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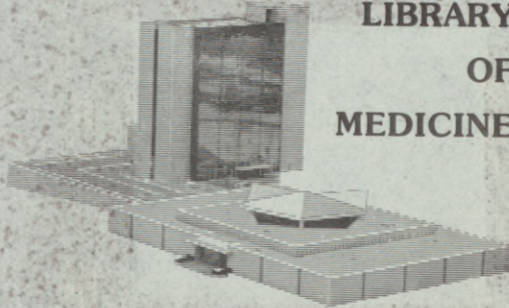
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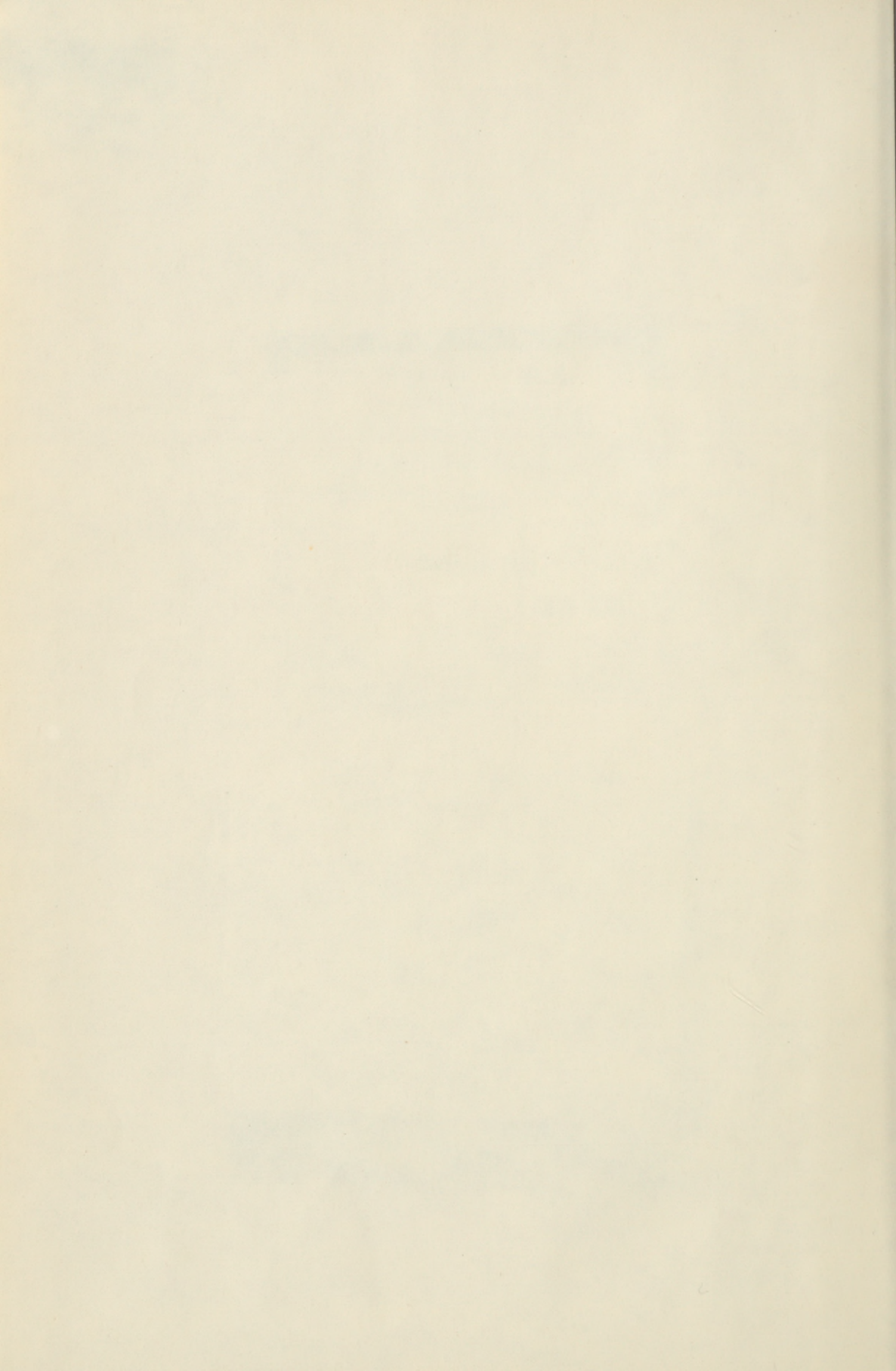


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MEDICAL DEPARTMENT, UNITED STATES ARMY

MEDICAL TRAINING IN WORLD WAR II

**MEDICAL DEPARTMENT
UNITED STATES ARMY
IN WORLD WAR II**

The Surgeon General, United States Army

Editor in Chief

Colonel Vernon S. McLean, MC, USA

Editor for Medical Training

Captain Robert J. Foy, MC, USA

OFFICE OF THE SURGEON GENERAL

DEPARTMENT OF THE ARMY

WASHINGTON, D.C., 1974

U. S. Army. Surgeon General's Office. Medical
Department of the United States Army

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Prepared and published under the direction of

Lieutenant General RICHARD R. TAYLOR

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The volumes comprising the official history of the Medical Department of the United States Army in World War II are prepared by The Historical Unit, U.S. Army Medical Department, and published under the direction of The Surgeon General, U.S. Army. These volumes are divided into two series: (1) Administrative and operational series, and (2) professional, clinical and technical series. This is one of the volumes published in the former series.

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Foreword

At the onset of World War II, problems of unprecedented size and scope challenged the U.S. Army Medical Department simultaneously. These problems ranged from mobilizing and housing personnel to receiving, storing, and shipping supplies and equipment from constructing facilities to activating installations. None was more demanding than the task of training thousands of men and women to provide the fighting forces with the finest medical care in the history of warfare.

Companion volumes in this series set forth in great detail the achievements of the Medical Department in the fields of personnel, supply, and hospitalization and evacuation in the Zone of Interior. This volume is a historical account of the success of the Medical Department in training thousands upon thousands of civilian soldiers in the practice of field medicine.

The problem began with the mass induction of recruits upon general mobilization. It was aggravated by the need to train personnel for a variety of duties—front-line combat service, support service in the theaters of operations, specialized and convalescent services in installations in the Zone of Interior—on an accelerated basis. It was compounded by the need to train medical personnel so they could practice their skills in any climate or environment anywhere in the world—from the tundra of Alaska to the jungles of Buna Gona, from the sands of North Africa to the swamps of Guadalcanal.

While it is true that the principles of medicine and surgery are the same in war and in peace, the application of these principles in the practice of field medicine is vastly different. To perform effectively, the soldier-physician must think in terms of treating and caring for masses of patients, learn to make do with what is available, and understand fully his role as a member of a team charged with the awesome responsibility of conserving the strength of the fighting forces. No more formidable task faced the Army Medical Department than that of turning a civilian into an effective member of a military-medical team.

Although there was extensive study and planning for the expansion of the Army Medical Department during the period of Limited National Emergency, from the invasion of Poland in August 1939 to Pearl Harbor in December 1941, little was actually done. The men who were inducted for 1 year under the Selective Training and Service Act of 1940 were given combat training in preference to specialized or technical training. The Army Medical Department was also handicapped by lack of funds to construct troop housing and classrooms at the training centers and to expand facilities at the technical and advanced technical training schools. The shortage of instructors at the training centers and technical schools was a chronic problem. Training equipment had to be improvised or simulated. Irregular arrivals and unscheduled transfers of trainees resulted in vast fluctuations in enrollments. During slack periods, supplies and equipment were underutilized or

wasted. In contrast, heavy training loads taxed facilities and facilities and required emergency shipments of food, supplies, and equipment.

In the initial stages of mobilization, the Army National Guard, the Organized Reserves, and affiliated medical units from civilian universities provided the trained physicians, nurses, and technical personnel. The rapid buildup required additional manpower to activate much needed medical units. This was achieved by stripping trained personnel from the medical training centers to make up cadres to activate new units. Unit readiness was accelerated by conducting advanced individual training in the units along with the unit basic and advanced training. Individual and unit training programs had to be adjusted continually to meet accelerated replacement requirements and deployment schedules. These problems were compounded by divided responsibility for the training of medical personnel after the reorganization of the Army in 1942. Although The Surgeon General retained technical responsibility for all medical training, he lost control of all training except that of the few units assigned directly to him.

This volume records the problems of training men and women for an Army Medical Department which at peak strength numbered 700,000, or more than three times the strength of the entire Regular Army in 1939. It is a tribute to those who were responsible for fulfilling the training requirements of a Medical Department that had to care for the health of the Army and simultaneously prepare for its role of providing combat medical support. It describes honestly and frankly the errors and failures as well as the achievements of the dedicated men and women who trained the physicians, dentists, nurses, others in professions allied to medicine, and the enlisted personnel, all of whom made up the teams that cared for some 14 million patients during the Second World War.

It is hoped that this account of the training of U.S. Army Medical Department personnel in World War II will be a guide to the planners of the future.

RICHARD R. TAYLOR,
Lieutenant General,
The Surgeon General.

