important at present in that it is the only current index to the medical literature in existence.

I would like to speak a little more extensively about two of these indices. The Index Catalog is now in its fourth series. This is the tenth and latest volume of the fourth series and covers the first half of the letter "M". Our records show that all Army general hospitals have this publication with the exception of three, namely, Murphy, Oliver and Valley Forge. I would ask that the Commanders of those hospitals request this publication from us and we will be glad to send you the first ten volumes of the four series and each successive volume as it is compiled. You will understand that the constantly increasing flood of medical literature has posed a problem which is very difficult indeed to solve. We have published five million references in the various volumes of this series, we have on hand one million, six hundred thousand references in an unpublished file, which is material still to be published, and if we were to proceed to publish that material on the same basis that we have published in the past, it would take us a minimum of ten years to publish it, if we stopped entirely our indexing activity at this moment. We are in the middle of the letter "M" now and if I looked through our files and looked under the letter "T", I would find under the subject of Tuberculosis alone, some 85,000 unpublished references. I hate to speculate on what will happen by the time we get to the letter "T", and if things keep increasing as they are at present, whether we will ever be able to finish publishing what exists on the one subject of Tuberculosis. These problems are very large and The Surgeon General has appointed a committee of consultants to consider these problems and make recommendations as to what we might do to solve them. This committee of consultants is also assisted by a research project which is being operated by Dr. Larkie, Librarian of the Welch Medical Library, Johns Hopkins University. Both the committee and the research project have been

in existence for a year and the research project has another year to run.

Besides the Index Catalog, we publish the current list of Medical literature. It is published weekly under a broad general classification with only Journal titles classified. There are monthly subject indices included. There were printed in this publication during the past year, 64,000 current references to the Medical literature, and as I said, it is the only current index available since Quarterly Cumulative Index Medicus has fallen way behind in its production schedule and the index for the first has only appeared in the last few days.

I have placed a few examples of our publications before you. There is a copy of the current list, a listing of selected recent book acquisitions which we publish from time to time and which may be had for the asking, and a list of journals currently received in selected subject fields. I would think that these lists would be very helpful to your librarian and to the library committee when they are considering the development of your own libraries.

Besides these various publications, we have several other services to offer. One service is that of inter-library loans. We will loan any book which we possess and which is in physical condition to travel anywhere in the United States. We loan approximately 25,000 volumes a year on such a basis. Any out-of-print or hard-to-come-by item that your medical people may wish to see, may be obtained from the Army Medical Library. All we ask is that they clear their request through your local library and let your local library send it to us or we would indeed be swamped if all requests came directly to us. We ask that local libraries screen first to make certain that the book wanted is available only at the Army Medical Library.

There is a small sheet before you which explains the regulation on inter-library loans. The service is rapid, you will get the book by express, you can keep it for a period of three weeks and may renew it, if you so choose.

Another service which should be of particular importance to you is our Photo Duplication Service. You have been furnished with the regulations concerning photo duplication service and a copy of the order blanks on which we like to have orders come to us. This service is offered at cost to the civilian profession and free to all members of the Armed Forces. Your officers may submit such requests direct to the Army Medical Library. We will copy anything in our entire collection which is copyable by reason of its physical condition and which is not prohibited by the copyright law. Our activities in this realm are very large. We have each year for the past few years made well over a million pages of microfilm and photostats and sent them all over this country and throughout the world. We have bibliographical and reference services to offer. Here again we ask that local facilities be exhausted before questions are brought to the Army Medical Library. Our staff is limited, but we will do the best we can to give you service. I would ask that you specify exactly what it is that you wish and to limit the field as much as possible. You can realize with the figures I have cited as to our holdings, it is very difficult to fulfill a request for all the material we have on the subject of anemia, for example. That is the kind of request we get and it is simply because the person making the request has no idea of the resources which are available to us. So I would ask you to limit your requests as much as possible. Do you wish to have only the literature that exist in Western European languages or do you want the literature that exist in all languages? Are you interested

only in the literature that has been written since 1940 or some other date? Requests which are specific in that way are much easier to handle and it is also helpful for us to know what tools have been searched for this literature prior to the submission of the request to the Army Medical Library, so that we do not have to recover ground already gone over.

We have cataloguing services to offer and anyone who has been connected with the Library knows that that is quite a large item although to the person outside it seems like there is nothing complicated about it. Give a girl a typewriter and a stack of cards and tell her to make a catalog. It is quite a bit more complicated and the Army Medical Library is trying to provide a central cataloguing service so that that large job may be done only once in a central place and made available to all our installations. Formerly we had a cooperative agreement with the Library of Congress, where we submitted our cataloguing copy to them and they printed the cards, which could be ordered for a nominal sum. In the process of reorganization, we found that we were no longer able to continue that arrangement and in the past two years this supplement of catalog cards has been printed and is available to anyone who wishes to use it. All the research for proper forms of names and entry has been done for the material that we have and can be obtained through this catalog. This edition was published last year; next month the second edition will be published, and I believe that edition would be the last because this week we are reopening negotiations with the Library of Congress so that they will again print the copy which we send them and once more your librarians will be able to order any catalog card for any medical book through the ordinary card service of the Library of Congress. That also means that the catalog copy would be printed in the Library of Congress Cumulated Catalog so that there will be a complete bibliographical



record of all the medical material available throughout the country.

There are other services. We have been asked if we can provide duplicates of out-of-print material for your libraries. The answer is "yes" and the details of the answer are found in sheets which have been distributed to you.

I would like to make a comment in this regard. I would advise being reasonable in requests. Please do not ask for everything since the year one. It would be my recommendation that in building a hospital working collection, great care should be exercised. The Army Medical Library has inter-library loan services and it has photo duplication services. There is no need to develop additional Army Medical Libraries throughout the country. You must remember that the cost of acquiring material is a very small part of the total cost of operating a library. The Army Medical Supply Library spends only about 5% of its budget on acquiring its material. There are other costs which are very large - the cost of cataloguing books, the cost of binding periodicals, the cost of providing shelf space, the cost of providing personnel to handle those volumes for you. I would urge you to concentrate on the acquisition of a small nucleus of the most important and most substantive medical journals, plus a selected group of modern medical texts. All should be carefully weeded from time to time with the older and less used materials being discarded. They may always be had from the Army Medical Library. One of our great functions is to try to keep that sort of material in one place so that others throughout the country do not have to worry about whether someone is preserving it for the time when it becomes necessary. I would say that besides concentrating on the small working collection, it would be desirable to have the best indexing tools possible in that library. You will want the current list,

the index catalog, the Quarterly Cumulative Index Medicus, some of the better abstracting journals except the Medica, etc. With such tools you have the key to the literature and anything which does not exist in your library we will be happy to supply for you. Not the least of the tools in a medical library is a trained librarian, someone who can manipulate the literature for you.

I have told you what we can do for you and I would like to close with suggesting what you may do for us. Special Regulation 40-405-5, 15 August 1949, directs that one copy of all publications of medical or scientific interest issued by any medical branch, division, or headquarters of the Army or Air Force be sent to the Army Medical Library. I am quite certain that we have received a very, very small fraction of such publications which have come out since that time. The Army Medical Library is the National Medical Library; it is the repository for medical literature; the archival collection of this country and we should have one copy of all your publications. Bear in mind that our definition of the medical field is necessarily wide. We include the basic sciences allied to medicine. The request would include copies of hospital papers which your institutions may publish. That same directive requires that all excess medical periodicals be sent to the Army Medical Library. They should be addressed to the Director for proper disposition. Occasionally, we can supply items which have become lost or mislaid in our collection. Most often the major proportion of such materials which we receive are reallocated. We have helped stock most of the Veterans Administration hospitals. They can go to other Army hospitals which may need the very material which is excess to you and lacking that we have sent materials throughout the world. We have sent literally boxcars full of material to the Library of Chile, which burned

down a few months ago. We have sent more material to the devastated libraries of Europe. I offer you our services, will give them freely and gladly, and I ask for your cooperation in getting your publications in to us.

Colonel Tynes - Major Rogers, will you bring us up-to-date on the plans for the new Library? This is 30 years old, but it is also 24 hours old.

Major Rogers - The plans for the new Library have been under way for thirty years, as Colonel Tynes says. That beautiful picture on the wall in General Bliss' office is the picture of the new Army Library painted in 1919. The program has had its ups and downs through the years and now appears to be closer to realization than before. Approximately a month ago, Mr. Johnson signed a letter and sent it to the Administrator of the General Services Administration, Mr. Judd Larson, asking him to budget for, plan, and build a new Army Medical Library. A week or so ago, we received a copy of Mr. Larson's reply in which he said he would be only too happy to do that. I had a conversation Friday afternoon (date: 4 November 1949) with Mr. Reynolds of the Public Buildings Administration, who assures me that they are going right ahead, so I think the prospect of a new library building is better than it has ever been. For those of you who have been in that old building that we now share with General Dart (Armed Forces Institute of Pathology) know that we really need one. It is the oldest public building in the city of Washington and the only one, I am sure, which still has outside toilets.

Colonel Tynes - Our next speaker will be Colonel John Caldwell, Chief of our Neuropsychiatric Consultants Division. His subject is the "Use of Doctors on Loan to Medical Schools" and "Induction Procedures and Induction Standards."

Colonel Caldwell - Colonel Tynes, Ladies and Gentlemen - Availability of psychiatric personnel. Inasmuch as only four officers trained in psychiatry will become available on 1 July 1950, it will be impossible to assign additional psychiatrists to Army Areas other than minimum coverage for training centers and disciplinary barracks. In January 1951 11 additional officers will be available and on 1 July 1952 approximately 24 more officers will become available. Then we will be able to give some real help in critical areas. For at least another year we will have to depend upon such help as can be obtained from civilian psychiatrists on a part-time basis, employing so far as feasible, plans now in operation in the Second and Sixth Army Areas. It would be helpful to this office to be in close touch with you and to be cognizant of the civilians so employed and the locations where they are employed.

Induction procedures and induction standards. In the Fiscal Year 1949 the Army and Air Forces lost approximately 58,458 men separated other than by termination of tour of duty. These men were separated under the provisions of AR 615-361 (14,500); 366 (800~~4~~); 368 (8,908); 369 (15,967); minority (5,143~~4~~) or who became general prisoners (5,946). At an estimated minimum cost of \$534.94 for each man, to include 4 weeks' basic training, the cost to the Army was \$31,271, 522.52.

The number separated through medical channels (14,500), with an average length of hospitalization of 77 days, a hospitalization cost of \$17.00 per day, and \$5.35 per day average pay represented a cost to the Army of \$24,953,775.00.

There was an average prisoner daily population of 4,793, with an average cost per prisoner of \$1,604.86, totaling \$7,691,837.29.

The total cost to the Army of \$63,917,134.81, and disregarding the cost for pension involved for those discharged through medical channels, should cause serious thought on our induction and enlistment procedures.

This chart represents experiences during World War II. There were 1,350,000 neuropsychiatric rejections, constituting 12% of all examined and 38% of all rejections for all causes. There were 545,000 separated from the Service, representing 49% of all those separated for mental or physical defects. This figure included those separated administratively (163,000) for unsuitability or unfitness.

The second chart shows graphically that the losses for rejections or by reason of disability discharge by reason of neuropsychiatric defects exceeded all other causes to an overwhelming extent.

Chart No. 3 represents the incidence of neuropsychiatric conditions and shows that the rate was greatly elevated during the war years but has leveled off at the rate of somewhere around 18 per 1000 men per year, being roughly comparable to the pre-war incidence.

Chart No. 4 shows that discharges for nervous and mental diseases has likewise leveled off at around 4 per 1000 men per year which is also roughly comparable with the pre-war rate.

Chart No. 5 shows, however, that our administrative dispositions by reason of unsuitability or unfitness is 22 per thousand men per year, which is far above the pre-war and even war experience. By reason of broadening the base for administrative separations many men are being separated administratively who in former years would have been separated through medical channels.

The experience with general prisoners has also shown a recent increase to a rate of 6.9 per thousand men per year, representing an increase over the rates for the war and immediate post-war years.

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As an aside, Chart No. 7 shows clearly that the number of general prisoners is increased disproportionately in the group with an AGCT score below 90. The increase in general prisoners may be a reflection of lax practices in administering intelligence tests on enlistments.

Chart No. 8 shows 30% of those separated through medical channels for 1948 were for neuropsychiatric reasons. Approximately another 20% were separated for diseases ordinarily regarded as psychosomatic in nature. Thus perhaps half of our losses through medical channels are reflections to some extent of emotional and personality problems.

Chart No. 9 shows the relative incidence of neuropsychiatric disorders within the different Army Areas. There is no marked difference in any of the rates. These represent a probable homogeneity of population, of stress or supportive factors and overall policies.

Chart No. 10 shows that among the different Army Areas for the Fiscal Year 1949 there was a 0.33% rejection rate for neuropsychiatric reasons in contrast to the 12% during World War II. There was an average failure on the R tests of 9.87%, with a greater variation among the Army Areas than was present for incidence of neuropsychiatric rejections. The rejection rates for both neuropsychiatric conditions and for intelligence qualification were considerably below expectations. There was also considerable variation between different stations in the Army Areas themselves. For instance, there were 160 rejections for neuropsychiatric reasons at Atlanta out of a total of 16,764 examined. There were 7 rejections at Birmingham out of a total of 21,839 men examined.

Chart No. 11 for the month of September 1949 shows no appreciable change in the extremely low rejection rate for neuropsychiatric conditions and not too much change in the rejections by reason of the R Test.

Chart No. 12, taken from the experience of the Third Army Area, shows 41,802 men examined, with 5,604 rejected on the R tests. Now the R Tests are so constructed that it is expected that 25% of men would fail the test within the age group eligible for enlistment in the Army. Therefore, in the Third Army Area 10,448 men should have been rejected. This means within the Third Army Area there were 4,844 men in September 1948 who were accepted but should have been rejected.

It seems fairly obvious that our enlistment procedures have been lax and that many of the medical and administrative problems encountered today are from men who should never have been inducted or enlisted. This matter has come to the attention of the General Staff, and it is expected that some change will be forthcoming in the standard operating procedure for enlistment and/or induction.

Current planning on enlistment procedures. Lt. Colonel R. E. Conine, Procurement Branch, Manpower Control Group, P&A Division, states that P&A has drafted a lengthy detailed letter which they are submitting to the Chief of Staff requesting that he send the letter to each Army Area commander. The letter points out the inadequateness of recruiting procedures during the past few months and indicates the cost to the Army of such practices. It urges each Army commander to take what steps he feels necessary to assure a higher quality of recruiting procedures in his Army Area.

Colonel Conine states that the P&A Division feels that a certain number of the unsuited recruits brought into the Army are passed by examining physicians who do not perform their job properly. They feel that the Army surgeons should give this matter closer attention and should work closer with the Military Personnel Procurement Officer in each Army headquarters.

Colonel Conine states that the P&A Division at this time is attempting to set up some kind of a reporting system which will let each recruiting station know when one of their recruits is separated from the Service within the first 14 weeks of service. They feel that such a reporting system will disclose the recruiting officials who persistently recruit unfit personnel. He emphasized that they hope this report will also disclose the examining physicians who approve physically unfit recruits. The purpose of the reporting system is to eliminate from the recruiting procedure those individuals who are not doing a good job, as well as encourage all recruiting personnel to apply more carefully existing standards. To this end, they are contemplating setting up net quotas instead of gross quotas which now exist. Under the proposed plan, each recruiting officer would lose points for each unfit individual he recruits. They have not worked out the details of this system as yet but they feel that something in this line will be initiated soon.