Preface

This study is one of a series dealing with the administrative history of the U.S. Army Medical Department in World War II. As an account of the programs developed in the Zone of Interior to train Medical Department personnel to operate fixed medical installations and field units, it focuses on the organization and administration of training, changes in scope and emphasis, the development of doctrine and technique, and responses to personnel and supply problems. Other volumes in the clinical and administrative series necessarily impinge to an extent upon the subject matter of this study, just as this volume deals with problems of organization and administration, personnel, and supply falling within the scope of training. In this book, training is considered in the context of the Army and the Medical Department over the period from 1938 to 1945, providing a unified picture of Medical Department training efforts.

The training volume itself has a long and complex history. Work on the project began during World War II, when the Office of The Surgeon General was directed to prepare a manuscript history of its training activities to serve as source material for a projected history of training under the Army Service Forces. Under the supervision of Lt. Samuel M. Goodman, MAC, AUS, several young officers at the Office of The Surgeon General were assigned to the project, and by the end of the war, these officers completed a 10-volume manuscript encompassing all phases of Medical Department training conducted under the jurisdiction of the Army Service Forces. Although these studies were of uneven value, they served as the foundation for all subsequent versions of the training volume.

In 1946, shortly after work began on the administrative history of the Medical Department in World War II, the project was assigned to Mr. Graves H. Wilson, a civilian historian employed by The Historical Unit. Although Mr. Wilson was unable to complete more than fragments of the study before leaving the unit in 1952, he compiled an extensive file of verbatim notes to supplement manuscripts written during the war.

Following the departure of Mr. Wilson, the training volume lay fallow until 1956, when it was reactivated under the aegis of an Advisory Editorial Board, whose members are listed on a preceding page of this volume. Key figures on this board included Maj. Gen. Paul R. Hawley, USA (Ret.), who acted as chairman until his death in 1965, when he was succeeded by Maj. Gen. Thomas J. Hartford, USA (Ret.). Determined to produce an exemplary volume, the board decided to tap the skills of officers with extensive experience in training and apply a technique of group authorship that had been used with great success in Medical Department clinical histories. After the board amended and adopted an outline prepared by the Medical Field Service School, Col. Charles A. Pendlyshok, MSC, USA (Ret.), and Lt. Col. John A. Ey, Jr., MSC, AUS (Ret.), were chosen as project officers. In cooperation with the Advisory Editorial Board, these officers selected a number of

individuals who had held important training positions during World War II to participate in the creation of a manuscript. Together, the project officers and the individuals cited in the list of contributors overcame many problems. After Colonel Pendlyshok left The Historical Unit for another assignment, Colonel Ey supervised the completion of a draft manuscript. By 1964, however, it had become apparent that the technique of group authorship could not be adapted to the requirements of the administrative series, and Colonel Ey's retirement made it impossible for him to undertake the necessary revisions.

Because staff replacements were not immediately available, the training volume was put aside until 1966, when the project was assigned to Mr. William D. Shaver, formerly of the Historians Branch. Working from a revised outline prepared by Dr. Charles M. Wiltse, formerly Chief Historian, Mr. Shaver began the process of screening documents but unfortunately left The Historical Unit before this phase of the revision could be completed.

Shortly after Mr. Shaver's departure, the project was assigned to Capt. Robert J. Parks, MSC, AUS, a Reserve officer who had been called to active duty at The Historical Unit. Captain Parks is a graduate of Western Michigan University, Kalamazoo, Mich., and completed the requirements for the M.A. and the Ph. D. degrees at Michigan State University. Working under the direction of the undersigned, and using as guidelines valuable suggestions made by the Office of the Chief of Military History, Department of the Army, he completed a stylistic, organizational, and substantive revision of the training volume, making maximum use of all previous versions of the manuscript.

If any one individual were to be singled out as author, it would have to be Captain Parks, but so many others have made important contributions that it would be unfair to give preeminent credit to any one of them. The entire list of contributors and reviewers appears under Acknowledgments. Very special thanks are due, however, to General Hawley and to General Hartford. Others who labored long and diligently to make the book a success are Mrs. Claire M. Sorrell of the General Reference and Research Branch and Mrs. Marjorie G. Shears of the Editorial Branch who did the editing and compiled the index. Thanks are also due to Dr. Stetson Conn, formerly Chief Historian, Office of the Chief of Military History; to Brig. Gen. John Boyd Coates, Jr., USA (Ret.), former Director of The Historical Unit, who set the project in motion; and to Col. Arnold L. Ahnfeldt, MC, USA (Ret.), and Col. Robert S. Anderson, MC, USA (Ret.), former Directors of The Historical Unit; and to the present Director, Col. William S. Mullins, MSC, USA, who sustained the project.

ROSE C. ENGELMAN.

Acknowledgments

The distinction between "Contributor" and "Reviewer" is sometimes tenuous, but, generally defined, a contributor actually wrote a draft manuscript which might vary from a few pages to one or more chapters, while a reviewer read and commented upon one or more of these drafts. It sometimes happened that the same man who contributed to one part of the book also reviewed another part, so that a few names occur in both categories. It should be pointed out, however, that the majority of the contributors devoted long hours and much time to the preparation of their contributory manuscripts and, thus, if any distinction were to be made, it must be in their favor. All names are listed here in alphabetical order, with grateful thanks to each and every one.

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CHAPTER I

Preparations for World War II

TRAINING BETWEEN THE WARS

Training facilities of the U.S. Army Medical Department in 1939 reflected adaptation to peacetime medical requirements. From a World War I peak of over 340,000, the Medical Department's strength had been reduced to a little over 11,500 officers and enlisted men by June 1939. Enlisted personnel had been reduced by the National Defense Act, as amended in 1920, from a wartime concentration of nearly 10 percent of the Army's enlisted strength to a statutory maximum of only 5 percent. Because all but a fraction of the enlisted strength was needed to care for the garrison army, field training had been neglected. The five Medical Department field units that existed were either understrength or skeleton organizations; trained enlisted cadre could not have been provided in case of mobilization. Without enlisted personnel to man units, officer training could be little more than theoretical.¹

Peacetime Components of the Medical Department

Under the National Defense Act, as amended in 1920, the Army was divided into three components: the Regular Army, the Reserves, and the National Guard.² The Regular Army consisted of officers and enlisted personnel who were continuously on active duty. The Reserves were designed to meet immediate needs for manpower in the initial stages of mobilization, and the National Guard was a state organization intended for use in an emergency or in actual hostilities. The Medical Department was divided by function into seven basic components: the Medical, Dental, Veterinary, Sanitary, and Medical Administrative Corps, composed of officers of commissioned rank; the Army Nurse Corps, whose members held relative rank; and the enlisted personnel necessary to support the professional staff. These medical elements were represented in each of the Army's Reserve and Regular components, with the exception of the Sanitary Corps, which was found only in the Reserves, and the Army Nurse Corps, which was not organized in the National Guard.³

In the peacetime Medical Department, technical duties were performed by a variety of personnel, including commissioned and enlisted members of the Regular

¹ (1) Committee to Study the Medical Department, 1942, Testimony, pp. 1-2. (2) Smith, Clarence McKittrick: *The Medical Department: Hospitalization and Evacuation, Zone of Interior. United States Army in World War II. The Technical Services.* Washington: U.S. Government Printing Office, 1956. (3) Medical Department, *United States Army. Personnel in World War II.* Washington: U.S. Government Printing Office, 1963. (4) 41 Stat. 766.

² 41 Stat. 759.

³ See footnote 1 (3).

Army, members of the Army Nurse Corps, and civilian specialists employed either under civil service regulations or by The Surgeon General under special contract. The commissioned Regular Army personnel consisted of physicians assigned to the Medical Corps, dentists assigned to the Dental Corps, veterinarians assigned to the Veterinary Corps, and nonprofessional administrative officers, who were assigned to the Medical Administrative Corps. Regular Army enlisted men were not assigned to corps but were utilized in administrative, clerical, training, and technical capacities for which they were qualified by civilian experience or Medical Department training. Civilians were employed at various installations, including hospitals, laboratories, supply depots, and offices, in a variety of positions, ranging from laborers and trained artisans to highly skilled technicians, therapists, and dietitians. The Surgeon General also employed a small number of doctors under special contract, usually for part-time duty at small posts.

To supplement these personnel in an emergency, the Army maintained a Medical Department Reserve. Commissioned members of the Medical Department Reserve were assigned to five Reserve corps: the Medical, Dental, Veterinary, Medical Administrative, and Sanitary Corps. Reserve officers in the first four of these corps had the same professional qualifications as officers in the corresponding corps of the Regular Army, and those in the first three corps were usually commissioned upon completion of the Reserve Officers' Training Corps program at civilian medical schools. The Sanitary Corps Reserve consisted of men with experience and college training in technical fields allied to medicine, such as chemistry, sanitary engineering, or hospital architecture. The Medical Administrative Corps Reserve consisted largely of World War I officers with administrative experience who continued in the Reserves after the war, senior active-duty non-commissioned officers who also held Reserve commissions, and, after 1936, graduates of accredited pharmacy schools who applied for Reserve commissions. The number of enlisted reservists was negligible. Reserve officers were required by law to attend periodic meetings, and the law permitted the Government to call them to active duty for 2 weeks each year. War Department policy, however, was to call them for such duty only upon their own application. Reserve officers were also required to complete a limited number of Army extension courses.⁴

In contrast to the Medical Department Reserve, which emphasized the training of individual officers, the Medical Department of the National Guard had a high level of enlisted strength and emphasized the training of field units (table 1). In addition to providing organic medical support for regiments and smaller units, the National Guard possessed a number of independent medical units designed to be attached to larger units. These included 19 regimental headquarters, 12 battalion headquarters, 20 collecting companies, 45 motorized ambulance companies, 29 hospital companies, and a number of veterinary and service companies. Taken together, they possessed a far greater capability for providing field medical service than did units of the Regular Army. In 1939, The Surgeon General reported that the National Guard had achieved the highest level of training in its history. Because of

⁴ The Army of The United States, Senate Document No. 91, 76th Congress, 1st Session. Washington: U.S. Government Printing Office, 1940.