Colonel Conine stated that the Navy has requested all of their medical installations to help Army recruiting stations in the examination of recruits. He stated that a number of recruiting stations have reported that they have been using adjacent Navy medical units and have found that service to be very helpful. He states that P&A feels that a medical officer of one of the Armed Services is much more capable of examining a recruit than is the average civilian physician.

Colonel W. G. Caldwell, Chief, Organization and Training Branch, MPPSD, AGD, also feels that the examining physician should be more closely supervised and that the Army Surgeon should make greater effort in educating the examining physician in respect to Army examining standards. He definitely feels that a closer relationship should exist between the Army

physician and the Army MPPO and that the Army Surgeon should have a more accurate knowledge of the situation by a closer liaison with the Training Division in their respective Army Areas. Colonel W. G. Caldwell also poses the following questions:

a. Would prompt report of fraudulent enlistments from the the Training Division to the Recruiting Station (through channels) tend to raise the standard of administration of the physical examination?

b. Is the present physical examination form and its administration adequate to disclose either physical or psychiatric defects? If not, what improvement is recommended?

c. Do enlistment quotas tend to result in lenience on the part of the medical examiner in what appear to be minor physical defects?

d. Is closer supervision of Recruiting Station medical facilities and personnel practicable?

e. Would a closer liaison between the Surgeon of the Training Division, Army Surgeons, and the Surgeon in the Recruiting field particularly in the matter of acceptable standards, be advantageous?

Recommendation: The recommendations of the Neuropsychiatry Consultants Division, with reference to enlistment and induction, include the following:

a. Information from schools. It is recommended that pertinent data on the individual who enters the service from school or who has been out of school for not more than five years be obtained from appropriate school written records.

(Information suggested: Age left school; last grade completed

successfully; grades failed; reason for leaving school; average academic standing in class; school years covered by the report; remarks to include significant fluctuations in grades and department and pertinent information from other schools, if available.)

b. Information from Police and Court Records. It is recommended that the individual's fingerprints be cleared through the Federal Bureau of Investigation before induction and that details of charges, convictions and sentences be obtained by direct correspondence to the police agency or court in which a record appears to exist as indicated by the Federal Bureau of Investigation report. (Information suggested: Type of conviction; nature of charge; nature of and disposition of sentence; and remarks from record which will help to evaluate the individual's adjustment to military service.)

c. Information from Mental Hospitals and Institutions. It is recommended that the individual's name be cleared through the central files of mental patients in the states that have a central filing system. In states where central files do not exist, it is recommended that the individual's name be cleared with each mental hospital in the state in which the individual has resided for a period of five years or more. (Information suggested if he had been a patient in any mental hospital: Date of his admission; date of his discharge; diagnosis; and condition at discharge.)

d. Information from Employers. It is recommended that information not be obtained from employers. Because it is believed that the number of pertinent evaluations by employers

will be so small, a general coverage in this area for all individuals is not warranted.

e. Information from Social Agencies. It is recommended that information not be obtained from social agencies. It is believed that only a few of the individuals in the induction age group will be known to social agencies and that an overall coverage is not warranted.

f. Attitude of Induction Personnel. It is inferred that if the persons making contact with the candidate for military service are sincerely directed toward adhering to existing procurement procedures and standards, it is believed that the individual candidate will (1) understand the purpose for which pertinent information is sought, (2) be motivated to present the factors honestly, and (3) be able to give considerable information of real value.

g. Clearance for Previous Military Service. It is recommended that effective and accurate clearance for previous military service be instituted so that the record of prior service would be available before induction. This can best be obtained through clearance of fingerprints at the Federal Bureau of Investigation.

h. Evaluation of Motivation. It is recommended that induction personnel should carefully evaluate the motivation for joining or staying out of the Armed Service before accepting the individual.

i. Assistance in Processing. It is recommended that personal assistance in completing the forms and understanding instructions

should be given to the inductee on the assumption that confusion and inaccuracies may be eliminated by such help. It is also recommended that the language of the forms and instructions should be lowered to the comprehension level of the average candidate.

j. Continuous Checkup Procedure. It is also recommended that the induction process should include a continuous checkup procedure so that the personnel at the induction level would become fully aware of each of their "failures." A record of these failures should be maintained to eliminate from the procuring program those procuring agents who persistently induct such failures.

Colonel Tynes - Colonel William S. Stone, Chairman of the Medical Department Research and Development Board, will now speak on Medical Department Research and Development during the past year.

Colonel Stone - Army medical research and development is confined to military medicine, except for minor work being carried out in various Army hospitals, in conjunction with clinical care of patients. The definition of military medicine used is the knowledge, skills, supplies and equipment required for the maintenance of health, the treatment and rehabilitation of the sick and injured occurring in war which are not developed, or inadequately developed, by non-military agencies. For the most part, military medicine consists of four main fields:

a. Preventive medicine on a world-wide basis under conditions where civil public health services are non-existent or operating in a totally inadequate manner.

- b. The treatment and rehabilitation of large numbers of traumatized individuals suffering from wounds, chemical, radiation and other injuries.
- c. Reactions due to stress.
- d. The classification of manpower on the basis of physical and mental health standards needed for the efficient use of personnel under conditions of war.

In recapitulation, the main fields of research and development of military medicine are:

- a. Physical and mental standards for the most efficient use of manpower.
- b. Preventive neuropsychiatry and psychology.
- c. Radiobiology as it affects medical practice, including preventive medicine.
- d. Arctic medicine.
- e. Traumatic surgery and resuscitation required for war casualties.
- f. Disease prevention, control and treatment.
- g. Metabolic diseases.

For Fiscal Year 1949, \$3,293,136 was appropriated by Congress for research and development of the Medical Department of the Army. This money supports: 225 projects in 10 Army installations, 3 other governmental agencies, and 42 colleges or universities or hospitals; moneywise, approximately 50% of the research is done in Army installations, and 50% by contract with other agencies.

I will not attempt to review all of the projects, but will briefly give a few details on progress made in some of the outstanding projects:

Army Medical Department Research & Graduate School, Washington, D. C.

- a. Chloromycetin treatment of typhoid fever was developed.

b. What appears to be an effective rodent repellent has been found and is undergoing test.

c. Purified virus vaccines with greatly reduced foreign protein content have been developed.

Medical Nutrition Laboratory, Chicago, Illinois

a. Further evidence on the role of cobalt salts in anemia has been brought forth.

b. That globin can be a source of protein in regeneration of red blood cells has been demonstrated, using N15 isotopes.

Medical Department Field Research Laboratory, Fort Knox, Kentucky

a. Additional physiological studies on man's ability to work and live under conditions of extreme cold have been made.

b. A new method has been developed for studying cell injury due to ionizing radiation.

Surgical Research Unit, Brooke Army Medical Center, Fort Sam Houston, Texas

a. Prevention and control of surgical infections have been further studied, using combined antibiotic therapy.

b. Plasma substitutes, Dextran and gelatin have been studied.

Engineering Development Division, ASMPA, Fort Totten, New York

a. Improved field X-ray equipment and new field chests have been developed.

CONTRACTORS

Dr. J. Garrott Allen, University of Chicago demonstrated the role of heparin in hemorrhages following radiation injury, and the value of promin, certain dyes and bone marrow shielding in the treatment of radiation injury.

Dr. Hugh Smith, et al, Campbell Clinic, Memphis, Tennessee - the use of intramedullary nails in the treatment of fractures, their value and limitations.

Dr. William S. Tillett, New York University - Bacterial enzymes in the handling of purulent and fibrinous exudates as an aid in the treatment of infections.

Dr. Harvey Allen, Cooke County Hospitals, University of Chicago - the treatment of thermal burns - a new first-aid dressing has been developed.

Dr. Edward L. Howes, Columbia University - the mechanism of wound healing. The inhibitory action of ACTH and similar substances on wound healing has been demonstrated.

Dr. Paul D. White, Harvard University - 20 year follow-up on cases of psychoneuroses of World War I and evaluation of psychotherapy as a therapeutic agent. Psychotherapy produced no better results than friendly counsel and reassurance.

Dr. J. W. Conn, University of Michigan - the chloride content of sweat has been demonstrated to be an index of stress experienced by the individual.

Dr. John H. Dingle - Dr. Charles H. Rammelkamp, Western Reserve University Studies on streptococcal disease at Fort Francis E. Warren - the value of penicillin prophylaxis for the prevention of rheumatic fever in exudative streptococcal disease of the nose and throat has been demonstrated to markedly reduce the incidence of rheumatic fever following known streptococcal infections.

Dr. Aram Glorig, Audiology & Speech Correction Center, Forest Glen - a

standard hearing test for auditory screening during mobilization is being perfected.

From this brief review of some of our research and development projects, I am sure it is apparent that much information is becoming available that is of great importance in medical training for national defense.

It is planned to inaugurate courses in military medicine in the near future to teach the lessons learned through professional experience in World War II, and to supplement that information by the products of research in military medicine as fundamental steps in military medical preparedness. It is hoped that this material can be made available to all medical components of the Army, civilian medicine and those interested in civilian defense.

Colonel Tynes: Our next speaker is General Hays, Chief, Supply Division. He will discuss problems of supply.

General Hays: I want to say "hello" to everybody. I haven't had a chance to see most of you as I have not been here most of the day.

On the subject of supply one of the urgent problems at this time is the development of a comprehensive policy with respect to the retention of an adequate level of "standby" medical equipment at station level.

The basic authority for the retention of "standby" or "housekeeping" equipment at stations is contained in Section II, War Department Circular No. 4, dated 4 January 1947. In general, this authority authorizes the retention of sufficient quantities of non-expendable, non-deteriorating medical equipment to support normal operating requirements for the planned total strength for the active forces listed in Progress Report, Section

3-D, Program of Installations, Volume II, dated 30 June 1947. Active forces as defined in the Program of Installations includes trainees under the Universal Military Training Program. The quantity of medical equipment to be retained is to be computed on the basis of three percent (.03) of planned strength.

Based on the above authority, Commanding Generals of Zone of Interior Armies and the Commanding General, Military District of Washington have established maximum levels of equipment to be retained at each Zone of Interior installation under their control. Similar action has been taken by this office in the case of general hospitals. The difference between the maximum equipment level and the current authorized bed capacity represents the actual amount of equipment authorized for retention in standby status.

The above mentioned policy is inadequate in several respects, insofar as medical requirements are concerned:

The procurement of additional equipment is not authorized until such items in a standby status have been utilized. Under this provision, items in standby would, of necessity, have to be withdrawn to meet current requirements thus obviating the retention of a firm level of equipment.

The justification for standby is based chiefly on requirements for the support of UMT. The repudiation of UMT as an approved national defense policy would result in the withdrawal of the majority of medical equipment now in standby and reduce levels for all practical purposes to the current authorized bed capacity.

If, as these hospitals are reduced in authorized bed capacity, and we are forced to dispose of equipment already on hand down to the bare

operating level, it will be impossible to re-expand them to their maximum constructed capacity with any degree of rapidity. There will probably be a decreasing number of authorized hospital beds as a result of decreasing morbidity rates and a decreasing Army strength. In other words, we will have no cushion to take care of needs for increased beds in any hospital. Such a local need might result from increased sickness rate, an epidemic, local disaster, or possibly even local enemy action.

The policy is expensive. As hospitals are reduced in size, we will be forced to go to the expense of packing and shipping equipment and inspecting and warehousing it in depots. Should the need develop for temporary or permanent expansion in any hospital, we will then have to go to the expense of shipping the materiel from the depot back to the hospital.

To alleviate this situation, the Surgeon General requested authority of the Department of the Army to retain standby medical equipment in Zone of Interior general hospitals to the extent of constructed capacity. It was recommended, also, that standby equipment in general hospitals be considered a firm reserve, not subject to withdrawal, to meet current requirements. These recommendations were approved and announced to the field under date of 23 August 1949 (letter, Office of the Surgeon General, MEDDE, 23 August 1949, Subject: "Standby Medical Equipment (Expansion Reserve)" addressed to Commanders of general hospitals through Zone of Interior Armies).

At the time the revision of standby policies was requested for general hospitals, the Department of the Army was advised a study would be made of Zone of Interior station hospital requirements and submitted

at a later date. This study has been completed and forwarded to the Department of the Army recommending an increase of approximately 40% in equipment levels for station hospitals. It was recommended, also, that standby equipment in station hospitals be considered a firm reserve under the same conditions authorized for general hospitals.

In the event that the revised policy is approved for station hospitals, this office will advise each Army of the total level authorized for their area. We will also furnish a suggested breakdown of equipment authorization for each installation, based upon the latest information available in this office concerning station hospital requirements.

This office has published to the field a specific list of items authorized for standby. This list includes approximately 250 items of medical equipment, many of which require installation, such as operating lights, dental units and x-ray machines.

Last spring we developed a certain procedure for mothballing equipment at hospitals. We conducted these tests at Camp Pickett when that hospital was closed. We have taken movies of it and we are preparing a manual. They should be available within the next few months, and we will be in a position then to give all hospital commanders assistance in mothballing their equipment. They can bring the movie into your hospital and give you the manual and we can send a detachment from a depot that has been carrying on this mothballing procedure to assist you in mothballing your equipment. It has been my experience that even in hospitals where we do not have much standby, or do not plan to have much, that this mothballing operation can well pay its way on many items of equipment that you have in stock. As soon as the film and manual are ready, we will let you know.

Section II of War Department Circular No. 4 of 1947 is being replaced by a new publication now in process. The new publication will restrict considerably the amount of equipment now authorized for standby. The Surgeon General's Office has concurred in the general policy of reduction since most technical services do not have an urgent need for the retention of equipment at station level. There is, however, a specific provision in the publication authorizing the retention of Medical Department equipment on the basis of 125 percent (.125) of authorized capacity or constructed capacity, whichever is lower. There is a provision, also, that exceptions to the overall policies will be made when indicated. Since the Surgeon General already has asked for specific amounts of equipment to be retained at general and station hospitals in the Zone of Interior, the new publication will not effect levels of medical equipment authorized to be retained at stations.

Another important phase of medical supply operations is the equipment survey of medical installations. This survey is a function of the "Medical Equipment Survey Committee" that has been operating as a field agency of the Supply Division for the past two (2) years.

This Committee was organized for the purpose of visiting hospitals and dispensaries and compiling accurate and up-to-date information on requirements of medical equipment. It supplements our normal requirements system and has rendered valuable assistance in improving standards of equipment in medical installations.

The Committee has visited all hospitals and dispensaries in the Zone of Interior and recently completed a survey in an oversea command. Members of the Committee are familiar with recognized standards of equipment in both civilian and military hospitals.

In conducting field surveys, visits are made to the various clinics and departments of a hospital and equipment requirements are discussed with operating personnel. Upon completion of the survey, a report of equipment requirements is submitted to the hospital commander for comment and transmittal to the Surgeon General's Office, through command channels. The report includes both standard and nonstandard requirements.

Upon receipt in this office supply action is initiated to the extent of available stocks and funds. Since the Committee was organized we have, as a result of field surveys, distributed standard stocks valued at approximately two million dollars and nonstandard funds amounting to approximately 1.3 million dollars.

A considerable backlog of both standard and nonstandard requirements has accumulated due to budgetary limitations. These requirements are reviewed in this office at periodic intervals and supply action is initiated automatically as stocks and funds become available. Due to rapidly changing conditions in medical installations, it is our policy to communicate with stations before initiating supply action, when there has been any appreciable lapse of time since completion of the survey. The cooperation of hospitals, in this respect, will be of material assistance to this office in effecting an equitable distribution and obviating the accumulation of excess stocks.

One of the projects under the Medical Equipment Survey Program is the replacement of white enamel and out-moded items with corrosion resisting metal and other preferred types of equipment. This includes such items as medicine cabinets, bedside tables, dressing cabinets and instrument trays. It will be necessary to continue this program over a

period of years since funds do not permit immediate replacement of all items. There is, also, the problem of excess equipment that would be generated at stations by mass replacement of serviceable items. As a matter of general policy, we propose to replace these items as they become unserviceable. Some stations have not understood this policy and have been of the opinion that we were in a position to replace all white enamel equipment within a short period of time. When we query stations as to their immediate requirement for a preferred item of equipment, we want them to consider their needs for replacement of unserviceable items, plus any requirements they may have for additional equipment. We do not expect as a result of this program that a station will accumulate an excess of serviceable equipment which will have to be returned to a depot.

Another problem we have found is the matter of funds for installation of new equipment. The Medical Department is responsible for the installation of technical medical equipment to the extent of placing, connecting, adjusting, calibrating and testing the item. Cost of installation which involves changing of utilities (plumbing, heating, electricity, gas, water, air conditioning, etc.), or modification or renovating structures or bringing in power lines are chargeable to Repairs and Utilities Fund. This policy has been announced to stations through medical distribution depots. Wherever possible we include cost of installation, properly chargeable to Medical Department funds, in the contract. In case an item is issued from stock and no provision is made for installation by the manufacturer, request for Medical Department funds required for installation should be directed to the medical distribution depot. The medical depots will either effect installation by a Medical

Equipment Maintenance Officer or authorize the station to procure the service locally from funds furnished by the depot. Estimates of repairs and utilities funds required should be submitted to the Repairs and Utilities Officer designated to service the station. Considerable delays have occurred in the installation of Medical Department equipment due to a lack of repairs and utilities funds. In a number of instances this was due to a lack of advance planning since Repairs and Utilities officers had not been informed, in advance, that certain funds would be required for installing medical equipment. We do not feel that requisitions for medical equipment should be delayed pending assurance of the Repairs and Utilities Officer that funds are available for installation, provided there is a definite need for the equipment. However, close coordination should be maintained with the local Repairs and Utilities Officer, and he should be advised when a requisition is submitted for equipment that will necessitate the expenditure of repairs and utilities fund for installation.

During visits to hospitals we have noted that medical equipment furnished under the survey program, as well as items received through normal requisitioning channels, are not being utilized to the fullest advantage. For example, we have found, in storage, new items of corrosion resisting metal equipment, as well as other preferred items of equipment while equipment in varying stages of serviceability was in use throughout the hospital.

We have found, also that some medical supply officers are not familiar with the survey program and the fact that a survey has been made at the hospital. Medical equipment survey reports are kept current

in this office. The data contained in the reports are used as a basis in computing requirements, scheduling procurement and in making distribution to individual stations. The particular items of equipment included in the program have been published to the field. It is recommended that hospitals make periodic surveys of requirements of these items and keep this office informed through medical distribution depots, of additions or deletions that should be made to the original survey report.

The Medical Equipment Survey Committee will continue to make visits to stations for the purpose of reviewing previously established requirements and keeping the survey program up-to-date. We make a policy of advising stations approximately one (1) month in advance of a proposed visit. It will assist the Committee materially if a thorough study of requirements is made by local personnel prior to their arrival.

Only one other thing I would like to say and that is the thing that I always say in talking on supply. That is that the weakest link in our supply chain is now and always has been between the professional man in the hospital and the supply man. It is half the fault of the professional man and half the fault of the supply man. All individual cases differ, sure, but totally speaking, both of them are at fault. The professional man does not do his part, and the supply man does not do his part. Now, it is the job of the supply man to get out, visit the professional men in their place of business, in their clinics, in their wards, find out what they need, and get it for them. Likewise, it is the job of the professional man to find out what the supply man has and take proper steps to get it. I do not think that can be emphasized too strongly -

that is always our weakest link and every time we find supply trouble in a hospital, that is always present. I think you as hospital commanders and as army surgeons can do quite a bit to improve that situation. You can encourage, and if necessary, insist that your supply officer get around to visit the professional activities in the hospital and get acquainted with the younger doctors, the older doctors, the dentists, and the nurses and find out what they need. Give him five minutes at your staff meetings and conferences. If he has the attitude that his professional people cannot come down in his supply room or warehouse and see what there is, get him straight on that. Those people ought to be able to come down there and look around just as much as they can go into a surgical supply house and look around and see what there is. I think that the hospital commanders can do quite a bit.

General Offutt: What do you mean by constructed capacity? Is that emergency capacity of 72 feet or is it constructed capacity of 100 feet?

General Hays: I cannot answer that off hand, but the letter that went to each hospital gave the constructed capacity as recorded on records in this office.

General Offutt: It does not say on what it was based.

General Hays: I cannot answer that. Colonel Riordan can you answer that?

Colonel Riordan: No sir, I am not sure.

General Hays: Will you check that? You can check that right now and we can have that answer for you this afternoon before the meeting adjourns.

Colonel Tynes: Colonel Goriup is our next speaker. He will speak on "Basic Requirements for Medical Service Corps Officers."

Colonel Goriup: Ladies and Gentlemen. The Medical Service Corps is slightly over two years old. I thought that perhaps you might be interested in a few statistics with reference to the Regular Army Medical Service Corps. These figures are approximate.

Our original authorization was 1,022, which has since been reduced to 832 as a result of the establishment of the Medical Department for the United States Air Force. Considering the numbers of Regular Army Medical Service Corps officers transferred to the Air Force plus the gains and losses, we have approximately 590 on the roster today, of which 505 normally fall under the Pharmacy, Supply and Administration Section; 11 in the Engineering Section; 73 in the Medical Allied Sciences Sections; and 1 in the Optometry Section. The 590 breakdown approximately in the following categories: 30 are preintegrated officers of which 11 came in by way of the professional examination for the old Pharmacy Corps. Approximately 75 were career enlisted men who came into the Army in 1939 and prior thereto. Approximately 400 were selectees who received their commissions through Medical Administrative Corps Officer Candidate Schools, and approximately 90 held Reserve commissions prior to World War II or received a direct appointment during the War. A few were integrated into the Medical Service Corps from other branches of the Army.

A recent study of records indicated that 42.0 percent hold baccalaureate degrees of one form or another, that 13 percent have graduate degrees up to and including the doctorate. Medical Service Corps officers with graduate degrees are not all in the Allied Sciences Section. Approximately 30 are enrolled in graduate schools at this time, including 4 pharmacists, who are assistant professors of military science and

tactics at pharmacy ROTC units.

I should like to mention a few words for those Regular Army Medical Service Corps officers who have less than a baccalaureate degree. In my opinion, I think it can be safely said that the Army is the greatest university in the world and that these individuals have received certain training that makes them equally qualified with their brother officers with academic degrees by their training, indoctrination, and experience gained while on duty. I believe it is safe to invoke the "grandfather clause" in their case.

We have approximately 2,000 Medical Service Corps Reserve officers on extended active duty. Time has not permitted a statistical analysis of their educational qualifications. Approximately 85 percent have had six years experience as officers on extended active duty, and it is felt that approximately the same number would reenlist in the Service upon attrition.

The subject of my address is "Basic Requirements for Medical Service Corps Officers." To my mind the basic qualifications of our officers are that they be intelligent, personable, and adaptable, or, more facetiously, he should be a mental giant, a veritable Solomon, and a miniature Dale Carnegie.

To determine the basic qualifications for a Service Corps officer, we must base it upon certain assumptions such as: It is altogether possible that in the event of hostilities, the United States and her allies could well be outnumbered in manpower by our only potential enemy and her satellites. It has been mentioned on many occasions by people in all walks of life that the necessary mobilization could well be a total

mobilization. It would also appear that the Army could hardly avoid participating in civilian defense in time of a mobilization. It is safe to assume that the current trend of our civilian population in placing more and more demands on our medical doctors will continue and that the supply will not be able to keep up with the demand in peacetime let alone in time of an emergency. This trend, I am sure, will further aggravate the supply of medical doctors and create a shortage for the Armed Services in time of mobilization. If this is true, then it becomes increasingly important that qualified assistants be made available to the Medical Corps to assist them in their mission both in peace and in war.

It can now be assumed that the efforts of the Medical Department of the past few years will result in the Medical Department's obtaining a sufficient number of medical officers for their requirements for the Regular Army. At such time as that requirement is met, we can ill afford to relax the continued development of the Medical Service Corps officer lest we be caught short of trained, qualified officers of this sort in time of mobilization. I feel that it is incumbent upon all of us that the training of Regular Army and the Reserve Service Corps officer on extended active duty should go hand in hand with the training and development of their counterpart in civil life.

It is traditional for a man to get a year older each year, which may not be true of a woman, and as such, we have and will continue to get attrition in our Reserve Corps. To that end, we must constantly look to new procurement. We expect to get this new procurement in the Reserve corps through the medium of Circular #210, ROTC of our own

pharmacy units, as well as from other ROTC units, and in the near future, from OCS. It is hoped that our total future procurement for the Regular Army will accrue to us by the direct appointment of Distinguished Military Graduates of our own as well as other ROTC units and as a result of successful completion of qualifying tours of our Reserve officers.

At this point, I feel that you can be of great assistance to us in the Surgeon General's Office by screening out at your level those individuals who apply for a qualifying tour with less than an academic degree and who are over 30 years of age. This is not a Surgeon General's policy, but rather the policy of the Department of the Army. The Medical Service Corps is authorized to appoint officers up to the age of 30 years, whereas the other corps of the Army cut off at 28 years. Public Law #381 provides for the Secretary of the Army to waive age requirements. However, the Secretary of the Army's Office has stated and reiterated on many occasions that they do not intend to waive the age requirements. We do have authority, however, to credit an officer with all service performed subsequent to 31 December 1947. In other words, a Service Corps officer who on 31 December 1949 is 32 years of age and who has been on continued active service since 31 December 1947 would be eligible for a qualifying tour, since his two years' service could be subtracted from his current age, which would bring him within the authorized age of 30.

Just a word about career development. It is our job to furnish you with Medical Service Corps officers to satisfy your requisitions. We do our very best to assign capable officers to your command upon your request. We are fully aware that it is your responsibility for their

subsequent assignment and utilization. We have only recently been able to analyze the background and other qualifications of our Regular Army Service Corps officers and voucher them in a systematic manner. During this study we observed several conditions that I believe you will be able to assist us in correcting.

We have observed that in some instances Medical Service Corps officers have been in the same type assignment for a number of years. We believe that in order to insure versatility in our Medical Service Corps officers that they be rotated. We are very reluctant to contact you with official letters in this regard. In the final analysis, we of the Medical Service Corps look to our senior medical officer for guidance and advice. We have also observed that in some instances there is a disproportionate number of Reserve officers in key positions. This also tends to prevent our Regular Army officer from obtaining the type of training necessary in his development. A recent study of the composition of field units indicated two conditions: One, that an inordinate number of combat arms officers were assigned to medical field units and that of 253 Service Corps officers assigned to field units, only 20 were Regular Army. We are attempting to correct this situation at this time by making available a larger number of Regular Army Medical Service Corps officers for this type of duty.

I believe you will all agree that the mere assignment of an officer from the field to the Surgeon General's Office does not make him any brighter, but the very nature of this assignment places him in the position of making certain decisions and recommendations to the Surgeon General. Many of these decisions are based upon reports and records,

such as efficiency reports and the general 201 file. In many instances, we find it extremely difficult to make erudite decisions on our Medical Service Corps officers due to the inadequacies of the records. In order to develop the Medical Service Corps to its highest pitch of efficiency, it is most important that we who work with records be insured that we have explicit data on each and every one of our officers. I do not wish to imply that I am advocating a witch hunt, but we would certainly appreciate your being factual in your statements on any Medical Service Corps officer should he not be up to standard in performance. A Reserve officer of this type can be declared surplus. A Regular Army officer will eventually be attrited.

If there are any cripples, we must ruthlessly "cut them out of the herd" to the end that we will have a pure strain.

We are not interested in thoroughbreds for they quickly become contaminated by inbreeding.

We are proud of the group we now have and will be prouder still of the new man we are now and hope to continue to attract in joining up with us.

Colonel Tynes: Before calling on our final speaker for the afternoon, I have one request - I would like an opportunity to see Colonel Keeler and Colonel Welch sometime tomorrow or Thursday, at their convenience. I will be in my office all day Thursday and five to ten minutes with you tomorrow, possibly on the way up to the meeting might be sufficient to take care of what I have to give you.

Our last speaker this afternoon is Colonel Wilson, who will talk on the subject "Current Situation of Civil Health Affairs in the Army."

Colonel Wilson: Gentlemen, you have no problem of potential greatness

equal to this one today. As time would prevent a complete discussion of this subject, I have prepared for you two sets of papers, one, an outline of notes on the subject assigned, another which includes some answers to the question submitted by Colonel Gorby with reference to the Army surgeon's responsibility in making plans for meeting biological warfare. As you can well see, that second set of notes will have direct application to this subject. The outlined notes which will be provided you and have not yet been, speak specifically of the responsibilities, as they may be seen now, which are faced by the Army surgeons. It also lists exact references in which you can find definitions or clarifications of terms which have been made by the Department of the Army and therefore should be uniformly used by all of us until someone gives us different definitions. Within the listing of definitions in that particular reference, one finds, also, clear statements of what is meant by military aid to civil authority, what is meant by civil defense, what is meant by responsibility for internal security and such terms which have been a little bit nebulous or vague in our minds for the past two years. The second group of references has to do with exact policies as they have been determined and published by the Department of the Army. The third set of references in that list of notes has to do with certain other things such as methods of planning, components of a plan, suggested activities in which the Army surgeon, or his station surgeons under his direction or supervision, or advice can proceed to aid local authorities in their planning; that is local civil authorities in their planning. Now you will see the significance of that a little bit later when we refer to a Special Regulation of the Department of the Army. In your

outlined notes there will also be a statement of your justification for interesting yourself in this subject. Up to now there has been some excuse for any one of us questioning whether we actually have any responsibility, and if we thought we did have, what justification we might advance to our command. What justification can we advance to any civilian when he wants to know why we poke into such affairs as this? You will have specific statements in the notes. Finally, there will be a rather detailed statement of the exact, current situation with reference to civil defense particularly, but much less on any other civil affair. That is primarily because of the fact that here in the United States we actually have no civil affairs responsibility of any great importance, except perhaps civil defense. I should like to stress to you certain specific references and if you don't mind I shall just hold them up for you to see. If you do not have them in your library and if you should have any trouble obtaining a copy of any one of these, we would certainly undertake to help obtain copies. The first one I should like to mention is the Hopley Report, i.e., Civil Defense for National Security. Now certainly I would recommend that no one further along the line than the Army surgeon undertake to read this report too carefully. It is a top level planning document, so except for the Army surgeon who might want to study it for federal organization, for potential military organization, or for integrating suggested local and state civil defense civilian organizations within his thoughts. I would recommend that no one do more than just look at it. A second document of real significance, which ought to be thoroughly understood by everybody to the farthest level is Special Regulation 580-10-1, Civil Defense.