TABLE 1.—*Approximate strength of peacetime components of the U.S. Army Medical Department, 1939*

Component	Regular Army	Reserves	National Guard
Medical Corps.....	1,098	15,198	1,085
Dental Corps.....	221	5,063	234
Veterinary Corps.....	126	1,381	66
Medical Administrative Corps.....	64	1,243	145
Sanitary Corps.....		454	
Army Nurse Corps.....	672		
Enlisted personnel.....	8,643	16	12,500
Total.....	10,824	23,355	14,030

Source: (1) Annual Reports of The Surgeon General, U.S. Army. Washington: U.S. Government Printing Office, 1940 and 1941. (2) The Army of the United States, Senate Document No. 91, 76th Congress, 1st Session, Washington: U.S. Government Printing Office, 1940, p. 117.

their low professional strength, however, National Guard units were thought to be better qualified in tactical training than in caring for the sick and wounded in the field. Members of the National Guard were under the jurisdiction of corps area commanders for training and were required to participate in weekly exercises, as well as 2 weeks of summer exercises.⁵

Training Responsibility

Full control over the training of Medical Department personnel was not vested in any single office. All training was under the technical supervision of The Surgeon General, but not all of it was under the same degree of control. In common with the other technical services, the Medical Department was an element of the War Department Special Staff, and The Surgeon General had direct access to the Chief of Staff. The Chief of Staff and the General Staff were responsible for coordinating the separate arms and services. Each of the chiefs of the arms and services acted as the immediate adviser to the General Staff in technical areas peculiar to his arm or service. Thus, The Surgeon General advised G-3, Operations and Training Division, on the technical training of Medical Department personnel and prepared master program guides, manuals, and instructional aids. In sum, The Surgeon General established the basic "doctrine" under which Medical Department troops were trained, regardless of their location or level of technical skill.

The degree of control exercised by The Surgeon General over the training of a particular body of Medical Department troops, however, was determined both by geographic location and by level of technical skill. The Surgeon General controlled the basic, advanced, and professional training of officers, the advanced technical training of enlisted men, and the routine training of enlisted personnel at the limited number of installations, known as exempted stations, under his direct control. The most important of these, from the standpoint of training, were the Medical Field

⁵ Annual Report of The Surgeon General, U.S. Army, 1939. Washington: U.S. Government Printing Office, 1940.



FIGURE 1.—Carlisle Barracks, Pa., home of the Medical Field Service School, about 1939.

Service School of Carlisle Barracks, Pa. (fig. 1), and the Professional Service Schools at the Army Medical Center, Washington, D.C. At the professional schools in Washington, officers and enlisted technicians were trained in medical specialties and in the military aspects of medical, dental, and veterinary service. The Medical Field Service School trained enlisted men and officers of all corps in the field aspects and administration of the Medical Department. The routine and basic technical training of other troops was under the control of corps area commanders, except at the schools and the named general hospitals classified as exempted stations.

Medical Department officers and men assigned to medical installations and field units at posts, camps, and stations under corps area jurisdiction were no less a part of the Medical Department than those assigned to exempted stations, but they were isolated from the Medical Department by several levels of command and administration. Their numbers far exceeded those at exempted stations. Training at corps area level was the responsibility of the area commander, who usually delegated the responsibility to the corps area surgeon. The surgeon, in his dual capacity as a local staff officer and technical representative of The Surgeon General, was then responsible to the corps area commander for conducting training according to War Department policies and to The Surgeon General for the technical content of instruction. The same command relationship existed on a lower level at posts, camps, and stations. Except for about 2 percent of the Reserve officers, who were assigned to The Surgeon General in event of mobilization, both the Reserves and the National Guard were under corps area control. In peacetime, the tendency of corps

and station commanders not to interfere in medical matters allowed local surgeons a considerable degree of autonomy.⁶

Officer Training

The peacetime pattern for training Medical Department officers was designed to meet the dual need for professional medical personnel capable of performing command and staff functions in the operation of military medical installations and for supplementing civilian professional training with instruction in specialties having a different emphasis in military medicine. As a result of problems encountered during World War I, training facilities were established to meet each of these needs. In 1920, the Medical Field Service School was established at Carlisle Barracks to conduct a program of instruction designed to transform civilian doctors, dentists, and veterinarians into medical officers trained to assume command in medical installations and units. Three years later, the Army Medical Center was established in Washington, D.C., to conduct a postgraduate program of instruction in the military aspects of medicine, dentistry, and veterinary service.

The Army Medical Center was a multiple institution whose components functioned as separate installations before 1923. These included the Walter Reed General Hospital, the Army Medical School, the Army Dental School, and the Army Veterinary School. The three schools, usually referred to as the Medical Department Professional Service Schools, had conducted training programs of their own long before the center was established. Indeed, the Army Medical School had been created as early as 1893. But the establishment of the Medical Field Service School in 1920, and the Army Medical Center in 1923, marked the beginning of a two-phase program designed to give comprehensive training to Medical Department officers in both military and technical aspects of their profession. Facilities at the Army Medical Center were not usually available to officers of the National Guard and Reserve, but the Medical Field Service School offered special courses for their instruction.⁷

Regular Army officers.—The Medical Department basic training program for Regular Army officers provided an academic year of postgraduate study in the professional and military aspects of military medicine. Beginning in late August or early September each year, 4-month courses known as "Basic Graduate Courses" were offered at each of the three service schools at the Army Medical Center. These programs were "basic" in that they presented essential professional knowledge required for the military practice of medicine, dentistry, or veterinary service, as distinguished from the same practices in civilian life, and "graduate" in that students in the classes had degrees in their professional fields and were prepared to cope with subject matter presented in a manner characteristic of graduate schools at

⁶ (1) See footnote 1 (2), p. 1. (2) Medical Department, United States Army. *Organization and Administration in World War II*. Washington: U.S. Government Printing Office, 1963.

⁷ (1) Annual Report of The Surgeon General, U.S. Army, 1922. Washington: U.S. Government Printing Office, 1922. (2) Annual Report of The Surgeon General, U.S. Army, 1924. Washington: U.S. Government Printing Office, 1924. (3) Hume, E. E.: *Training of Medical Officers for War Duty*. War Med., vol. I, September 1941.

civilian institutions. When these professional courses were completed in December, students transferred to the Medical Field Service School for a 5-month course of military indoctrination. This course, which emphasized tactics, logistics, administration, field sanitation, and instructional methods, was designated the "Medical Department Officers Basic Course," to distinguish it from the basic graduate courses at the Army Medical Center. After 9 months of intensive training, the officer was considered ready to assume duties as a member of the Regular Army Medical Department.⁸ Unfortunately, peacetime requirements for professional personnel made it impossible for each newly commissioned medical officer to participate in the basic training program, and the program was too cumbersome for use during mobilization.

In addition to basic officer training, the Medical Department offered opportunities for continuing education. A program of "Advanced Graduate Courses" at the Army Medical Center allowed medical officers to receive 4 months of training in technical subjects. More intensive training could be pursued through "Professional Specialists Courses," individual courses in medical specialties corresponding to residency at civilian hospitals, that varied in length from 2 to 4 years. Because of the administrative burden of formal reports required by regulations, the professional specialists courses were not formally offered in the closing years of the interwar period.⁹ The program was carried on the books to comply with regulations, but in practice, students were ordered to the Army Medical Center and became in fact, if not in name, regular duty officers at Walter Reed General Hospital, where they received informal training. Through these programs, the Medical Department attempted not only to keep its personnel abreast of developments in medical science but also to provide the specialists necessary for complex medical installations. At the Medical Field Service School, field grade officers were provided with additional training in command techniques by a 3-month "Advanced Course."

To supplement training available through formal courses at the Army Medical Center and the Medical Field Service School, the Medical Department offered extension courses and subsidized study at civilian institutions. Correspondence courses covering military and administrative subjects were prepared by the Department of Extension Courses of the Medical Field Service School. Regular Army officers were allowed to enroll in a series of basic extension courses designed for officers in Reserve components. The number of Regular Army officers taking such courses was always small, totaling only 59 in the 5-year period preceding 1940.¹⁰ During the same period, 369 Regular Army officers completed the "Special Extension Course for Medical Department Officers, Regular Army" for field grade

⁸ Annual Report of The Surgeon General, U.S. Army, 1936. Washington: U.S. Government Printing Office, 1936.

⁹ (1) Memorandum, Lt. Col. Charles B. Spruit, MC, Training Subdivision, Planning and Training Division, OTSG, for Col. Albert G. Love, MC, Chief, Planning and Training Division, OTSG, 16 Apr. 1940, subject: Schedule of Courses for Medical Department Special Service Schools, School Year 1940-41. (2) Annual Report of The Surgeon General, U.S. Army, 1940. Washington: U.S. Government Printing Office, 1941. (3) See footnote 7 (3), p. 5.