These all are listed for you in the outline of notes. This is a clear statement of civil defense and it places specific responsibilities upon the Army area commanders. The third reference which you may not have, and I would suggest that you be sure you have, is this "Guide to Terminology and Policies with Reference to Military Aid to Civil Authorities," dated 30 September 1949. That was sent out to all Army commanders. Knowing how things happen I wouldn't be surprised if it didn't filter down to each Chief of Technical Service in the Army headquarters. It is essential for all of us to use a uniform terminology henceforth. A fourth reference of particular value to you in reassuring you that you are on safe grounds from a security viewpoint, and in giving you something that you can clearly refer to civilian planners or any civilian interested in this subject, is the Secretary of Defense statement on biological warfare potentialities. Each visiting officer has been provided with a copy. That is unclassified as you will see, and it is a step in the right direction. Another reference which is purely of a press nature is the outline that was handed to you, "Articles Published in the Philadelphia Inquirer" by John McCullough. Those are as clear a statement as I have seen of many of the aspects of atomic warfare. You and I have seen reams and reams of literature and we see pamphlets and we get confused before we can get started. Now these four consecutive daily issues of the "Philadelphia Inquirer" include a very clear and usable statement that you can apply and can refer to civilians readily. The Office of Civil Defense Planning before its abolition in the Department of Defense, was authorized to reproduce this in full for use by military personnel in their regular duties so no copyright was infringed in this, and you therefore can use

it freely as long as you cite the source. There are two other references which may be of some help that you can cite to civilians. One was an article and I apologize to you for mentioning this, but in the January 1942 issue of the Army Medical Bulletin was published a through and complete outline, a check list actually, that could be employed by civilians in drawing up Civil Defense plans. That's listed in your outline too - it was Medical and Sanitary Care for the Civilian Population Necessitated by Hostile Aircraft. A second one which you may not have and is very difficult to obtain, practically impossible through official channels, is a directive that went out in 1943 on Military Hospitalization and Evacuation Operations. Now I want to urge that there be no confusion about the applicability of that total document. It no longer has any official standing as a directive but in that, for your use in planning or discussing civil defense, there's still a very sound basis for integrating military and civilian planning. In that directive, I think that General Offutt will remember, we had from the Surgeon General's Office a determination of mobile units which could be quickly thrown together as an expedient for an Army station, either a general hospital or any one of our large stations, in the event as a last resort civilians or civil authority were compelled to call upon the Army for aid in a situation of civil defense. The reverse is covered somewhat satisfactorily there too. What the military could expect from civil authority on such questions.

When you have had an opportunity to glance through some of these notes, I think that you will find that five conclusions which I shall present to you here are thoroughly justified:

First, that the only real civil affairs problem that might exist

for you today in the United States is civil defense.

Second, that there is no agency of government charged by law with civil defense responsibility except indirectly, and that applies mostly to the Army.

Third, if a major disaster or enemy attack should occur within the next few years, the Army and other Armed Services could not avoid participation in the necessary activities to re-establish the civilians in their communities.

Fourth, only by considered effort now, and this is by you, with appropriate military understanding and organization for civil affairs, can we insure civilian preparation and readiness for handling their own civil defense at a later date, perhaps five years from now, if civil defense actively got going at this time.

Fifth, that this special regulation that I have cited to you placed such definite responsibility for readiness upon the Army commander that it cannot be avoided.

Now, as a matter of interest here at the end of the day, in order not to tax you, you might like to know that there are many agencies, many individuals, many people interested in this subject. For example, repeatedly, medical societies over the country are asking for speakers from the Office of the Surgeon General. No doubt you are having them out in your own areas the same or a similar way. I know that several divisions of this office have provided speakers on particular subjects in which medical societies have been interested. In many instances, they ask for discussions for which they are not prepared because they haven't even gotten these basic problems solved, but in every instance, it seems to me,

all of us should make every effort to provide a speaker who can discuss the subjects they want and can tie these military policies, to the extent that you can reveal, to them, should tie our own limitations, our primary military responsibilities, should tie in the necessity for these civilian communities or societies or groups to immediately "get going" on their own organization, their own planning. There are four of the ten active schools of Public Health in this country who now are putting into their schedules exact and definitely delineated courses in this field. They may not be any more than an assigned problem in Public Health administration, which involves at Johns Hopkins, for example, approximately three full afternoon sessions. That's nine hours. At the California School of Public Health, which was cited by Colonel Gorby to bring up this question of biological warfare, there are forty five hours being given to a special group interested in special weapons and administrative planning and organization for such problems. At another school there is a one hour lecture. That's just an example of those four schools that we have had a direct part in sponsoring and in suggesting content for the course. There are medical schools which are including exact lectures on this subject, that we have had a little part in. You'd like to know perhaps, that there is a possibility that the Association of American Medical Colleges will implement in the orientation of medical students a specific course in integration of military and civil medical affairs, that being visualized as valuable because such a small proportion of the medical students actively engage in the ROTC program; so that the 71 medical schools in this country, if the plan should develop under Colonel Wergeland in our Education and Training Division of this office, would be

implemented as a part of their regular orientation. I think we can all appreciate the value of such a thing as that to the undergraduate medical students.

Several of our reserve units have requested speakers in this field. They are probably the most active of the so-called civilian groups, those who can most thoroughly understand and aid us in our efforts to persuade civilians to do their own planning and get set to do their own job.

Under current directives, you could have the job to do if civil defense becomes necessary. In that event, you will have to do it all if local plans and systems are not set up by the time they are considered necessary. I won't stress that! Therefore, it seems to me that all of the supervised station surgeons should go out and preach the gospel at the tops of their voices to offer every aid, and every advice, and every reasonable participation with the civilians and civilian groups in setting up their own organizations. You are not only authorized to do that but this special regulation directs that it be done. I should like to repeat, you are authorized and directed to furnish advice and support in the civilians' efforts, but you are not, under any circumstances, authorized to provide training (yourself) to the civilian groups.

Let me urge that you should call for help from here if anything is needed. Many times we may not be able to give it, but if there is any possibility that we can help we have direct contact with all of the agencies here in Washington. We are working closely with them in the friendliest sort of voluntary way. There is no agency, as I stressed, that has the authority to tell any of us from the federal level what we are doing in civil defense. Perhaps that makes it even stronger because

we try to keep each other informed and it is entirely possible when you do have a question or you want some support, we can cite to you the exact agency which could provide it, immediately, or we could get it for you and forward it. We are definitely in from the Surgeon General's Office on the establishment of policy by the Department of the Army. We actively participated in this special regulation on civil defense. We actively participated and really stimulated the publication of that mimeographed directive on the guide to terminology. So, anything, not only in the way of questions, but suggestions or advice, you feel is worth transmitting in here may very well be applied to the advantage of all the other Army areas. We'd be glad to have you, while you are here if you care to come to my office. I would like to show you some of the things that we have presented to civilians at their request in the form of addresses or suggested approaches to this problem. We have some charts down there that may particularly interest you - a step by step process that local civilian groups could undertake today. Glass slides of this are not satisfactory, and all of you could not have seen the large colored charts had I brought them here. So, if you are interested, I would consider it a privilege to quickly show you these and as soon as they are published, if you want them, we can get any number of copies for you.

Let me stress finally, the real problem is for you on the military side to aggressively integrate military and civilian planning in the organization for civil defense by civilians. They are going to look to you; they have no other source to really get educated, experienced and properly trained advisors. Thank you very much.

References:

I. 1. Civil Health Affairs might involve the Army in plans or operations for:

a. Civilian populations for which the Army is or might be responsible:

- (1) In liberated territories.
- (2) In occupied territories.
- (3) In theaters of operations.
 - (a) In the United States.
 - (b) Outside the United States.
- (4) In the United States without war.
 - (a) Disasters.
 - (b) Civil defense.

b. Civilian populations for which the Army has no current responsibility:

- (1) Normal civilian population.

2. The Army area surgeons have little if any direct responsibility for planning or implementing civil health affairs operations for:

- a. Liberated territories.
- b. Occupied territories.
- c. Theaters of operations.
 - (1) Outside the United States.
- d. Normal civilian population.

3. The Army area surgeons could have certain responsibilities for civil health affairs, as follows:

- a. Theaters of Operations created in the United States.
- b. Disasters.

- c. Civil defense.
- d. Civilian population under certain circumstances of martial law (Federal).
- e. Mass evacuations or relocations, if directed.

II. 1. Reference applicable to the circumstances listed in I-2:

- a. Definitions and terms:
 - Directive AGAO-S 400.38 (28 Sept 49) CSGPO-M) dated 30 September 1949, subject: "Guide to Terminology and Policies with reference to Military Aid to Civil Authorities."
- b. Of policy nature:
 - (1) Joint Army Air Force Bulletin No. 13, Functions of the Armed Forces and the Joint Chiefs of Staff, 13 May 1948.
 - (2) FM 27-5, United States Army and Navy Manual of Civil Affairs Military Government, October 1947.
 - (3) FM 27-10, Rules of Land Warfare, as amended, October 1949.
 - (4) T/O & E 41-500, 3 June 1948, Military Government Service Organization.

2. References applicable to the circumstances listed in I-3:

- a. Definitions and terms - same as above.
- b. Of policy nature:
 - (1) Theaters of Operations in United States - same as other theaters.
 - (2) Disaster relief - AR 500-60, 1 December 1939, Employment of Troops and Supplies - War Department Activities in Connection with Disaster Relief.

(3) Civil defense.

SR 580-10-1, 30 August 1949, Civil Defense.

(4) AR 500-50, 17 August 1948, Employment of Troops - Aid of Civil Authorities.

(5) T/O & E 41-500, 3 June 1948 - Military Government Service Organization.

III. 1. References of possible aid in planning:

a. Wilson, William L: Medical and Sanitary Care of the Civilian Population Necessitated by Attacks from Hostile Aircraft, The Army Medical Bulletin, No. 60, January 1942, p. 63. This article has a bibliography of 120 references; all of the principles enunciated are still fundamentally sound.

b. Wilson, William L: Medical Plans for Civil Defense and Disaster, to be published by Fulton County Medical Society. A copy, if published, might be obtained from Dr. E. M. Dunstan, 215 Doctors Building, Atlanta 3, Georgia. This later article, applicable to current possibilities, details many aspects of local planning, and has a more current reference list of 84 articles.

c. War Department, Headquarters, Services of Supply: Military Hospitalization and Evacuation Operations (SPOPH 322.15) 15 September 1942, which required a simple, reasonable integrated military-civilian system of mutual medical support. It is still basically sound.

d. Wilson, W. L.: Civil Defense Planning, Bulletin of U. S. Army Medical Department, IX:11, 380, November 1949.

2. Discussion:

a. The justification for our interest in civil defense

planning can be stated as follows:

- (1) Complete responsibility rests upon the Commander in the theater of operations abroad and at home for foreseeing, planning, and implementing adequate civil defense, as well as passive air defense, and for the immediately subsequent civil affairs administration.
- (2) While less clearly defined in the United States, where clear operational responsibility for civil defense may not be established for the Army, certain responsibilities are prescribed and limited by laws for relief furnished by the Army in disasters, for military aid to civil authority, and for the establishment of martial law under certain prescribed conditions.
- (3) The third responsibility, which the Army may always have because of the nature of war and the technical training, experience, and understanding of such matters by military personnel, would be to sponsor and support the main objective of civil defense in the future; thus, complete civilian responsibility and readiness for proper conduct of all necessary civilian reactions and response to immediate enemy attack is assured. Only by that means may the Armed Services concentrate upon their primary missions of conducting war against an enemy without diversions of their energies or resources.

(4) On three occasions the Army operational staff of the British actually planned with civil defense authorities on a large scale and produced operational plans on a military coordinated basis for active defense, passive air defense, and civil defense. The first was in 1941 to resist possible invasion of the United Kingdom; the second was during late 1943 when threatened unpiloted bombardment of London and United Kingdom was immediately in prospect, and the third was during preparations for the invasion of Europe when specific planning for civil defense, passive air defense, and other necessary measures for covering assembly, communications and transport areas required consideration.

b. In the United States the situation has been as follows:

(1) The Office of Civilian Defense was dissolved by Executive Order 9562, dated 4 June 1945, with effect 30 June 1945. It had existed since 20 May 1941 when established within the Office for Emergency Management by Executive Order 8757, which, as amended, had the purpose to assure effective coordination of Federal relations with state and local governments, to provide for necessary cooperation with those governments with reference to measures for adequate protection of civilians in war emergencies.

(2) The subject was, so far as I can determine, dormant

until the War Department Civil Defense Board was established pursuant to W. D. Memo 400-5-5 dated 25 November 1946, as amended. The War Department Board, after some delay, conducted an extended study resulting in the "Report of War Department Civil Defense Board" released February 1948. The report was a line of departure for the next important active step in civil defense planning.

(3) By letter dated 27 March 1948, the Secretary of Defense established an "Office of Civil Defense Planning," which met and worked from April 1948 until release in October 1948, of the so-called Hopley Report, "Civil Defense for National Security."

(4) The President eliminated existing uncertainties as to the status of the Hopley Report by his letter 3 March 1949 to the Acting Chairman, National Security Resources Board, in which he called upon the Board to develop leadership in a program of civil defense planning under civilian control. Following consideration within the National Security Resources Board there developed a report which resulted in the following:

(a) Leadership in developing the program of wartime disaster relief has been delegated by the National Security Resources Board to the Federal Works Agency, which, by Public Law 152, 81st Congress, is redesignated General Services Administration.

Participating in planning would be the Atomic Energy Commission, National Military Establishment, Federal Security Agency, and the Departments of Agriculture, Interior, Treasury, and Justice. The National Security Resources Board will still coordinate the planning within the Federal Government and serve as focal point of contact in civil defense planning between the Federal Government and the states, municipalities, and the federal and trade organizations, if the present understanding prevails.

(b) The Department of Defense has been assigned planning for voluntary civilian participation in defense activities against armed forces, embracing air raid warning, civil air patrol, aircraft detection and identification, auxiliary defenses, camouflage, protective construction, and other physical measures of defense.

(c) Internal security measures, including sabotage and espionage related to the civil defense program will be coordinated by the National Security Council.

(5) While the program of the General Services Administration is currently expected to include planning for the following, slight progress has occurred:

(a) Medical supplies and services, including hospitalization, sanitation, and blood banks.

- (b) Decontamination and measures to minimize the effects of chemical, radiologic, and biologic or other unconventional attack.
- (c) Fire protection and fire fighting.
- (d) Emergency measures for the regulation of transportation and communication facilities and services and the restoration of order, including conditions under which martial law would be declared and methods for invoking it.
- (e) Rescue and evacuation, including feeding, clothing, and sheltering.
- (f) Repair and restoration of water, gas, electric, and sewage systems, including antipollution measures.
- (g) Demolition.
- (h) Formation and use, only in the event of war, of warden or auxiliary services, and mobile battalions, whose members will be prepared to implement appropriate phases of plans developed for wartime disaster relief.

(6) As all of this was developing, the Office of Civil Defense Planning within the National Military Establishment was abolished. At the same time, there was set up the position of "Assistant for Civil Defense Liaison" in the Office of the Secretary of Defense. His duties, detailed in JAAF Bulletin 27, 19 September 1949, have been briefed as follows:

"(a) Provide for the full coordination within the National Military Establishment of planning and preparation for (1) any military aspects of civil defense; (2) any other civil defense matters which may from time to time be assigned by appropriate authority as a responsibility of the National Military Establishment, and (3) any voluntary civilian participation in related military defense activities.