¹⁰ (1) Annual Report of The Surgeon General, U.S. Army, 1935. Washington: U.S. Government Printing Office, 1935. (2) Annual Report of The Surgeon General, U.S. Army, 1937. Washington: U.S. Government Printing Office, 1937. (3) Annual Report of The Surgeon General, U.S. Army, 1938. Washington: U.S. Government Printing Office, 1939.

officers seeking promotion to grades of lieutenant colonel or colonel.¹¹ Completion of this special extension course exempted officers from the portion of their promotional examination consisting of a medicomilitary problem, which probably accounts for the high level of participation. In addition, the National Defense Act, as amended in 1920, allowed up to 2 percent of the officers of the Regular Army to enroll in courses at civilian institutions in subjects not taught at service schools but essential to the efficient conduct of their duties. The number enrolled for such study varied from year to year, as did the subjects, length of courses, and institutions involved. In the 5-year period preceding 1940, 150 Medical Department officers participated in this program.¹² Finally, a limited number of Medical Department officers were enrolled in service schools operated by other Army agencies, such as the Army War College and the Army Industrial College, Washington, D.C., the Infantry School, Fort Benning, Ga., the Command and General Staff School, Fort Leavenworth, Kans., the Chemical Warfare School, Edgewood Arsenal, Md., and the School of Aviation Medicine, Randolph Field, Tex. Most of these officers were being groomed for high-level command positions, and the number was always small.

Other facilities for special training were offered by the School of Aviation Medicine which had been established as a Special Service School in 1921. In name and function a Medical Department school, it was funded by the Air Corps and, exempted from corps area control, was under the command of the Chief of the Air Corps. Courses were offered to qualify members of the Medical Corps assigned to the Air Corps as flight examiners and flight surgeons and to train enlisted men as flight surgeon's assistants. The special school was formally justified by the need for special physical standards for flight personnel and the need for special methods to control disease in a highly mobile command. In common with other Special Services Schools, the School of Aviation Medicine offered extension courses for officers in Reserve components.¹³

Medical Administrative Corps officers in the Regular Army had neither the need nor the background for the professional courses offered by the Medical Department Professional Service Schools at the Army Medical Center. Commissioned and appointed to perform nonprofessional administrative duties, these officers were at first drawn exclusively from the enlisted ranks after at least 5 years of service, and after 1936, from graduates of recognized pharmacy schools. Once they had been commissioned, they were eligible to attend the basic course at the Medical Field Service School.¹⁴

National Guard and Organized Reserve Corps officers.—Reserve and National Guard officers were qualified for appointment through a variety of programs. For the Medical Department, the most important of these was the Reserve Officers' Training Corps, which had medical units in operation at the professional schools of colleges and universities. To qualify for commissions in the Medical Department, students were required to complete a 2-year basic course, a 2-year ad-

¹¹ See footnotes 5, p. 3; and 8 and 10, p. 6.

¹² 41 Stat. 786.

¹³ See footnote 7 (2), p. 5.

¹⁴ 41 Stat. 767.

vanced course consisting of 5 hours of weekly instruction in military subjects, and a 6-week summer encampment, as well as their professional training. Summer camp training for students in Medical Department Reserve Officers' Training Corps was held at the Medical Field Service School and included indoctrination in sanitation and the administration and deployment of medical field units, as well as basic military instruction. Upon graduation, candidates were eligible for Reserve commissions or to compete for appointment to the Regular Army and were required to complete 5 years of Reserve duty. Another opportunity for commissioning was offered by Citizens' Military Training Camps. By attending four successive summer camps, each 1 month in length, interested civilians could also qualify for Reserve commissions. Others, who had no previous military service, or who had not attended military academies or colleges with Reserve Officers' Training Corps units, could qualify for National Guard commissions by successfully attending officer training camps.¹⁵

Once commissioned, Reserve and National Guard officers could participate in a variety of training programs, in addition to regular drills. Instead of the 5-month basic course for Regular Army officers at the Medical Field Service School, the basic training of officers in the Reserve components of the Medical Department was accomplished through a combination of summer camps and correspondence courses. A 2-week program, known as the Basic Summer Training Camp for Reserve Officers, was conducted for junior officers each June. Approximately 200 officers enrolled annually for instruction in basic military subjects, administration, field sanitation, and the operation of medical detachments. In July, a 2-week program designated the "Unit Training Camp for Reserve Officers" was held for officers assigned to medical regiments, squadrons, battalions, general hospitals, field hospitals, and evacuation centers. Approximately 350 officers of the Reserve components attended annually. To supplement camp training, the Medical Department offered a series of extension courses in the fundamentals of military science and tactics. With the retention of commissions and promotion providing incentives, these correspondence courses played a major role in the basic training of Reserve and National Guard officers. In 1939, for example, 7,445 officers of Medical Department components completed 15,848 subcourses of the extension courses, representing a total of 223,121 hours of work.

Advanced training for field grade officers and senior captains of Reserve components paralleled that of Regular Army officers. When authorized, the Medical Field Service School conducted a 6-week counterpart to the 3-month advanced course for Regular Army officers, known as the National Guard and Reserve Officers Course, that was designed to develop commanding officers, executive officers, and planning and training officers for medical field units. Eighteen officers were authorized to attend the session held in the fall of 1939. Extension courses were also a part of the advanced training of officers in Medical Department Reserve components, and promotion depended, in part, upon the completion of successive series of subcourses.

Opportunities for professional training for officers in Reserve components were

¹⁵ (1) See footnotes 5, p. 3; and 7 (3), p. 5. (2) 41 Stat. 781.

much less extensive than those in military subjects. A course in forage inspection was open to National Guard officers at the Army Veterinary School, and inactive duty training could be pursued at civilian medical centers under the "Skinner Plan." Under this plan, medicomilitary courses were offered by various institutions, in the interest of national defense, at no expense to the Government or the officers attending. Reserve officers were not ordered to active duty while attending these courses and did not receive pay. They were, however, given credit for course completion. The pattern for inactive duty training was set by the Mayo Clinic, Rochester, Minn., which offered two courses annually: one of 4 to 6 weeks' duration in the spring, and another of 2 weeks, in the fall. During the morning hours, student officers studied purely medical subjects, and during the afternoon, attention was devoted to military subjects. The success of the program, both in keeping physicians abreast of current medical developments, and in creating interest in military medicine, encouraged the program's expansion. By 1939, similar courses were offered by medical groups in Cincinnati, Ohio, Cleveland, Ohio, St. Louis, Mo., Boston, Mass., Kansas City, Mo., Chicago, Ill., New Orleans, La., and Nashville, Tenn.¹⁶

Regular Army Enlisted Personnel

Training programs for enlisted personnel of the Medical Department reflected the critical shortage of personnel. To use personnel efficiently, the Medical Department neglected routine military and field training and relied on the specialization and division of labor, supplemented by on-the-job training. Limited by statute to a 5-percent strength allocation, barely adequate to provide routine medical care for a garrison army, the Medical Department found itself progressively squeezed between the need for technicians to support the increasing tendency toward specialization in medicine and the growing demands for medical service. In a number of installations, men served 12-hour shifts, and the rotation of duties was suspended.¹⁷

Enlisted soldiers in the Medical Department performed a wide variety of duties, in installations ranging in size and function from hospitals to dispensaries, laboratories, and medical supply agencies. Regardless of their assignment, all Medical Department enlisted personnel were required to engage in training basic to the trade of soldiering, such as dismounted drill, physical conditioning, military courtesy, and army administration. In addition, the medical soldier required instruction in the functions of the Medical Department and, depending upon his assigned duties, technical training in skills ranging from simple emergency medical treatment to complicated laboratory technique. Medical soldiers as a group required all the skills necessary for supplementing the professional services of a functioning medical installation. Responsibility for training the enlisted personnel of any medical detachment or installation, regardless of its size or specific mission, fell on the commanding officer.

¹⁶ Patterson, R. U.: *The Medical Reserve Corps of the Army*. Mil. Surg. 74 (5): 256-258, May 1934.

¹⁷ See footnotes 5, p. 3; and 9 and 10, p. 6.

Skills were developed through on-the-job training. Training schedules were established for drill and physical exercise periods and for lectures and demonstrations on military courtesy, military law, and technical subjects. The degree to which such schedules were followed, however, depended upon the demands which routine care of the sick and injured made upon the time of instructors and students. Because these demands were usually heavy, more technical training was accomplished in wards, dispensaries, and operating rooms, where men could learn by "seeing and doing," than in classrooms. Since the length of peacetime enlistment was 3 years, and many men remained in the service for more than one term of enlistment, the more enterprising often became highly skilled specialists through on-the-job training. Those who desired technical ratings had to pass Armywide promotional examinations in both technical and military subjects.¹⁸

A limited number of courses for enlisted men were offered by the Medical Field Service School, the Army Medical Center, and the School of Aviation Medicine. The Medical Field Service School initiated an annual Noncommissioned Officers Course in 1924 designed "to teach noncommissioned officers correct and effective methods of instruction and the art of handling and training Medical Department troops of the components of the Army of the United States."¹⁹ This 8-week course included instruction in company administration, leadership techniques, logistics, tactics, map reading, sanitation, control of communicable diseases, first aid, and teaching methodology. It was particularly valuable to experienced enlisted men preparing for annual promotional examinations, although it was not a prerequisite. Between 1935 and 1940, numbers enrolled ranged between 41 and 100. Extension courses were offered to enlisted personnel through the Medical Field Service School also, but the number of participants was always small.²⁰

In addition to the Noncommissioned Officers Course, four technical courses were conducted by the Professional Service Schools at the Army Medical Center. These included the X-ray Technicians Course and the Laboratory Technicians Course at the Army Medical School, the Dental Technicians Course at the Army Dental School, and the Veterinary Technicians Course at the Army Veterinary School. All were courses of long standing, established before the organization of the Army Medical Center, and army regulations required that they be offered annually. The courses were 4 months in length and could be offered twice yearly if enrollment requests warranted.²¹ In 1939, all courses, except the Veterinary Technicians Course, were lengthened to 12 months, and 12-month courses for pharmacy technicians and orthopedic appliance technicians were added to the program. Such courses were designed to contribute to the quality of Army medical service and to be of personal value to students who anticipated taking promotional examinations for advanced technical ratings. They were not prerequisites for examination, and between 1935 and 1939, enrollments were low. In no course did enrollments exceed 33, and in most, enrollments were below 12.²²

¹⁸ Army Regulations No. 615-15, 25 May 1937.

¹⁹ Army Regulations No. 350-1030, 30 Dec. 1926.

²⁰ See footnotes 5, p. 3; and 8, 9, and 10, p. 6.

²¹ See footnote 7 (2), p. 5.

²² See footnotes 5, p. 3; and 10, p. 6.

The School of Aviation Medicine conducted a 3-month "Flight Surgeons Assistants Course." Offered twice annually, the course was designed to train students not only to prepare instruments used in examining applicants for flight duty but also to assist in examinations by taking pulse counts, blood pressure readings, and similar measurements. Enrollments were small, reaching a peak of 44 in 1939.

Field Training

At the close of the interwar period, tactical training continued to be the Medical Department's most striking training deficiency. With the exception of the men assigned to existing understrength field units, few medical soldiers received actual training in tactical medical operations. These units, consisting of the 1st Medical Regiment, which was used for demonstrations at Carlisle Barracks (fig. 2), the 2d Medical Regiment at Fort Sam Houston, Tex., the skeleton 1st Medical Squadron (Cavalry) at Fort Bliss, Tex., and the 11th and 12th Medical Regiments,



FIGURE 2.—Members of the 1st Medical Regiment at the Medical Field Service School, Carlisle Barracks, Pa., load simulated patients on an ambulance at an ambulance loading post set up by the collecting company of the regiment during a field problem.



FIGURE 3.—Four-mule ambulances such as these were used in the training of Medical Department personnel at the Medical Field Service School, Carlisle Barracks, Pa., before World War II.

in Hawaii and the Philippines, respectively, were the only units receiving what was deemed adequate field training. Yet, on the field of battle, the mission of providing aid stations, collecting stations, and clearing stations for the first and second echelons in the chain of evacuation was basic to the Medical Department's combat mission.

Soldiers assigned to these units received tactical and field training that could not be given to members of the Medical Department assigned to duty in dispensaries and hospitals. Their training included instruction in such subjects as emergency medical treatment, first aid, litter carrying, ambulance service, and the establishment, movement, and operation of medical facilities in the field (fig. 3).

Opportunities for practicing actual field support were limited. The 1st Medical Regiment, in addition to its training program, acted as a demonstration unit at the Medical Field Service School and for the training camps operated at Carlisle Barracks for the Organized Reserves and Reserve Officers' Training Corps units. The 2d Medical Regiment, in addition to its routine activities, actively participated in 1938 and 1939 in the experimental exercises and maneuvers of the newly streamlined infantry division in Texas. Shortages of personnel handicapped the training of these units just as they handicapped the training of personnel in dispensaries and hospitals; the four medical regiments were maintained at "peacetime" strength, rather than mobilization strength, and the medical squadron was usually described as "skeletonized." As late as 1939, The Surgeon General reported that the "lack of adequate enlisted strength from which to form the required regimental medical detachments and Medical Department field units to be ready for use on M-day

presents a problem as yet unsolved, in furnishing adequate medical service for units in the protective mobilization plan." Units scheduled for activation in fiscal year 1939 were deferred until the following year because of manpower shortages. In a sudden mobilization, the Medical Department would have been unable to care for combat troops and, at the same time, to provide cadres for an expanding medical field service.²³

Summary

Despite the effects of peace, disarmament, and depression on the machinery for mobilization, some developments of the interwar period proved beneficial. The Medical Department developed techniques and programs to train officers for their role in a technical service. In a like manner, programs were set up for the advanced training of enlisted technicians and noncommissioned officers. But, the Medical Department's training program was adapted to meet the needs of a small garrison army and would have to be restructured to function efficiently in a period of mass mobilization. Physical facilities, of course, would have to be expanded and, more important, tempo accelerated. The luxury of an academic year of training for newly commissioned officers, and a full year for enlisted technicians, would have to be abandoned to train a service expanding more than proportionally with the Army and to provide immediate medical care for mobilized troops. Skills acquired informally through on-the-job training, or by a gradual process of see-and-do, would have to be taught by formal methods. Medical Administrative Corps officers, who previously acquired their training through long years of enlisted service, would have to be trained in great numbers to free the limited number of available physicians from administrative duties. Had the Medical Department been confronted with mobilization in the summer of 1939, the problems of creating a functioning organization capable of providing both routine health care and field medical support might have proved insurmountable. The 2-year period that intervened provided an opportunity to adjust the program for the crisis that lay ahead.

PREPARATIONS FOR WAR

The gradual deterioration of international affairs between 1939 and the attack on Pearl Harbor allowed the Nation to mobilize gradually. Public opinion limited U.S. involvement in the wars of Europe and Asia, but defensive reaction to the deepening international crisis produced a continuous buildup of forces. By July 1941, the strength of the Army was comparable to that projected by mobilization planners for a point in time 8 months after a declaration of war. Expanding the Army from approximately 189,000 on 1 July 1939 to 1,461,000 on 1 July 1941,²⁴ required not only restyling to adjust the training program for volume but also adjusting for

²³ See footnote 6 (2), p. 5.

²⁴ (1) Annual Report of the Secretary of War to the President, 1939. Washington: U.S. Government Printing Office, 1939. (2) Annual Report of the Secretary of War to the President, 1941. Washington: U.S. Government Printing Office, 1941.

the changing quality of new soldiers. In the Medical Department of the Army, as in the entire Defense Establishment, piecemeal response to the deterioration of world affairs provided a cushion against sudden mobilization, but the buildup was a mixed blessing.

Staff mobilization planning continued unabated throughout the interwar period. Annual revisions of basic plans were required as a part of normal staff procedure, and periodic reassessments of basic planning were required by the growing obsolescence of stockpiles, the aging of men who served in World War I, and the changes in strength and diplomatic posture of foreign nations. Frequently, basic changes in mobilization planning coincided with the appointment of a new Chief of Staff. Following the disarmament conferences of the 1920's, staff planning was little more than an academic exercise. By the mid-1930's, growing international tensions and the obvious degeneration of U.S. military power focused staff attention on the need for more realistic planning.

The Protective Mobilization Plan of 1939

It was at this point that Gen. Malin Craig replaced Gen. (later General of the Army) Douglas MacArthur as Chief of Staff in October 1935. Less publicized than his predecessor, General Craig assumed command in a period of moderate economic recovery and slowly reviving concern about national defense. Distressed at commanding an Army ranking 18th among the world's powers, General Craig directed his staff to begin work on a new Protective Mobilization Plan in December 1936. General Craig's anxieties, which he revealed in subsequent statements, focused on the time necessary to train and equip men to fight increasingly technological warfare. He later wrote as follows:

* * * This is an immensely rich nation, but all of its wealth, all of its industrial capacity, all of its intelligent manpower, is helpless before the inexorable demands of *time* in manufacture and training. The period has long passed when ineffectively armed or insufficiently trained men can succeed in war. We know to a day the time necessary to produce every item of armament and equipment—the time it takes to train our military specialists. As an instance, the sums appropriated this last year will not be fully transformed into military power for 2 years. This fact, that it takes years to resolve the will of the people into efficiently handled munitions of war, must be remembered. The same persons who now state that they see no threat to the peace of the United States would hesitate to make the same forecast through a 2-year period.²⁵

As a result of staff efforts, a new Protective Mobilization Plan was formulated, revised, and approved as the Protective Mobilization Plan of 1939, in December 1938.²⁶

The Protective Mobilization Plan of 1939 was designed to mobilize a balanced Army of moderate size, consistent with limitations on the procurement of men and materiel. At the beginning of hostilities, or on receipt of mobilization orders, the plan anticipated creation of a defensive Army of 400,000 men, designated the "Initial

²⁵ Annual Report of the Chief of Staff to the Secretary of War. *In* Annual Report of the Secretary of War to the President, 1939. Washington: U.S. Government Printing Office, 1939.