"(b) Assure that there is effective liaison and cooperation between the National Military Establishment and other governmental and private agencies with respect to such matters to the end that planning and preparation for civil defense are closely related to planning and preparations for military defense.

"(c) Provide the several departments and staff agencies with a central source of technical information, advice, and assistance on civil defense matters in general."

(7) In May 1948, the Surgeon General of the United States Public Health Service established within his office the Health Emergency Planning Unit for the purpose of developing public health service plans for disasters and other major emergencies. The missions of that office within the Public Health Service are markedly

similar to the research missions of the Special
Assistant to the Surgeon General (Army) for Civil
Health Affairs.

IV. 1. Army area commanders can easily have wide responsibilities at present regardless of our disclaiming them. Hence, SR 580-10-1 should be thoroughly understood, the medical portions fully developed under the commander's policies.

2. Many matters cannot be presented here because of limitations of time and space. Any questions or advice desired will be gladly furnished by the compiler of these notes. Sources for references can also be provided.

Colonel Tynes: I have the answer to the question raised a while ago as to the constructed capacity of general hospitals relative to the standby for supplies. I'm not too sure you will be satisfied with it, but the capacity of your hospital is the capacity developed by the last trip of the "flying circus" to your hospital. I think, actually, if you will recall, at that particular time, Mr. Cogan and several of us went around, there was no real percentage that actually counted. Now, if you are not satisfied with that capacity as such, relative to your headquarters, there may be some other files that we may be able to dig into for another capacity. If there are no other questions, we'll adjourn for the afternoon and reconvene in this room tomorrow morning at nine o'clock.

* * * * *

Colonel Tynes: I have one rather important announcement that is a change from the one on the original sheet. As you know our meeting this afternoon is a joint meeting with the Army, Navy and Air Force under the

auspices of the Navy and will be held at their auditorium at Bethesda. We will have two large busses ready to leave here promptly at 1:15 PM. They will leave from the police box between this building and the old Munitions Building, that is the building next to this building on Constitution Avenue. They leave promptly at 1315 hours.

Our first speaker today is Colonel Paul Robinson, Chief, Personnel Division, who is going to discuss various personnel problems.

Colonel Robinson: HOSPITAL COMMANDERS AND ARMY SURGEONS: The Personnel Division has decided that it would utilize its time today in the presentation of a number of current subjects. In order that you may know the subjects which we have decided to discuss, a list of them are shown on the blackboard:

1. Army-Air Medical Department transfers.
2. Current and projected status of the Medical Corps.
3. Promotion criteria.
4. Current reduction in strength.
5. Intern and Residency Programs.
6. Utilization of enlisted personnel.
7. Legislative topics.

It is proposed that after presentation of each one of these subjects, a few minutes will be allotted for questions and discussions. I have asked a number of the officers of the Personnel Division to be present today to answer completely and accurately any of the questions which may arise.

Army-Air Medical Department transfers: We have a series of charts which will assist in emphasizing the important features of this problem.

The first chart illustrates, for each Corps of the Medical Department, the number of those, by Regular and other components, who did and did not request transfer to the Air Force before the 26th of July of this year. You will note that in the Medical Corps 3151 did not request transfer, whereas 1264 did so request. There were 4415, which is approximately 97% of those on active duty, who submitted a request one way or the other. You will note also that 1206 of those not requesting transfer were also in the Regular Army. The remaining were Reserve officers on active duty or AUS or National Guard officers. With regard to the Dental Corps, 517 out of 1024 requested transfer to the Air Force. In the Veterinary Corps, 113 out of 349 requested transfer. In the Medical Service Corps 1256 out of 3081 requested transfer. In the Nurse Corps 2006 out of 4425 requested transfer and in the Womens Medical Specialist Corps 127 out of 396 requested transfer to the Air Force. I think it is evident that the Air Force is particularly popular with the Dental Corps, the Army Nurse Corps and the Womens Medical Specialist Corps. In all but the Medical Corps, there were sufficient who desired to transfer to fill the agreed upon allotment of the new Air Force medical service.

Chart No. 2 shows a breakdown of those who were approved for transfer to the Air Force by the overall board composed of Army and Air Force Medical Department officers. In the Medical Corps, 1153, of which 405 were Regular Army, were approved. In the Dental Corps 423, of which 175 were Regular Army. In the Veterinary Corps 78, of which 42 were Regular Army. In the Medical Service Corps 729, of which 158 were Regular Army. In the Army Nurse Corps 1199, of which 307 were Regular

Army. In the Womens Medical Specialist Corps 90, of which 31 were Regular Army.

Chart No. 3 shows a breakdown of those approved for transfer to the Air Force by grade in which serving. I think it is evident that there was no serious malproportion by grade transferring to the Air Force. The most serious might be said to be that of the Army Nurse Corps, where only 12 Majors and 1 Lt. Colonel elected to transfer. The general trend, of course, was for a large majority to be in the younger age and rank group.

Chart No 4 shows the Regular Corps as distributed by permanent grade who requested transfer. Here again the proportion can in general be said to be equitable. Probably the most severe disproportion is in the Army Nurse Corps, where only 3 permanent Majors elected to transfer.

Chart No. 5 indicates those who were finally approved and appointed in the Air Force. You will note that the difference was not remarkable. Of the 435 in the Medical Corps who desired transfer, 405 were approved. Of the 199 in the Dental Corps who wanted to transfer, 175 were approved. Of the 49 in the Veterinary Corps who desired to transfer, 42 were approved. In the Medical Service Corps, 158 of the 210 desiring to transfer were approved. Of the 417 Army Nurse Corps desiring to transfer, 307 were approved. Of the 41 Womens Medical Specialist Corps desiring to transfer, 31 were approved.

Chart No. 6 illustrates what happened to those in the Medical Department Reserve who were not on active duty. We made every effort to get information to the individual Reserve officer; however, it seems doubtful that the information could have permeated to all of them.

Nevertheless, 1039 Reserve Medical Corps officers not on active duty transferred to the Air Force; 567 Dental Corps officers; 58 Veterinary Corps officers; 1008 Medical Service Corps officers; 312 Army Nurse Corps officers and 18 Womens Medical Specialist Corps officers. All requests for Reserve officers not on active duty were approved by both boards.

The points which might be said to be illustrated in this series of charts are:

a. The number of officers transferring to the Air Force was remarkably equitable, both in the Regular and non-Regular components.

b. If the Regular authorization in the Air Force and the Army remains substantially as it now exists, there will result no great permanent grade promotion advantage in either Department.

c. Because of the fact that the number of officers who would transfer to the Air Force are serving in the lower grades, it can be anticipated that some advantage will accrue to those who transfer to the Air Force in temporary promotions. However, even this advantage is not as great as might well have been expected.

d. We did not feel it was feasible to attempt to break down the transfer by Military Occupational Specialty numbers. Had we done so, such a breakdown would have revealed that the Air Force did not receive its proportional share of the B and C grade specialists. A number of residents, however, desire transfer to the Air Force and it should therefore not be too long until this situation can right itself.

You are all aware that a Congressional Act which was passed only a few days after the transfer had been consummated extended Army and Air

Force transfers for an additional year. We are at present receiving a few requests each way every week. From the 26th of July until the present, from those on active duty, we have received 10 applications from Army Medical officers to transfer to the Air Force; 2 from the Dental Corps; 1 from the Veterinary Corps; 8 from the Medical Service Corps and 12 from the Army Nurse Corps. 8 of the 10 Medical Corps officers have been approved for transfer, 1 of the 2 Dental Corps, none of the Veterinary Corps, 8 of the 8 Medical Service Corps officers and 5 of the 12 nurses. We have no definite criteria. Each case is considered on its own merits, and approved or disapproved as the case seems to warrant. In reverse, the Air Force has approved, to our knowledge, 3 Medical Corps officers for transfer to the Army, 2 of which were Regular and one Reserve. We know there are other cases pending in the Department of the Air Force. This subject is now open for questions and discussion.

Colonel Robinson: General Cole, you have a question?

General Cole: Colonel Robinson, I have several residents who transferred to the Air Force and they are disappointed to find their stations unfavorable to them and they are contemplating steps to transfer back. Are they looked on favorably or not?

Colonel Robinson: Yes sir, each case will be considered individually.

General Cole: When they put in a written application to the AG?

Colonel Robinson: Yes sir, that is correct.

Current and projected status of the Medical Corps:

I believe every time you have been in the office during the past two years, the Personnel Division has attempted to portray the actual

situation with regard to Medical Corps officers at that time, and has each time attempted to project it into the future. Previously, we have outlined the measures that have been taken to interest doctors in serving with the Medical Department and have reported on our progress. The next chart, No. 7, might therefore be said to be the next in such a series. You will note that we have divided our requirements into two phases; operating and training. Our operating requirement at present is 2500; our training requirement 1175. We have available against the operating requirement 666 who are employed on a civilian status. We actually have an operating shortage of 88. The training requirements, as you can see, are fully met by 431 military residents, 323 civilian residents, 172 military interns and 200 civilian interns. Also, you will note that there are 49 officers in other training. These Regular Army officers who are taking training in addition to being professors of military science and tactics, plus a few who are being trained in such specialties as neurosurgery and preventive medicine, where we do not feel that we have the volume requirement to establish training programs. I will not go into detail to point out the numbers in each of these categories that can be expected in March of 1950. However, it can be followed easily by the chart. You will note that until the first of July 1950, because of the release of Reserve and AUS officers, the shortage will continue to increase. After July 1950, however, the situation will definitely reverse itself. Officers will be finishing the training programs in substantial numbers and will revert to the operating side of the chart. In 1952 there should be no shortage of operating personnel, provided it will be possible to hire approximately

350 civilian doctors. I would like to add here that this chart can be considered a conservative one; probably extremely conservative, because in making projections we always attempt to make them on reliable data only. We intend, during this entire period, to continue our procurement program, which should probably increase the number of both Regular and Reserve officers in Fiscal Years 1951 and 1952. I think it might even be safe to say that the availables in this period might easily be 100 to 200 more than is depicted.

This is the first time, I believe, that I have been able to portray to you that a substantial increase in the number of officers available to us is definitely a fact in the not too distant future. I think you are all aware of the efforts that have been made to accomplish this; but some of the points might be just mentioned to refresh your memory:

a. In 1947, additional pay of \$100 per month was gained from the Congress. This was extended in the Officers' Compensation Act which was passed last summer.

b. The various professional training programs were integrated with the procurement program early in 1948, and this chart certainly speaks for the success of that program.

c. The Moral Suasion Program netted the Army only about 158 doctors. They are on duty at the present time for two years.

d. You are all very well acquainted with the various published programs that have been effected during the past two years. All of you have been instrumental in circulating many of the pamphlets and movies - and in preparation of much of the material which has appeared in magazines, newspapers, and scientific journals.

e. You are also aware of the part the Society of U. S. Medical Consultants of World War II has played in disseminating information, as well as in assisting in the operation of all these programs.

f. Priority on quarters, special consideration on promotions and concurrent travel have all been established as policies by the Department of the Army General Staff.

g. The Personnel Division has exerted every effort to personalize its work to guarantee that the transfers not only were within the individual officer's career pattern, but that it met with his present situation insofar as his present livelihood and family are concerned.

I shall have more to say at a later time on two other subjects; (1) short tours of active duty for Reserve officers and (2), civilian doctor utilization.

Before leaving the subject of requirements and availabilities, it is appropriate that you should know the distribution as it will be on the 31st of December 1949, as nearly as we can now project it. Chart No. 8, therefore, projects the assignment by commands to the 31st of December 1949 for operating personnel only. You will note that the 1st, 2nd and 6th Armies appear to be somewhat better staffed than any of the other command areas. This is because they have been able to employ a number of civilian doctors. The number of military in these areas, however, is considered about as low as could be possible in order to cover the primary mission of the Army Medical Department. The 3rd Army fares better with regard to military doctors because of the number who are assigned to Reserve Units in that area, even though the large majority of them are also on duty in the station hospitals. The civilian doctors

in the European Command are displaced persons or German doctors. There have been no serious repercussions from their employment, although everyone recommends that they be replaced by American military doctors as rapidly as possible. Civilian doctors in the Far East are American doctors who have been employed for Military Government work. In general, it can be said that this distribution is reasonably equitable. The apparent maldistribution in some instances results from many factors, among which are insufficient remaining tour of duty to warrant a move, personal commitments and Military Occupational Specialty shortages. The overall situation as far as Medical Corps officers is concerned is now open for questions and discussion.

Colonel Robinson: Colonel Gorby, you have a question:

Colonel Gorby: Relative to the transfer of the ORC group I feel that the real reason that they did not apply in the same proportion as the Regulars is the fact that the training program in the ORC program of the Air Force is not good in the field and a lot of them knew that. I feel that they have not built up their program and that was the main reason.

Colonel Robinson: Yes sir, they had that reason.

Promotion criteria:

A discussion of promotions is always most difficult. In order to simplify it we have again a series of charts with which we will attempt to portray the situation. There has been much discussion as to whether or not the Army and Air Force criteria on the recent promotions were in any way equitable. These charts may appear to you to be somewhat complicated because it is necessary in showing criteria to show years of service for each grade, as well as the effective date of years of service.

The blue bars and lines indicate Army criteria and the red bars and lines indicate Air Force criteria. You will note that in the Medical Corps the criteria from 1st Lt. to Captain are identical. From Captain to Major the number of years of service is identical but there are 25 days difference in the date of the completion of the service. From Major to Lt. Colonel the years of service is identical but here again there is 4 months' difference in the time of completion of that service. The reasons why it was necessary for the Air Force to vary from the Army criteria are two: (1) It was administratively more convenient for the Air Force to use these dates and (2) It was necessary to extend the dates slightly further than the Army in order to obtain sufficient eligibles. Corresponding data is shown for the Dental Corps, the Veterinary Corps, the Medical Service Corps, the Army Nurse Corps and the Womens Medical Specialist Corps. You will note that the most variable discrepancies appear in the Veterinary Corps, the Dental Corps and the Army Nurse Corps. The Army has no 1st Lieutenants in the Dental Corps eligible to be promoted to Captains. The number of Captains to be promoted to Major in the Air Force was not sufficient without greatly extending the time. However, that extension of time in the Air Force is also slightly augmented by a lesser number of years of service. The Veterinary Corps is having to depend upon the workings of the law for promotion into the grade of Lt. Colonel. In both the Nurse Corps and Womens Medical Specialist Corps Army criteria is just about 11 months behind the Air Force in the promotion from Captain to Major.

All of the discussion up to now has been concerned with Regular Army promotion as it has pertained to the boards which are currently

operating or have just completed their activities. Announcements of the actions of these boards should be made within the next few weeks. As far as the Medical Corps of the Army is concerned, delay in announcement of promotions from this board is necessitated by the fact that there are still 5 professional examination reports not in, even though we have gone to the commands concerned for the fourth time, in some cases, since September. If any of these instances should happen to be in your command, I hope action will be expedited.

We thought it would be interesting to again show, in this somewhat complicated chart, the status of the Regular Army Medical Department by Corps. Our authorization for the Regular Army Medical Corps is now 2271. At present we have an authorization for 182 Colonels. As of the end of this year there will be 46 vacancies and we expect in the next promotion board, which will probably be soon after the first of the year, to fill all of those vacancies and select a group to fill the vacancies that will occur during the remainder of 1950. If so, approximately 55 officers will be selected. You will note that the authorized number of Medical Corps Colonels will be completely filled. You are all aware that there is an 8% limitation on the number who can be Colonels in the Medical Corps, as well as the rest of the Army, and that there is no statutory provision for compulsory promotion into the grade of Colonel as exists for all other grades. There are 318 spaces in the grade of Lt. Colonel. The promotion board which has just finished its deliberations will have selected approximately 85 and there will remain 68 vacancies in the grade of Lt. Colonel. This is occasioned by the fact that there are insufficient Majors in the

determining Zone of Consideration to fill all vacancies in the grade of Lt. Colonel. After this promotion there still should remain approximately 68 vacancies in the permanent grade of Lt. Colonel. The same general situation exists insofar as Majors are concerned. Due to the overall shortage of Medical Corps officers there are insufficient officers with length of service qualifications to fill approximately 157 of the Major spaces and 166 of the Captain spaces.

You will note that in the Dental Corps the Colonel spaces are now practically taken up and the number who can be promoted each year depends upon the attrition from now on. The situation is exaggerated in the Veterinary Corps, in that there are actually an excess of 15 Colonels, which results from the workings of the law before the present Officer Personnel Act was passed. Only one of the Colonels in the Veterinary Corps transferred to the Air Force, which also makes the situation seem worse. There is a statutory limitation in the Medical Service Corps on the number of Colonels, which is 2%. Actually, by utilization of the same criteria as is used for Medical Corps and Dental Corps, there are insufficient eligibles to fill even this 2% for the next 3 or 4 years. There has been considerable discussion as to whether or not that limitation of 2% should be raised to 8% in order that it may correspond to the rest of the Army. Legislation has been prepared, but at this writing it has not left the Surgeon General's Office. The red figures in the Dental Corps, Veterinary Corps and Medical Service Corps indicate present overages in these permanent grades. A number of you have probably been wondering about the large requirement shown for the Nurse Corps and Womens Medical

Specialist Corps. This results directly from the legislation establishing these Corps, which set a number on the strength of the Army as it then existed. This law was prepared in 1947 and, while the number is specifically stated in the law, the requirements do not now equal this number. As a matter of fact, the requirements for nurses and members of the Womens Medical Specialist Corps are calculated by G-3 of the Army and do not represent as high figures as are here stated. Nevertheless, this is the legal and correct presentation. As calculated, the legally authorized number of Captains and Lieutenants in the Nurse Corps is 5736, and the Womens Medical Specialist Corps is 889. The actual requirements of Regular nurses is somewhere in the neighborhood of 2000, and for the Womens Medical Specialist Corps is approximately 350.

The next chart shows the overall status of the Medical Department by Corps by grade. Taking the Medical Corps again as illustrative of the chart, you will note that of the 325 authorized spaces in the grade of Colonel, 3, not now serving in the grade, would be promoted to the permanent grade of Colonel and there would remain 35 vacancies which might be considered for temporary promotion next year. Of the 502 spaces for Lt. Colonels, 7 remain who have been on the eligible list since the last temporary promotion, and vacancies would exist for approximately 125. There are 82 of the 360 Major spaces vacant. There are 550 Captains overstrength, due to the workings of the special promotion privileges for Medical and Dental Corps officers. It might be said that this chart, throughout, shows a net picture because consideration has been given to the shifts that may result

within all grades in the event certain promotions are made. A similar picture exists in all the male Corps. The criteria for temporary promotion for the Nurse Corps and Womens Medical Specialist Corps have been forwarded to Personnel and Administration Division, General Staff, to effect the promotions as shown on the chart in the grades of Captain and Major. It is thought that our recommendations will be approved. The subject of promotions is now open for questions and discussion.

Colonel Robinson: Mr. Cogan.

Mr. Cogan: While on this subject I would like to point out something that came out and was decided upon yesterday, which would be of interest particularly to the Army surgeons. You are all acquainted with what we used to call ceilings or staff might call manning levels which controls the number of assigned military. In the past these were issued as part of the manpower voucher. You will notice that the last manpower voucher did not have a breakout of Medical Department personnel ceilings by Army area. The reason they were not on there was because of the confusion at staff level. Some of you will recall that when they in staff went out of the picture, ceilings stopped for a little while. The reason at that time was because O&T and P&A could not decide whose responsibility it was. An identical thing happened now with a change of a few officers and they got in the same place. Anyway, that question has been resolved and those ceilings will be issued. However, they will not be issued on a War Manpower voucher. They will be issued on a separate sheet in the Troop Program so that the Troop Program will show requirements with the Troop Basis and will show a separate sheet of

planning level up to which you can requisition. So from now on that will be the procedure and you can always look for it.

Colonel Robinson: Any comments or questions?

Colonel Billick: What is that O&T in the first part?

Colonel Robinson: Organization and Training Division, General Staff.

Colonel Iiston: Are these requirements balanced against the shrinking military population that we are anticipating in the United States up to this point?

Colonel Robinson: These requirements take into consideration every projected change in troop status throughout the world, is that right Mr. Cogan?

Mr. Cogan: Yes, and we might add there is a possible release right now.

Current reduction in strength:

I am sure you are all interested in the reduction in force of the Army which is currently going on. As you know, the Army-wide objective is 3300 officers. Medical Corps, Dental Corps and Veterinary Corps officers were excluded, as were both the female Corps of the Medical Department. In Phase I of the program, 1069 officers were selected, and of the 1952 Medical Service Corps Reserve officers on duty, only 20 were selected by the major commands. You will note that the Army ratio was 1-48, whereas the Medical Service Corps ratio was 1-100.

Phase II of this program is now being determined. The Surgeon General's command was given no specific quota, but was told that it was expected that certain recommendations would be made to the overall board which is making the determination of those who will be eliminated. We asked each of our commanders to submit names in order of their value

to the military service. We appointed a board in the Surgeon General's Office consisting of a representative of each of the Corps and asked them to review the record of every individual regardless of Corps, who had two or more efficiency reports which scored less than 70. Remarks from the various Class II commanders were also taken into consideration by this board and the Surgeon General, as a result of the action of this board went on record as recommending 81 for separation. Whether or not this 81 will be finally selected is not presently known, because they, in turn, will be compared with submissions from all other commands on a value to the service basis. It is conceivable that a number of the 81 individuals nominated will not be separated. It might be emphasized that our board's action was not limited to the Class II installations, but was a world-wide survey.

You will be interested to know, that of the nominations made by the Surgeon General's board, 16 were from Class II installations and 65 from all other major commands. The ratio of selection was, nevertheless, quite close because of the much greater number of Medical Service Corps officers who are assigned to major commands other than the Class II installations had 1-31.

Of the 81 individuals selected, 6 had already been nominated by the major commands under Phase I. Of the remaining 75, 9 were recommended by major commands in submission of their Class II quotas. We feel the nominations made by the Surgeon General are in every way as fair as is possible. Utilization was made of as much as 10 years' official information on many of the individuals, as well as the current performance. We have presented only the Medical Service Corps charts, because the few

other nominations which were made were incidental. This topic is now open for questions and discussion.

Colonel Robinson: Are there any questions that have been bothering you on this subject:

General Cole: Can these men be notified between now and the first of the year?

Colonel Robinson: Isn't it immediately after the first of the year, Major Richards?

Major Richards: Prior to 1 January.

Colonel Robinson: Any other questions? As far as other Corps of the Medical Department are concerned, I did not include any information because any recommendations that have been made by the Surgeon General on any of the other Corps are fairly incidental and not sufficient to chart. I have very few remarks on the interne and residency program.

Intern and Residency Programs:

I think the general hospital commanders are probably already aware of the current residency selections since representatives assisted this office in making the determinations. A few general statements, however, might be made. A priority selection method as follows was utilized:

(1) Those in the Regular Army who have not yet had an opportunity to participate in the Residency Program. (2) Military interns. (3) Civilian interns. (4) Direct from procurement. Since, at the time of selection, all applications from the Regular Army group were not available, approximately 25% of the spaces have been reserved for applications which will straggle in between now and the first of April. Seventy military residents have been selected contingent, of course, upon their applying for

and being accepted in the Regular Army.

In the selection of interns this year, emphasis has been placed on whatever information is available that may indicate that the applicant is sincerely interested in an Army career. We had 1014 applications for 228 positions. No service obligation is established for military interns. The reason for this is that we desire to maintain this as a permanent procurement procedure and we do not feel that it is necessary to have such a requirement. From the 25 interns we had in 1947, 18 are still in the service — and from the 113 we had beginning in 1948, 78 are still in the service. This represents approximately what we would desire to retain and we hope each year will cause a proportionate number of individuals to remain in the service. We realize this can be done only with the assistance of the hospitals to which interns are assigned.

Colonel Robinson: Colonel Fielding just suggested that he would like to say a few words in behalf of the interns that were selected this year.

Colonel Fielding.

Colonel Fielding: Not so much as to how they were selected but to the type of individual that was selected. As you know, the year before we went considerably on past standings. This year it plays a part but not quite so important a part. It was more if the man was interested in a military career. You find among the interns that come to your general hospitals, everything from ex Lt. Colonels of General Staff Corps, to Lt. Colonels of MSC, on down to enlisted men who were in Medical Department activities in the line and military intelligence, etc. Practically 75% are veterans which will mean that there is a large number who will probably enter and stay in the service. They know what the service is

like, so I think you will find a reasonable military minded group of interns. We have efficiency reports from some of them and looked at them. They contain answers to questions, also their battle decorations, silver stars and on down. I think you will find them a very interesting group to work with.

Colonel Robinson: Any questions or comments?

General Gaines: If I understand you correctly, there are 100 or more interns now in hospitals who have not been selected for residency training. As far as I know, we do not have that list.

Colonel Robinson: It is in the mail. Any other questions?

Colonel Fielding: General Gaines brought up that question of lists. There is in the mail to reach the general hospitals, a letter stating which of your interns were selected for which specialty in which hospital. Also, a notice to the effect that any other applicant's name that did not appear on that list was not selected at this time and advising that they may submit additional applications, if they desire, for the April selection. Other information is also contained in that letter.

Enlisted personnel:

There are many features of the enlisted personnel management program that could be discussed. We have selected what we consider the three most important to discuss today. These are considered the most important for two reasons. First, they constitute the framework of the enlisted personnel management system and, second, information continues to reach this office indicating that the real enlisted problems result from the improper application of these three features. The three features I refer to are:

a. Careful synchronization of enlisted strength reports with particular reference to Tables of Organization and Tables of Distribution.

b. Classification and assignment of enlisted personnel.

c. Utilization of enlisted personnel.

I shall discuss these three features separately.

First, Synchronization of enlisted strength reports:

Tables of Organization and Tables of Distribution constitute the personnel authorization representing the personnel requirements for the particular command. Such tables are prepared jointly by the interested agencies; those agencies being the using commander and the major force commander. Those tables if carefully prepared and kept current, by MOS and grade, should constitute a framework or requirement wherein the enlisted personnel system can operate. Those tables are consolidated at Department of the Army level and when compared with actual strength, by MOS and grade, represent the basis for procurement, the basis for the assignment of priorities to requisitions, and the basis for training needs. Tables of Distribution that do not reflect the true requirements upset the entire system.

Second, Classification and assignment:

Classification of personnel cannot be accomplished by one individual. The principles of Department of the Army Circular 202, 1948, as amended, are believed to be sound. That circular states that classification will be accomplished by a Classification Board consisting of at least three officers — a classification or personnel officer, a training officer, and a representative of command. A technical specialist

should be included where technical MOS are concerned.

This board should be able to consider all factors having any bearing on the MOS to be assigned, and in the best interests of the individual and the service, should be able to "label" a soldier with the proper MOS. That is classification and proper operation will eliminate all other methods that we hear so much about which give only temporary relief. Too much emphasis cannot be placed on the operation of the Classification Board. That is a command responsibility.

Assignment of enlisted personnel follows classification. Assignment of enlisted personnel at Department of the Army level is an administrative procedure. Enlisted qualification cards are not maintained at this level. Names of individuals do not ordinarily enter into the assignment procedure at this level. The Department of the Army knows what personnel are available. Likewise, the existing vacancies are known. Availables are matched against vacancies, necessary priorities applied, and orders are issued, completing the assignment activity. "Force issues" are necessary at times to absorb "over" availables. The whole system is based upon proper "labeling" of availables reported and a correct picture of personnel requirements.

Assignments at unit level means placing the right man on the right job. When that is not possible, the man should be reported as available for reassignment adjustment.

Third, Utilization of personnel:

Utilization is another phase of personnel management shared by every echelon of command with the using agency carrying final responsibility for proper utilization.

Proper utilization implies that avenues for advancement will be opened, school opportunities will be offered, and that the unfit and unqualified will be eliminated after reasonable attempts to qualify the individual concerned by elimination and not by transfer.

The waste of technicians and specialists, of which the Army is critically short, is in a great part a utilization problem. Many such men are improperly assigned at lower levels. Reports continually reach this office of individuals who were school trained for several months at a great expense to the government and then assigned to duties that bear no relation to the training received. This practice results in a manifest waste of school training, forces further school training to fill the vacancies, and expends funds so urgently needed. Experience indicates that there will always be a shortage of school trained specialists and mal-utilization tends to aggravate the condition. For example: surgical technicians assigned as typists; mess stewards assigned as first sergeants; laboratory technicians assigned as clerks; orthopedic technicians assigned as training noncommissioned officers.

Enlisted men who have not attended schools and who possess interests and ability to absorb school training in critical MOS should be sent to schools and assigned upon graduation to fill the vacancies. By such action the shortages of technical specialists can be met.

In working with the enlisted personnel management system, it is necessary to receive the enlisted personnel that enter the Army through the recruiting service. Provided that the personnel does not bring into the Army skills and experiences that can readily be converted to Army use, it is necessary to start training, either formal schooling or on-the-job

or both. Training and classification are then continuous throughout the enlisted man's military career and experience tells us that in the Army there will probably never exist a situation where the individual soldier is a finished product. Provided he is, it is necessary to train someone to take his place.

We believe the majority of enlisted personnel are being properly handled from a personnel management standpoint. While a great deal is being said on a general basis that is adverse, the number of specific instances "pointed up" do not bear out the general complaints.

We will cooperate in all programs to effect the proper classification and utilization of personnel. The Department of the Army and The Adjutant General's Office have published innumerable directives outlining the enlisted personnel management system. The continued efforts of all echelons of command operating as a team should be able to close up that area of poor enlisted personnel management. The result will be a planned and organized personnel system for the enlisted peacetime program that will be capable of expansion in the event of mobilization.

Colonel Robinson: There have been some questions sent in on enlisted personnel that have been answered in your booklet. Unless there is some questions on that, I hope they will not be brought up again. Major Martin, do you want to add anything to what I have said?

Major Martin: No sir.

Legislative topics:

Everyone is always interested to know of pending or proposed legislation which will affect the personnel of the Medical Department. Seven proposals have been made in recent months, none of which have, at this

writing, actually been incorporated in draft legislation. I will mention these proposals and discuss them very briefly.

(1) Elimination of professional examinations for promotion:--

With the advent of selection as a method of promotion, the continuation of professional examinations had become farcical. Actually, some of the selection have been made without the professional examination by the various boards, because it was not possible to get world-wide information available to the board in the time intervening between the determination of the Zone of Consideration and the meeting date of the board. Promotions, as I mentioned before, have actually been held up because of the necessity of waiting for the professional examinations. There have been instances where professional examinations have not been adequately given-- and certainly no one is making the preparation for them that was common practice in previous years. One instance of an officer having to fly 3000 miles from Puerto Rico to Panama in order to appear before officers senior to him, is a concrete example of the fallacy of attempting to continue this examination.