²⁶ Kreidberg, Marvin A., and Henry, Merton G.: *History of Military Mobilization in the United States Army, 1775-1945*. Washington: U.S. Government Printing Office, 1955. (DA Pamphlet 20-212.)

Protective Force," consisting of the Regular Army, the Reserve, the National Guard, and a corps of volunteers who would act as fillers. Thirty days after the onset of mobilization, this force of four Regular Army and 18 National Guard divisions was to be ready to protect U.S. soil from attack. Once the Initial Protective Force had been prepared for action, the Protective Mobilization Plan called for a second phase of troop activation designed to bring the U.S. Army to a strength of approximately one million enlisted men, and the officer strength necessary to command them. Assuming that Selective Service would be functioning by the second month of mobilization, draftees and volunteers were to be inducted as rapidly as equipment could be supplied, and then trained by selected Regular Army or Reserve cadres either as fillers for existing understrength units or as new units. Material shortages limited the induction of personnel for new units to approximately 150,000 per month, although an additional number of fillers requiring only the issue of personal equipment could also be trained. A serious handicap to the program's success was the shortage of Regulars and Reservists to fill cadre positions and command the Initial Protective Force. Once the second phase was completed, some 8 months after M-day, it was assumed that superior trainees could be utilized as cadre, and the process could be either continued or expanded until manpower requirements for the particular emergency were satisfied.

To provide for the induction and training of new troops, the Protective Mobilization Plan specified the location of reception centers, enlisted replacement training centers, and unit training centers, and the location at which each unit would begin and complete its training. Under the program, recruits were first assigned to a corps area reception center, where they would be processed, classified, and issued basic clothing and equipment. Those assigned as fillers to understrength units would then report directly to their units for additional training. Others would be sent to enlisted replacement training centers for a vigorous 90-day training cycle. After a period of training, these men would be shipped overseas as fillers, sent to new units in training, or assigned for technical training at service schools or civilian trade schools. In general, troops were to be trained in the traditional military manner, beginning with the broad general problems of physical conditioning and discipline, and progressing gradually to more specialized subjects.

Officer training was to proceed along different lines. At the onset of mobilization, the Army War College and the Army Industrial College were to be closed, but the Command and General Staff School would offer special courses shortened to 3 months. Special service schools, such as the Infantry School and the Medical Field Service School, would offer short courses to refresh Reserve officers called to active duty, and give specialist training. If the emergency continued for more than 2 months, Officer Candidate Schools would be inaugurated at both special service schools and at other necessary locations.²⁷

The Protective Mobilization Plan had many flaws. In spite of the realization that enlisted replacement training centers would not have enough Regular Army or prior service personnel to man them, no attempt was made to provide cadres for

²⁷ (1) See footnote 26, p. 14. (2) Watson, Mark Skinner: Chief of Staff: Prewar Plans and Operations. United States Army in World War II. The War Department. Washington: U.S. Government Printing Office, 1950.

these centers. Operating under the assumption that troops would be hurriedly trained in the South and shipped overseas for final training in a manner similar to that used by the American Expeditionary Forces in World War I, the plan did not provide for the construction of adequate housing. Plans for reservations large enough for division and corps maneuvers were neglected. Designed primarily for the mobilization of combat elements of field armies, provisions for the training of technical and support elements were admittedly inadequate. Plans for Zone of Interior hospitalization were inadequate, and War Department planners made no provision for the use of affiliated units, which had made important contributions to medical care in World War I. Despite these defects, the program outlined in the Protective Mobilization Plan of 1939 was more realistic than any offered before the war.

The Surgeon General's Protective Mobilization Plan, 1939

The plan issued by the War Department was brief but specific and designed to be supplemented by army regulations, mobilization regulations, and the progressively more detailed plans of subordinate units. Plans prepared by subordinate agencies, such as the Medical Department, followed a format parallel to that of the War Department and were more detailed only in providing general outlines for their specific areas of responsibility. Formulating plans for implementing the details of these general outlines was the responsibility of specific commands within the agency.

The War Department mobilization plan, within which Medical Department plans had to be framed, severely limited the scope for discretionary action. The sites of replacement training centers and unit training centers were specified, as well as the sites for unit activation, and the length and size of training cycles for both basic and technical training. Cycle length was standardized at 90 days throughout the Army. The Surgeon General's Protective Mobilization Plan, issued on 15 December 1939, reflected these strictures.

Providing for the routine health care of an expanding army and creating the support units for combat medical duty placed heavy burdens on the Medical Department. Within 120 days after receiving mobilization orders, the Medical Department was required to expand more than tenfold to a strength of over 140,000 officers and enlisted men, and this figure did not include members of the Air Corps and those assigned overseas. To achieve this strength, it was necessary to strain facilities to the limit and, in some instances, to omit the luxury of formal training and to rely on the assumption that men with suitable skills could be channeled directly into their military occupations by induction centers. Other new members of the Medical Department would be channeled through training programs.²⁸

Officer training.—To meet requirements for officers, both for War Department overhead and for medical command, the Medical Department relied heavily

²⁸ The Surgeon General's Protective Mobilization Plan, 1939, with annexes.

on the Reserves. Because of prewar neglect of field training, efforts were concentrated on preparing officers for field medical service. Those officers required for units mobilized before the 30th day of mobilization were to receive only refresher course training in the troop schools of the unit to which they were assigned. Officers required by units after that time were to attend a 1-month refresher course at Carlisle Barracks, and other installations, designed to prepare them for duty in field medical units. Because officer candidate schools could be activated only with War Department approval, and the selection of officer candidates was a corps area responsibility, no formal plans were announced. The Medical Field Service School, however, was charged with the responsibility for preparing a 3-month training program in the event of such authorization. The peakload of trainees for both of these programs was estimated at 2,000 by the 60th day of mobilization.

Officers destined for duty outside field medical service units were to be trained by a variety of techniques. The Army Medical Center, charged with concentrating available facilities on the training of enlisted specialists, made no provision for the continuing training of incoming professional officers. General hospitals were charged with the responsibility of training key administrative officers for general, surgical, and evacuation hospitals. Medical supply depots were required to train officer replacements for similar depots destined for both the Zone of Interior and theaters of operations. Any officer not attending one of these facilities was to receive refresher training "in the troop schools of the units concerned." Enrollment and classification of nurses, dietitians, and highly trained technicians were responsibilities of the American Red Cross, and these people were to be given only routine training. Recruitment of nurses was a responsibility of the commanders of corps areas.²⁹

Affiliated units.—The most serious defect of the War Department Protective Mobilization Plan, from the viewpoint of the Medical Department, was its failure to provide adequately for the creation of hospital professional staffs. On paper, the Medical Department was required simply to mobilize 32 general, 17 evacuation, and 13 surgical hospitals, in addition to the units required by corps, army, and General Headquarters Reserve, but in practice, the creation of a hospital required more than the simple assignment of professional personnel and the allocation of equipment according to tables of authorization. To carry out their mission, both mobile and fixed hospitals were required to be completely integrated units, with a harmonious staff of competent physicians and surgeons who could function as a team. During World War I, the use of affiliated units, hospital staffs drawn from a single parent civilian medical institution, demonstrated its value in allowing the Medical Department to avoid the time-consuming problem of solving the complicated equation of professional skills required by a medical team. After the war, the close relation between The Surgeon General and civilian institutions had continued, but in 1924, as a result of War Department policies requiring the decentralization of Reserve affairs, affiliated hospitals were transferred to corps area control, and in 1928, the Medical Department lost control of personnel assignments to these organizations. Between 1928 and 1939, age and frustration with the obstacles created

²⁹ See footnote 28, p. 16.

by corps area administration caused many key officers to resign or allow their commissions to lapse and many of the affiliated units disintegrated.³⁰

The Surgeon General was convinced that the only possibility of developing a properly integrated peacetime reserve of medical units, particularly evacuation, surgical, station, and general hospitals, suitable for mobilization under the War Department Protective Mobilization Plan lay in the revitalization of affiliated units. Despite the failure of that plan to specifically include such units, authority for their utilization existed in a War Department publication, MR (Mobilization Regulations) 1-1, dated 14 August 1938, which stipulated that: "Procurement of entire organizations, where advantageous to expedite their formation with trained personnel or for other appropriate reasons, may be utilized for elements requiring a relatively large number of occupational specialists, as in the case of certain engineer, signal, and medical units. When corps area commanders desire to provide such procurement, they will request the authority of the War Department in each such case."

In March 1939, The Surgeon General recommended to the War Department that selected medical institutions be invited to create or maintain affiliated organizations. By October, after a lengthy struggle over personnel policies, the War Department authorized The Surgeon General to organize affiliated hospitals from a list of selected institutions and to appoint personnel. Planning for the organization of affiliated units was still not completed by the end of 1939, when The Surgeon General's Protective Mobilization Plan was issued. At that time, activation of units was a corps area responsibility when directed by the War Department, while the Medical Department retained control over organization and promotion. Few formal plans were made for training after activation, because the period between activation and utilization would be so short that performance depended heavily on the proper prior selection personnel.³¹

Enlisted personnel.—Training enlisted men to perform the duties of the Medical Department in a mobilized Army presented serious problems. For practical purposes, there was no reserve pool of skilled manpower comparable to that existing for Medical Department officers. The enlisted strength of National Guard medical units was inadequate for the support of mobilized National Guard divisions, and the Enlisted Reserve did not exist in meaningful numbers. But enlisted men were required for supporting duties ranging from the common specialties of truck driving, cooking, and litter bearing, to the technical specialties of X-ray technician, surgical technician, and dental assistant.