(2) Increase in general officer grade authorization:--At the time of passage of the Officer Personnel Act of 1947, the Army as a whole was granted .75 of 1% of the authorized strength of the Army in the grade of general officers. The Medical Corps was granted .5 of 1% in the grade of general officer. It is understood that in the first drafts of the legislation, .75 of 1% was also included for the Medical Corps, but was changed to .5 of 1% during discussions with Navy representatives. At the present time, Navy representatives are highly in favor of increasing general officers for the Medical Corps to .75 of 1%.

(3) Increased service credit on appointment:—As you now know, the Personnel Act grants to the Medical Corps 4 years' service credit on appointment; the Dental Corps 3 years; and the Veterinary Corps 2 years' service credit on appointment. Because of the fact that medical students in the future are to be almost 100% college graduates, and whereas the same fact is generally true of dentists and veterinarians, it is considered that the service credit should be raised to 5 years, 4 years and 3 years for the Medical, Dental, and Veterinary Corps, respectively. A counter proposal has been made by Personnel and Administration Division, GSUSA, of giving service credit in accordance with the number of years actually spent in education over and above a college degree. We consider that such a scheme has many loopholes and would prefer that credit be given on the basis of degrees rather than years of schooling. The final solution of this problem as you can see, has not been determined.

(4) Elimination of the grade of Second Lieutenant in the Veterinary Corps:—If service credit as I have just discussed were approved, a natural corollary would be the elimination of the grade of Second Lieutenant in the Veterinary Corps. We believe this is fully justified and have proposed this as a separate item from the increased service credit.

(5) Promotion to Colonel after twenty-five years of service:—If you will recall, in our promotion charts which I presented earlier, the time is not far distant when there will be many eligibles from the standpoint of service who cannot, because of space limitations, be promoted to the grade of Colonel. Statistically, it has been estimated that 64 out of each 100 officers in the Medical Corps can expect to

become Colonels under the workings of the present Officer Personnel Act. There is no mandatory provision in the act for promotion to the grade of Colonel, as exists for all the other grades. It has been proposed that a revision of the law be made to provide promotion to Colonel after 25 years of service creditable for promotion purposes. You all know that the service credit which has been allowed the Medical, Dental and Veterinary Corps is creditable for promotion purposes. This would guarantee the promotion to Colonel of all competent Medical Corps officers after they had 21 years of actual service; Dental Corps officers after 22 years of actual service and all Veterinary Corps officers after they had 23 years of actual service. It does not preclude the promotion to Colonel of officers of a lesser number of years of service, providing a vacancy exists and they are selected.

(6) Training in civilian institutions:—There exists on the statutes a provision that not more than 8% of the Army can be in training in civilian institutions at any one time. Under the war powers of the President, however, which are still in effect, there is no limitation in the number of officers who can be in training in civilian institutions. As you know, we have a considerable number of officers in training in civilian institutions, particularly in our civilian intern and residency procurement programs. As a matter of safety, therefore, more than a year ago we proposed draft legislation to provide for the Medical Department unlimited numbers who could be in civilian institutions in a training status for a period of 6 years to cover the programs I have just mentioned. We were told only last week that it has been determined by the Secretary of Defense and the Bureau of the Budget that there is no contemplation that

the war powers of the President will be terminated in the foreseeable future, insofar as this provision is concerned. This legislation, then, will be held in a "standby status," ready to introduce in the event there is a contemplated change in the war powers of the President.

(7) Reserve retirement benefits — ANC and WASC:—As all of you know, the Army Nurse Corps had a relative status until the passage of their act in 1947. The Womens Medical Specialist Corps did not exist until that time, although many had been career individuals on a civilian basis. This proposal would give retirement benefits to those individuals who served on a relative basis in the Nurse Corps and on a civilian basis in the Womens Medical Specialist Corps. I should make clear that this proposal pertains only to the Reserve and not the Regular components of these two Corps.

There are two bits of legislation still remaining before the Congress which we hope will receive consideration in the session starting in January.

(1) Appointment of women doctors and other specialists:—This bill proposes that women doctors, dentists, veterinarians and other specialists may be appointed in both the Regular and Reserve Corps of the Medical Departments of both the Army and the Air Force. It has passed the House of Representatives, but was held up in Senate Committee because the Navy did not desire to participate in this legislation. In the Navy law establishing the WAVES, appointment of women doctors can be made in the Navy. While women doctors so appointed may work with the Medical Department of the Navy and be eligible for benefits such as the additional \$100 per month, they do not have the promotion privileges of male doctors in the Navy — and there are other features which are objectionable to the Department of the Army and Air Force. At this time, the Department of the Navy is actually taking

some female interns and have commissioned at least 4 women doctors in the Regular Navy. There is no statutory authority for the Army or Air Force except in the WAC or USAF, where they would not be eligible for the additional \$100 per month or promotions and other privileges accorded male doctors. There is no objection on the part of anyone to the principle of this bill and as soon as the difficulties I have just mentioned have been ironed out there is every expectation that it will become law.

(2) Procurement of the ANC and WMSC:--The essentials of this bill raise the age limit so that many fine nurses who are still serving with the Medical Department and did so serve during the war might become eligible for Regular appointment. It would extend integration for appointment into the Regular Army in the ANC and WMSC for one year, and grant credit for retirement purposes to certain members of the WMSC for civilian service in the Medical Department of the Army. This bill has been cleared by the Bureau of the Budget and has been passed by the House of Representatives. It was passed late in the session, and consideration could not be given it by the Senate. There is every expectation that it will become law in the second session, which meets in January.

Colonel Robinson - Would anybody like to comment on that or would anybody like to suggest any other thing that we can think of, we need thoughts on this bill.

Colonel Bauchspies - How is this five years in permanent grade of Colonel going to affect the Medical Department?

Colonel Robinson - The provision of the law is that you will be in the grade of Colonel 5 years or 30 years service, whichever is the later. As it now stands, after 1953 you can extend on to 30 years service because it will be less. Do you want to answer that question more fully, Major Benade?

Major Benade - Yes, sir. What Colonel Robinson has said covers the point but I might amplify it a little by pointing out that Colonels who serve in grade, either 5 years from the date they are appointed in that grade or 30 years of service, whichever is the later, and in addition to that there are provisions for the retention of 10% of those Colonels who would otherwise be eliminated from active service under the provisions I have just mentioned. Not more than 10% of the number authorized in that grade may be retained on the active list after the date specified for their retirement. At the age of 60 they must be retired as a statutory requirement and there is no getting around that. One other feature is to hold a certain number of Colonels on active duty even after 30 years of service if they appear on the recommended list for promotion to Brigadier General. With the operation of the retention of 10%, plus the retention on active duty of those on the recommended list for promotion to Brigadier General, it gives you enough to take care of any officer who might happen to be in that situation.

General Discussion:

Colonel Robinson - As time will allow, I want to mention two or three other matters of which you may or may not be aware.

Utilization of Reserve Officers under the short term plan:--We were able, some time ago, to obtain authority to utilize Reserve officers on a 1 day to 29 days plan, payment to be made from pay of the Army. It was necessary at that time to put the program out to all commands, telling them that it could be utilized under their overall ceilings, for each grade. This caused no little concern in the commands; some interpreting it rigidly, some afraid to use it because of this provision, and others not considering this provision in any way deterrent to them. We expected

the program to be helpful in accomplishing physical examinations, in projects of short duration and in the transport service. It has been extremely helpful in all these categories. Actually, last month the equivalent of some 20 medical officers were gained by the utilization of this plan. We have worked out a definite allocation of grades by command under this scheme and this has been submitted to Personnel and Administration Division, Department of the Army General Staff. We expect that it will come to you within a short time. This should eliminate the questions which have arisen in the utilization of Reserve medical officers on short tours of active duty.

Utilization of civilian doctors:—A year ago, when the employment of civilian doctors was authorized, we felt that it would be necessary to maintain a very close control of the program. For that reason we set up a system whereby each of you would have to call to our office by telephone, or otherwise communicate with us when you had a doctor who was employable. This program has become somewhat stabilized and we now are able to decentralize the 600 positions intelligently to the commands. Representation to this effect has been made to the General Staff — and it is expected that it will be promulgated within a short time.

General Noyes - Must they remain at that level or go up $1\frac{1}{2}\%$ of our current authorization?

Major Monnen - The Army Comptroller wants to stay down to that $1\frac{1}{2}\%$. Actually there is an anticipated reduction up to 1 November and I think that $1\frac{1}{2}\%$ is what it will take. That is the reason for this policy. Many of the commands are down to 95% and some lower. Some of them are hard hit.

Colonel Robinson - Mr. LaCross, did you want to add anything further on this subject?

Mr. LaCross - No, sir, nothing to add.

Conclusions:

Colonel Robinson - We hope the Personnel Division has portrayed to you today that almost every conceivable means has been utilized in providing professional personnel for medical service. We feel that each of these means has contributed to the successful operation of the Medical Department during the past several months and will continue to give the necessary support until greater stabilization can be accomplished. Under the present concept of rendition of medical care in the Army, some 30 to 35% of the doctors of medicine are to be specialists. The remainder need not have specialty training under the present concept. I would like to submit to you that the American philosophy of medical education has changed to the extent that a great proportion of all medical graduates demand postgraduate training in the form of residency programs. It has been our experience that more than 90% of all the young doctors we have dealt with make such a demand. Furthermore, the teaching in our medical schools apparently has ingrained in these doctors the fact that they are inadequately trained to practice medicine until they have had postgraduate training. It appears, therefore, that the future holds for us a group of trained officers, a second group in training and a third group that we might classify as awaiting training. As time progresses -- in fact, beginning at present, the number in training will be reduced. Nevertheless, there has been no plan evolved whereby 65 to 70% of our officers in the permanent structure can be held without residency training being made available to them. There are then, two courses open to us:

(1) To devise some plan which will make military medicine and medical practice in the Army so attractive that young officers will be willing to forego specialty training.

(2) To change our concept of medical practice in the Army to utilize a much greater percentage of professionally trained officers.

At the present time work is being done along both these lines. Consideration is being given to establishment of courses in military medicine which might eventually result in a specialty board in that field. This would incorporate all of the advances that are being made in our various Reserve programs as it affects military and field medicine. This program would not be limited entirely to nonspecialists, since it also visualizes further specializing many of the specialists in military problems. The difficulty to this program is that it is unpopular with younger officers. Since military medicine is our sole reason for existence, a program for its development is imperative. Such a program must be made popular and it must also be good. The development of such a program, therefore, must be our prime objective in the months and years ahead.

With regard to the second proposal; that of changing our concept of rendition of medical care to utilize more specialists, preliminary work has been started along this line. Possibly our sick call and station and general hospital system as it now exists is outmoded. Probably a better concept would be a development of a group practice system such as is in effect in many communities and in many large medical centers.

Colonel Robinson - Is there any comment as to the possible utilization of this machine (ADmatic Projector), or the possibility of producing better slides and things of that sort, does anybody want to make a comment?

Colonel Gorby - It looks to me as if it might have some application at these various medical meetings where you would utilize it to advantage. There is an advertising medium for you as well as for instructional purposes.

Colonel Robinson - That is really what we had in mind for the use of it.

Colonel Gorby - It could be used for instructional purposes for enlisted and officer personnel, with proper slides set up for circulation.

Colonel Potter - I was only able to secure six of these machines out of procurement funds. The Army Area Surgeons can have them for whatever use they care to make of the machine. You know you are all called on to put some sort of exhibit up at the time of various professional meetings within your areas and it is hard for you to get something made every time for each release. Therefore, having a machine like this does give you something that you can put almost anywhere that you are called on to display. We thought it might be quite useful to you. You cannot get more of them out of these funds so that they would be available for training. We just wonder if they are adequate to help you out.

Colonel Bauchspies - I have a question, it is a double question. There are a number of medical students who are graduating in December, particularly the ones at Duke. A number of these students hold commissions in the various branches and are asked to come on active duty for 90 days or more until their internship begins some time next year, about the first of July. Our training funds are not available to put these men on active duty. What provisions do we have to bring these men in? Along with that same question, would we bring them in on the grades that they hold in the Air Force or Engineers, Chemical Warfare, etc., or would they be eligible for a commission in the Medical Reserves?

Colonel Robinson - We have made special provisions for that, which Colonel Potter will tell you about.

Colonel Potter - The idea of opening Beaumont and Murphy to internships was set up so that the graduates of the schools, and there are several of

them now who graduate individuals in the various quarters of the year, can turn to internship beginning upon their completion of the school. As to your other question of bringing them on duty if they are going into internships in July and graduating in December. Those who are ROTC will accept their commissions as 1st Lieutenant, Medical Corps, upon completion of their four years of medical school and they will no longer hold any other commission. The other commissions will have been terminated when they accept that commission in the Medical Corps as 1st Lieutenant. It is not desirable to bring to active duty as a medical officer an individual who has not yet had his internship. I know we tried it in some cases last year but we are not planning to do it this year. The Duke people, a number of them have been offered internship beginning 1 January and 1 April.

Colonel Bauchspies - Well, I don't know if that answers my question.

Colonel Potter - You are quite right, those who hold other reserve commissions, why not just bring them to duty?

Colonel Robinson - Training funds are the only method by which you can bring them to duty in their line commissions.

Colonel Bauchspies - You cannot bring them to duty in their line down there. They will, maybe, in the summertime but they will not this time of the year. We are losing a lot that way.

Colonel Robinson - Is there another question?

Colonel Liston - I thought that my question was rather insignificant after picking up the microphone. It was just to say that from my experience as a PMS&T, the ADmatic would be of greater value to the PMS&T's than anyone else for temporary display. I would personally like to take a machine like that and send it to the various PMS&T's and with the approval of the

Dean of the Medical School put it in a prominent place, say for a month, then move it on to another unit.

Colonel Robinson - Major Nelson, do you have any comment on that?

Major Nelson - I think the general service machines would fit into Colonel Liston's idea. I am sure that most of the Medical Schools would welcome the opportunity to have one on display. The group in the Medical Schools are our primary targets. I might add that in many cases where you have local problems and local ideas and facilities, there is nothing to prevent making photographs and slides locally that fit your own needs and ideas because we are not going to be able to furnish too much in the way of supplies and materials from this office.

Colonel Robinson - Since that seems to be about all the comments, I will close this session. The utilization of methods which have been in vogue in the postwar years have held the Medical Department intact and has the potentiality of building us back into a strong and competent organization. It is necessary, however, that further study and further progress be made in order that our personnel may work on the plane to which they are entitled by virtue of the advancement of the profession and military ideas. Before closing, I do want to say that I appreciate very much all of the things that all of you have done to assist the Personnel Division during the past few years. I expect that you will continue to do the same in the coming years.

Colonel Tynes - Your next speaker is Major Sheehan, who will speak to us on "Medical Legal Problems."

Major Sheehan - Fellow Officers - In the remarks that follow, there will be put before you some of the medico-legal problems presented to the Office of The Surgeon General. These problems deal with the rights and duties

of individuals and the Government of the United States.