Under the prevailing system of War Department control, The Surgeon General was directly responsible for the activation of named general hospitals and installations classified as exempted stations. The activation and administration of other medical units, as well as the establishment of Medical Department Unit Training Centers and Enlisted Replacement Training Centers, were corps area responsibilities. The Medical Department was responsible only for the technical supervision

³⁰ Letter, The Surgeon General to The Adjutant General, 17 Mar. 1939, subject: Affiliation of Medical Department Units with Civil Institutions, and Appointment and Promotion in Medical Corps Reserve.

³¹ See footnotes 1 (3), p. 1; and 28, p. 16.

of training at these installations for the preparation and issue of training programs. Enlisted training in the Medical Department followed lines laid down by the War Department for the entire Army. After a short period at corps reception centers, devoted to discipline and physical conditioning, recruits were to be selected and sent to branch replacement centers for initial training. Both Enlisted Training Centers and Unit Training Centers for the Medical Department were to be opened at Fort George G. Meade, Md., Fort Oglethorpe, Ga., and Fort Warren, Wyo., during the first 30 days of mobilization. Medical Department enlisted training was restricted to basic subjects and military discipline, on the principle that success lay "not in the actual technical training given the soldier, but in having suitable men for such training properly selected from those with similar civilian vocational training." Unit training centers, responsible for the training of nondivisional units, and divisional units activated after the 30th day of mobilization, were to be activated under similar controls.

Anticipating a shortage of critical technical skills, plans called for the activation of training facilities for nonprofessional enlisted specialists. Courses were to be offered to qualify men as X-ray, medical, surgical, pharmacy, dental, sanitary, and laboratory technicians. Installations charged with the responsibility for providing facilities included the Medical Field Service School, the Army Medical Center, and named general hospitals under The Surgeon General's direct control. Each installation was to be prepared to begin training on 10 days' notice and to draft programs of instruction to be incorporated in its own mobilization plan.

Mobilization cadres.—In addition to other requirements, the necessity of providing cadres for newly activated units placed a serious strain on the Medical Department's limited resources. During the first 30 days of mobilization, planners had to rely heavily on the expedient of draining trained manpower from existing units and installations. Three exempted installations alone—Army Medical Center, Fitzsimons General Hospital, and Army and Navy General Hospital—were to furnish 44 officers, 20 nurses, and 27 enlisted men during the first 30 days of mobilization. Other exempted installations and those under corps area command were to provide corps area commanders with 2,201 officers and 829 enlisted men for cadre duty during the same period. The following month, 1,070 officers and 1,122 enlisted men would be required, but it was hoped that these could be selected from less experienced personnel who could receive additional training at Unit Training Centers before being assigned to newly activated units. After this initial drainage, staff planners expected to draw cadre from officers in training and enlisted graduates of the replacement training centers.

The precipitous mobilization envisioned by staff planners would have severely strained the manpower and facilities of the Medical Department. Unlike a fighting arm, which could usually count on an indefinite period after basic training and unit training to improve its skill before being committed to combat, the Medical Department had to care for the health of an expanding Army and simultaneously prepare for its role in combat medical support. Peacetime experience had proved that over 80 percent of the Medical Department's statutory allocation of 5 percent of the enlisted strength of the Army was required in routine health care. But

mobilization plans called for the use of over 20 percent of the Department's strength for cadre duty alone, with an unspecified force required for War Department overhead and training at special service schools. Fortunately, the precipitous mobilization envisioned by staff planners never occurred.

Negro troops.—The use of Negro troops presented a complex problem for War Department planners. Failure to achieve racial balance in mobilization for World War I had resulted in bitter criticism, and top level planners were determined to avoid repeating the mistake of discriminatory recruitment during the enlistment period and the subsequent disproportionate drafting of Negroes required to restore racial balance in later phases of mobilization. But, at the same time, fear that public endorsement of policies favoring racial balance would result in criticism of the disproportionately white peacetime Army led the War Department to keep its policies secret from all but a few top level planners. It was not until 1937 that new plans for the utilization of Negro troops were incorporated into mobilization regulations, which were then in the process of revision. This step resulted in only a limited dissemination of policies because access to mobilization regulations was restricted to a few headquarters, including corps area commanders and the chiefs of the arms and services. And even then, lag time in printing and the practice of issuing revisions in segments resulted in an unabsorbed and unfamiliar body of doctrine.

In theory, policies revealed in the revision of 1937 provided for the creation of a racially balanced, segregated Army. Negroes and whites were to be regarded as separate, but almost equal. Negro manpower was to be incorporated into mobilization plans in a ratio equal to their proportion of population of military age, and corps areas were to provide manpower according to manpower ratios in their respective geographical areas. Negroes and whites were to be utilized in representative proportions in both the arms and the services. Negro units could be commanded by either Negro or white officers, preferably Negroes when qualified officers were available. No decision was made concerning the level of command at which separate units would be organized.

On the eve of Pearl Harbor, the U.S. Army had failed to fully implement the policies of 1937. Negro manpower was well below the 9-percent level regarded as a representative proportion, and Negroes were distributed unevenly within the arms and services. Three-fifths of the entire number were almost equally divided between infantry, engineer, and quartermaster units. In the Air Corps, Medical Department, and Signal Corps, less than 2 percent of all enlisted men were Negroes.³²

Within the Medical Department, plans for the utilization of Negro manpower were limited. Citing mobilization regulations, The Surgeon General's Protective Mobilization Plan provided that the percentage of Negro manpower in installations under his direct control would be at least equal to the percentage of Negroes in the total male population of military age. Specific provision for the mobilization of Negroes at exempted installations was not incorporated into the plan, and openings for Negroes in activities under corps area command, over which The Surgeon General had only indirect control, were far below population ratios.³³

³² Lee, *Ulysses: The Employment of Negro Troops*. United States Army in World War II. Special Studies. Washington: U.S. Government Printing Office, 1966.

³³ See footnote 28, p. 16.

It was not until 1940 that the Medical Department began to make plans for utilization of its share of Negro manpower. In October 1940, Negro wards were established at certain hospitals in the United States, and The Surgeon General recommended the establishment of a new type of unit to absorb most of the Negro increment of enlisted personnel. In November 1940, this "sanitary company" was authorized for the performance of unspecified general duties. At the same time, it was clearly stated that the Medical Department would not willingly create mixed detachments unless such a policy was adopted by both the arms and the services. Because The Surgeon General would not willingly adopt a policy which forced white soldiers to accept treatment by Negro physicians and personnel, further decisions on the size and type of Negro units had to be postponed until the War Department announced the size and type of Negro units the Medical Department would be servicing.³⁴

The Limited Emergency

Within months after the publication of the War Department Protective Mobilization Plan, and even before The Surgeon General was able to issue the Medical Department's subordinate plan, events were set in motion that began to transform U.S. mobilization from the anticipated crash program to a gradual buildup of forces. The U.S. responses to the degeneration of world affairs in the late 1930's had been cautious, and even after the outbreak of hostilities in Europe, U.S. response was limited. Between 3 September 1939, when Britain and France declared war on Germany, and the Japanese attack on Pearl Harbor, U.S. mobilization was carried out not as a result of planning but in sporadic response to a gradually deepening world crisis. On 8 September 1939, 7 days after the beginning of World War II in Europe, President Roosevelt responded with the declaration of a limited national emergency, the meaning of which was not entirely clear. In the same proclamation, the President authorized an increase in the enlisted strength of the Army from 210,000 to 227,000, and an increase of National Guard strength to 235,000 men. Despite the disappointment of Army planners, who had hoped for authorization to increase the Army to its full peacetime enlisted strength of 280,000, the emergency proclamation and the 17,000 increase in troop strength were not without benefits. Limited emergency powers allowed the War Department to increase the number of National Guard armory drills from 48 to 60 per year and to increase the length of their summer camps to 3 weeks. Immediately following the President's declaration, Gen. (later General of the Army) George C. Marshall, Chief of Staff, issued orders reorganizing the Army from its three square divisions, consisting of four regiments, to five new triangular divisions of three regiments each. The new divisions, together with the troop increase, allowed the creation of corps and army headquarters to give higher commanders an opportunity to gain experience in the techniques of large-scale field operations. Late in the spring of 1940,

³⁴ See footnote 1 (3), p. 1.

some 70,000 Regular Army troops were assembled for the first corps and army maneuvers since 1918.³⁵

In the months following the fall of Poland, fiscal caution and the fear that increased strength would lead to U.S. involvement in a European war led Congress to adopt a noncommittal attitude toward further military expansion. It was not until the German armies began the campaign on 10 May 1940 that by 22 June had forced evacuation of the British Expeditionary Force and the surrender of France that Congress was spurred to action. Within weeks of the renewal of the German offensive, Congress surpassed Presidential recommendations in two separate bills that brought the total authorized Army troop strength to 375,000 and increased War Department appropriations to nearly \$3 billion. Two months later, when threatening German attitudes and the uncertain future of the French Fleet raised the possibility that most of the Regular Army would have to be dispatched to Latin America, leaving the Nation defended solely by raw recruits without adequate cadre to train them, Congress again took the bit in its teeth. Despite both Executive and General Staff restraint, Congress passed a joint resolution on 27 August authorizing the President to call the National Guard and Reserves to active duty for 1 year, and on 16 September, it passed the Burke-Wadsworth bill, authorizing Selective Service for 1 year. By two acts, Congress had, in effect, authorized the strength of the Army to be temporarily increased to 1.4 million men.³⁶