What About Censoring the Mail of Psychiatric Patients? There are no Federal laws which authorize such examination. Now hear this - it's good - and I quote from Gerty's "Psychiatry and the Civilian," "The right of liberty is only one of the fundamental rights and, under the conditions of mental illness, should not always take precedence over the preservation of life or the opportunity to recover that measure of happiness for which mental health is necessary."

It is the opinion of this office that the commander of an Army hospital legally may require examination of the communications of psychiatric patients. Such power to be exercised, incident to medical treatment, within the bounds of sound discretion and in the best interests of the individual concerned and the Department of Defense. The protection of the patient, the hospital and, in some instances, society demands these letters be examined.

What About the Consent of Minors in the Military Service to Surgical Procedures? Enlistment in the military service by an infant is a contract between the soldier and the Government, which involves a change in status which cannot be thrown off at will. By enlistment the minor ceases to be a part of his father's family and puts himself under the control of the Government. A minor who enlists, with or without the consent of his parents, is emancipated so long as such services exist because such enlistment gives rise to a new relationship inconsistent with subjection to the care and control of parents.

It is the opinion of this office that by virtue of such emancipation and the general powers exercised by military authorities over persons subject to military law, and when incident to medical treatment, surgical

procedures, as deemed necessary, may be accomplished on minors in the military service without the consent of the parents and the infant's consent would be sufficient.

What About Self-Medication and Its Possible Relation to Line of Duty?

An important feature of the Federal Food, Drug and Cosmetic Act sometimes misunderstood is that it recognizes the public right to self-medication but aims at making self-medication safer and more effective by requiring the labeling of drugs to bear information essential to the consumer. The medical profession recognizes that there is self-medication and that a good deal of self-medication is warranted. There has never been any essential protests over the sale to the public of aspirins, laxatives and certain cough mixtures.

What About Foreign Nationals Practicing in Army Hospitals?

A foreign military physician attached to an Army Hospital may be sued in the United States Courts for torts committed while attached to such hospitals in the same manner and under the same conditions as a medical officer of the Army may be sued. Whether claims arising from torts committed by foreign medical officers in the United States military hospitals would be considered as falling within the provisions of the Federal Tort Claims Act, i.e., the United States being held liable, must be regarded as an unsettled question. Observer training of foreign nationals is to be confined to observation and only such actual participation as may be considered to not in any way adversely affect the health and welfare of patients. The extent of participation will be determined by the commander of the installation conducting such activity and the immediate supervisor of an observer student is considered to be responsible for the activities of such foreign student.

What About Malpractice? Malpractice is a personal wrong and the liability for acts of such cannot be waived or assumed by another. The individual medical officers are subject to suit for malpractice or negligence and in the event of judgment there is no means of reimbursement from the Government. In case of suit against an individual, the Department of Justice will furnish an attorney to assist in the defense thereof. However, under the Federal Tort Claims Act of 1946, the Government has authorized individuals to present for consideration or adjudication claims for damages, personal injuries or death arising out of certain acts of commission or omission of officers, agents or employees of the Government acting within the scope of their authority. The "fad" seems to be to sue the United States. Here is a resume' of the latest cases in point appearing on the records:

Wilscan vs. United States, 76 Fed Sup 581 (Hawaii). In this case, action was brought under the Federal Tort Claims Act for death of plaintiff's (Naval Warrant Officer) four year old child allegedly caused by error of Naval Pharmacist in filling a prescription. The United States was held liable.

Jefferson vs. United States, 77 Fed Sup 706. In action under the Federal Tort Claims Act for damages resulting from alleged negligence of Army officer as a surgeon who performed operation on plaintiff, it was held plaintiff could not maintain action against the United States. It is to be noted that the instant case differs from the Wilscan case which involved the death of a dependent, whereas Jefferson was an enlisted man on active duty and the operation in question was incident to his service.

In the Jefferson case the judge, among other things, ruled that an implied exception to the Federal Tort Claims Act existed in this case, not from the wording of the act but from other existing Federal legislation on soldier's benefits pertaining to pay, allowances, hospitalization, retirements, etc., and that in view of the elaborate provisions for the Armed Forces, including the Veterans Administration, it is probable that the claim as illustrated was not contemplated by Congress. I understand an appeal to a higher court has been taken.

Brooks vs. United States, 69 S Ct 918. This is the first case to reach the United States Supreme Court involving a claim by a soldier for injuries or death not incident to service under the Federal Tort Claims Act. The soldier on leave was killed when the car in which he was riding was struck by a United States Army truck. Recovery was allowed. Justice Murphy (deceased) delivered the majority opinion. In so doing, Justice Murphy stated that, were the accident incident to Brooks' service, a wholly different case would be presented and mentioned that provisions in other statutes for disability payments to servicemen, and gratuity payments to their survivors indicate no purpose to forbid tort actions under the Tort Claims Act but it would seem incongruous at first glance, if the United States should have to pay in tort for hospital expenses it had already paid, for example. This interesting case gives some indication of the thinking of the United States Supreme Court on the problem.

The Office of the Judge Advocate General, Department of the Army, at the present time, in the administrative consideration of claims of the United States military personnel, has consistently disapproved claims for personal injuries incident to service.

Colonel Tynes - Recent passage of the new retirement law, the Career Compensation Act, has brought up a good many problems which are of extreme interest to all of us personally and also to you who are commanders of hospitals. Title IV of this act had to do with physical retirement of individuals from the service. The responsibility for the implementation of Title IV for the services was assigned to the Department of the Army, and further passed along to the Medical Department of the Army. We have two speakers today who will try to bring you up to date on the interpretation of Title IV as we see it and as it will be implemented in the hospital system. First Captain Imbelli and then Captain Watson.

Captain Imbelli - Title IV of the Career Compensation Act of 1949 makes certain changes in the mechanism for the separation of individuals from the service because of physical or mental disability. It establishes uniform procedures for officers and enlisted men, and establishes generally the principle of fixing retired pay in accordance with the degree of disability. Therefore, certificates of discharge for disability are eliminated and a fixed retirement pay of 75 percent of base pay for officers and enlisted men with more than 20 years of service are discontinued.

Under the provisions of this new legislation, individuals who are found incapacitated for duty, whether officers or enlisted personnel, are retired or separated from the service.

An individual not physically fit for active duty who:

- a. Has a disability which was not due to his own misconduct,
- b. Has a disability which is 30 percent or more,
- c. Has a disability which is the proximate result of performance of active duty (any disability incurred in line of duty in time of

war or emergency is deemed proximate to the performance of active duty), or

- d. Has completed at least 8 years of active service,
- e. Has a disability which may be permanent,

will be placed on the Temporary Retired List unless it is determined conclusively that the disability is permanent, in which case he will be permanently retired. However, even though an individual may have less than 30 percent disability but has 20 or more years of active service he will be retired under the provisions of this act.

An individual not physically fit for active duty who:

- a. Has a disability which is less than 30 percent and has less than 20 years of service, or
- b. Regardless of the degree of disability, has less than 8 years of service and the disability was not the proximate cause of performance of active duty,

will be separated from the service.

If retired an individual may elect to receive retirement pay computed by multiplying the degree of disability by the basic pay of the highest rank held or multiplying the number of years of service by $2\frac{1}{2}$ percent of his basic pay.

If separated from the service, an individual receives disability severance pay computed by multiplying two months' basic pay of the highest rank held by the number of years of active service not to exceed a total sum equivalent to two years' basic pay.

An individual placed on the Temporary Retired List will be reexamined every 18 months for a period of five years, and as a result of such re-examination, may be either

- a. Permanently retired,
- b. Restored to active duty,
- c. Have his disability pay increased or decreased, depending upon his physical condition at time of re-examination; but in no event will he receive less than 50 percent of his basic pay while on such Temporary Retired List.

Captain Watson - In considering retirement procedures, oversea hospitals may be eliminated inasmuch as they participate in the retirement of individuals only in the following respects:

- a. To return to the United States individuals who are likely to require separation from the service by reason of physical disability.
- b. To take care of retirement procedures (except review and repeal) of those individuals domiciled in an oversea area such as Porto Rico, Hawaii and the Philippines.

From the foregoing it is seen that the retirement procedures apply mostly to ZI hospitals.

Workload. It is anticipated that approximately 1300 Army and Air Force officers or enlisted men will be processed for retirement per month. This will result in a considerable increased load upon the hospital system; in order to minimize this load and in order to enable the utilization of accommodations ordinarily not used for patients it has been provided that individuals who do not require active hospital inpatient care may be treated so far as quarters are concerned essentially as duty personnel.

There are two new terms that must be remembered.

- a. A medical board has essentially the same functions as a disposition board used to have.

b. A physical evaluation board has essentially the same functions, plus certain additional functions as a retiring board used to have.

For the purpose of clarification we will classify ZI hospitals not into general and station hospitals but as:

- a. Hospitals having an evaluation board,
- b. Hospitals not having an evaluation board.

All hospitals down to and including 25 bed station hospitals are authorized to have medical boards.

Only certain general hospitals are presently authorized to have physical evaluation boards.

There are then two procedures for handling physical disabilities; one is the procedure where the individual is admitted to a hospital which does not have an evaluation board, the other is the procedure that pertains to the individual who is admitted to a hospital that has an evaluation board.

Hospitals not having physical evaluation board authority. As soon as practicable after admission to a hospital it should be determined whether an individual will require physical evaluation board action. If physical evaluation board action is indicated and:

- a. He has a disability which clearly and without a reasonable doubt existed prior to entry into the service,
- b. He has less than 20 years of active federal service and a disability which is clearly and without a reasonable doubt less than 30 percent in accordance with Veterans Administration standards,
- c. His base pay is such that under existing Veterans Administration laws and regulations he would receive higher compensation thereunder.

Such individual will have his rights explained to him by the commanding officer or his representative and will be requested to consider foregoing personal appearance before an evaluation board. The commanding officer or his representative will execute a certificate to the effect that the individual's rights have been explained to him and that he has or has not agreed to forego his appearance before a physical evaluation board.

If he does not agree to forego an appearance before a physical evaluation board he will be transferred immediately or as soon as transportable to a hospital having physical evaluation board authority. If he does agree to forego a personal appearance before a physical evaluation board he is then retained in the admitting hospital until he has reached maximum hospital benefits and is then brought before the medical board of the admitting hospital (unless these patients have conditions which require their transfer to general hospitals under existing instructions).

The local medical board may reach one of the following findings:

- a. Return to duty.
- b. Temporary defect with return to duty at a specified later date.
- c. Condition not stabilized and examination and reevaluation deferred to a future date.
- d. In certain unusual cases refer the case to the Surgeon General's Office for review and recommendation.
- e. If it is determined that the individual's case should be referred to a physical evaluation board, the necessary papers giving the required facts in the case are prepared and forwarded directly to the appropriate physical evaluation board.

When the papers reach the appropriate physical evaluation board it considers the case on the basis of the papers and will ordinarily reach specific findings. These findings will ordinarily either be a recommendation that the patient return to duty, be retired or separated from the service with or without severance pay. The board may, however, call for the personal appearance of the patient in which case the patient will be transferred to that hospital and personally appear before said board.

Hospitals having physical evaluation board. The same procedure occurs in a hospital having physical evaluation board proceedings except that there is no transfer of the patient from one hospital to another whether or not he foregoes personal appearance before an evaluation board. The only instant when transfer to another hospital would be indicated would be in case an evaluation board was located at a station hospital and the patient needed treatment for which personnel and facilities were not available at that station hospital. In this instance the patient would be transferred to a general hospital having an evaluation board at which the necessary personnel and facilities for the required treatment existed. This transfer of course would be effected as soon as practicable after the patient's original admission to the hospital.

General Cole - Have these instructions gone out to the hospitals?

Captain Watson - The advance copies of the Special Regulation which carried these instructions have gone out and the printed copies are now in process of either the last stages of printing or they may have at this date been sent out to the field.

General Cole - Can we proceed with the copies of the tentative regulations which we now have?

Captain Watson - I think that is what Colonel Tynes has just told me, that you may.

General Cole - One more question. Many officers who are now retired and many reserve officers who are now retired as I understand under this law, will have to be re-evaluated. Will that be done by these evaluating boards in general hospitals?

Captain Watson - I think not, General. That question is now in process of discussion in P&A and they are also, in that connection, in the process of publishing a pamphlet of instructions to those people. However, the thinking on it is that those cases will be reviewed from their records alone upon application by the individual concerned.

Colonel Villars - Who appoints these evaluation boards?

Captain Watson - That is handled the same as the authority for appointing the old retirement boards. The Army Commanders appoint the board as directed by the Secretary. In other words, he may from time to time require that the Army Commander appoint various boards. This regulation that we spoke of does specifically name the boards that will be formulated currently and in the future it is contemplated that there may be some additional boards appointed. That announcement will be made from the Department of the Army to the Army Commanders concerned.

Colonel Liston - I did not get a distinction, if it was made, between the case that has disability incident to service and the case of disability which existed prior to service. What do you do with the latter man?

Captain Watson - That is the man who has come into the service to find that he has a disability that existed prior to service.

Colonel Kilgore - If I may, I would like to explain that question. It is rather a wild one and in connection with this training we had last week, that question was brought up and discussed at quite some length by both members of the Surgeon General's Office and P&A.

Colonel Tynes - I believe that you can ask questions all day on this subject. Captain Watson, Captain Imbelli, and Colonel Fitzpatrick were the three principal speakers at the orientation meeting with the Army representatives last week and the week before. I have been to several of them and actually, questions were asked as long as we could stand on our feet. Now each of you had a representative from your own hospital or your own Army Headquarters who attended this course and I believe they are pretty well oriented by this time. I think they can answer the questions that you specifically have. If not, then I believe it would be better to put them in writing, send them back to this office, or leave them with us before you leave and we will get the answers back to you in writing.

I say this because I had to interrupt two other conferences in the past, otherwise we would never have finished with any of our work. I do not mean that we are not willing to answer questions, if you do have questions on this subject, but we do have a meeting with the Navy. We still have one other speaker today and unless I am interrupted now we will complete our schedule. I am going to let Captain Watson make one other statement.

Captain Watson - Just to relieve your concern on these questions, in coordination with P&A, SGO is taking all of the questions that were brought up at this conference last week and they are preparing a pamphlet which will be sent to all the commands concerned.

Colonel Tynes - General Armstrong will close our conference.

General Armstrong - May I express for The Surgeon General the appreciation of General Bliss personally and his entire staff for your coming into this meeting and the interest I know you have shown in the various discussions which have taken place.

JOINT ARMY-NAVY-AIR FORCE CONFERENCE
Auditorium, Naval Medical Center
Bethesda, Maryland

Wednesday, 9 November 1949

1315-1400	Journey to Navy Medical Center, Bethesda, Maryland	
1400-1420	Joint Medical Problems	Dr. Richard L. Heiling Director of Medical Services, Office of Secretary of Defense
1420-1500	Question and Answer Period	
1500-1515	Recess	
1515-1700	Joint Discussion of Cross Hospitalization	
(10 min.)	Care of Army and Air Force Patients in a Navy Hospital	Capt. W. T. Brown, MC (USN)
(10 min.)	Care of Navy Patients in Army General Hospitals	Lt Col J. T. McGibony, MC (USA)

Thursday, 10 November 1949 - Military Surgeons Conference, Statler Hotel,
Washington, D. C.

Friday, 11 November 1949 - Military Surgeons Conference, Statler Hotel,
Washington, D. C.

Saturday, 12 November 1949 - Military Surgeons Conference, Statler Hotel,
Washington, D. C.

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