Saddled with a massive expansion, the Army turned its full attention to inducting, training, equipping, quartering, and organizing its expanded forces. During the next year, the Army managed to overcome difficulties that have since become legend and organized a ground force consisting of four armies of nine army corps and 29 divisions, and an armored force of four divisions, including support troops. By staggering inductions and the activation of National Guard units, the Army was expanded sixfold during 1941. Even before expansion was completed, however, the General Staff faced the threat of demobilization when the authorization for Selective Service and National Guard activation expired. In Congress, a more relaxed national attitude toward the war, prompted by the persistence of British defenses and the diversion of German offensive forces against Russia, weakened the hand of interventionists and threatened the continuation of mobilization efforts. It was only at the last moment, and by a narrow margin, that Congress, on 12 August 1941, extended the service of men on active duty for 1 year and voted to continue Selective Service.³⁷

By December 1941, when Japanese attacks ended debates over U.S. commitment, the Army was more thoroughly prepared for the outbreak of war than ever before in its history. Troop strength projected for the third phase of the Protective Mobilization Plan of 1939 had already been reached, and 36 divisions, with their support troops, had been activated. Many of these units were admittedly understrength, poorly equipped, and manned by recruits with limited training. It would

³⁵ (1) Biennial Report of the Chief of Staff of the United States Army to the Secretary of War, 1 July 1939 to 30 June 1941. Washington: U.S. Government Printing Office, 1941. (2) See footnote 26, p. 14. (3) Weigley, Russell F.: *History of The United States Army*. New York: The Macmillan Co., 1967.

³⁶ See footnotes 26, p. 14; and 35 (1) and (3).

³⁷ See footnote 35 (3).

be many months before the Nation could do more than assume the defensive and minimize the loss of outlying possessions but, at the same time, industry had begun its retooling, supplies had been ordered, the machinery for induction and training had been established, and the cadre for expansion was being created. As inadequate as these preparations would appear, once war had begun, mobilization was accomplished less painfully than it could have been from the troop base of 1939.

In the months preceding Pearl Harbor, the Medical Department expanded even more rapidly than the Army as a whole, sharing in common its problems and growing pains. Between June 1939 and December 1941, Medical Department enlisted strength grew from less than 10,000 to over 107,000, increasing proportionally from less than 5 percent to 6.4 percent of the strength of the entire army. Officer strength increased similarly from 6.1 percent to over 7.7 percent of the strength of the officer corps. This more than proportional expansion, made necessary by the requirement to create field medical units as well as administer routine medical care, began in 1940, when Congress lifted the statutory strength limitation of the Medical Department from 5 to 7 percent, and authorized the President to make further increases in the event of hostilities.³⁸ By June 1941, all tactical units attached or assigned to field forces had been activated at table-of-organization strength, including the organic medical units below division level; 34 divisional medical battalions, regiments, and squadrons; nine corps level medical battalions; and seven army level medical regiments.

The activation of so many new units would have been a difficult task, even had a large number of field medical units existed from which trained cadres might have been drawn. As it was, hospitals assigned to the field forces had to be activated on the basis of one-half enlisted and nominal officer strength. Numbered general hospitals, for example, were activated with five officers and 250 enlisted men, when their table of organization entitled them to 73 officers, 120 nurses, and 500 enlisted men. These units, including 22 station hospitals, 22 general hospitals, 17 evacuation hospitals, and eight surgical hospitals, were activated in the belief that their limited strength would provide a trained nucleus of enlisted personnel for the activation of affiliated units if and when called to duty and to train the cadre for additional units. Finally, a number of Medical Department installations, including nine named general hospitals (750-2,000 bed), 10 supply depots, eight corps area laboratories, and 175 station hospitals (50-2,000 bed) were fully staffed, equipped, and placed in operation. The strain placed on the Medical Department, even by the comparatively gradual expansion of 1940-41, stretched its facilities to the limit and pointed up the need for having medical facilities available before mobilization began.³⁹

Training the Expanding Army, 1939-41

With the passage of time, the problems of training the Army created between 1939 and 1941 have become legendary. Ideally, an army should be built from the

³⁸ See footnote 1 (3), p. 1.

³⁹ (1) Annual Report of The Surgeon General, U.S. Army, 1941. Washington: U.S. Government Printing Office, 1941. (2) Wakeman, F. B.: Medical Department Training. Army M. Bull. 57: 46-49, July 1941.

bottom up, beginning with the conditioning and training of the basic soldier, and progressing through unit tactics from the lowest to the highest level of field organization, in order to weld individuals into seasoned, efficient combat teams and to develop the command leadership and staff techniques necessary for managing large units on the battlefield. With the activation of the National Guard and the passage of Selective Service legislation, manpower became immediately available. But the timelag required between appropriations and the procurement of equipment and facilities, in combination with the drainage of critical material through lend-lease, forced the implementation of less than ideal training procedures.

During the year between the President's declaration of a limited emergency and passage of the Selective Training and Service Act, training programs centered on integrating the additional troops authorized in 1939 into the Army's new triangular divisions and field testing these divisions in large-scale maneuvers. During September and October, armory drills for the National Guard were increased by 12, and 7 additional days of summer field training were authorized. Five complete Regular Army divisions and one cavalry division were assembled for intensive field training, and corps area commanders were ordered to assemble their nondivisional troops for similar training. In January 1940, the 3d Division, assembled at Fort Lewis, Wash., participated in amphibious exercises near Monterey, Calif. In April 1940, 3 weeks of corps maneuvers were held at Fort Benning, Ga. During the same period, division and corps troops maneuvered in eastern Texas, followed by 3 weeks of corps against corps maneuvers in the Sabine River area of Louisiana. The spring maneuvers of 1940 focused attention on the training weaknesses of the Army: lack of equipment, poor minor tactics, lack of basic leadership in many units, and some inept command leadership by senior officers. Such weaknesses could be corrected only by the tedious process of basic, small unit training. Maneuvers reinforced the idea that training must begin at the bottom and provide uniform and standardized instruction focused on the fundamentals of soldiering.⁴⁰

Little could be done to correct deficiencies without additional appropriations. Shortages of equipment and facilities were aggravated by the sudden decision to federalize the National Guard and to inaugurate Selective Service. The original request for National Guard federalization had been made in May, not only to gain control of its manpower and equipment, but also to utilize summer camps while preparing winter quarters. The prolonged debate that followed consumed most of the summer, and resulted in the activation of the National Guard, Selective Service, and the prospect of having to give basic training to a large number of raw recruits. In contrast to World War I, in which newly activated units were given basic training and shipped overseas, the Army now faced the unanticipated problem of housing its expanded troop strength for a protracted period, and providing large unit training areas. Supply bottlenecks and the onset of winter forced planners to place the rate of induction and activation below planned schedules and to pursue less than ideal training programs.

Until replacement training centers could be completed, selectees were assigned

⁴⁰ See footnote 26, p. 14; 27 (2), p. 15; and 35 (1) and (3), p. 22.

directly to Regular Army and National Guard units, where basic training and advanced unit training were conducted concurrently. Although the replacement training center program was initiated immediately and 21 centers opened as rapidly as construction could be completed, the majority did not begin operating until March and April 1941 and did not reach maximum capacity until June. In the meantime, an annual training cycle was prescribed that divided the year into three 4-month periods: The first devoted to individual and small unit training; the second, to progressive combined arms training; and the third, to corps and army training. After replacement training facilities became available, selectees and recruits were subjected to basic training in their arm or service for a period of 13 weeks before being assigned to their units. The unit training centers called for in the Protective Mobilization Plan were never activated. When Pearl Harbor thrust new demands on the Army, the machinery for enlisted training was functioning. Tests conducted during the fall maneuvers in 1941 did not produce entirely satisfactory results, but the performance of units was well above that demonstrated in the spring of 1940.

Service schools.—During the initial phases of mobilization, service schools followed the policies laid down in the Protective Mobilization Plan and mobilization regulations. The Army War College and the Army Industrial College suspended operations in June 1940, and the Command and General Staff School shifted to a short course program in November 1940. Special service schools discontinued peacetime courses in June 1940, and initiated short courses designed to give refresher and specialist training to those Reserve and National Guard officers who could be spared to attend. In most instances, refresher courses were designed not only to provide basic instruction for company grade officers but also to teach them in such a manner that they would become capable instructors.

Because the pool of National Guard and Reserve officers was adequate for the mobilization of an army of 1.4 million, the officer candidate program was postponed through the 1940 phase of mobilization. Opposition to activating the officer candidate program was based on the fear that it would create a surplus of officers who would become a personnel problem for the Army. After General Marshall became convinced that the opportunity to earn commission would improve the morale of selectees, the officer candidate program was activated on a limited basis in July 1941. By the end of the year, officer candidate schools had graduated only 1,389 officers. Mass training was delayed until after Pearl Harbor. Had the program been delayed much longer, the time consumed in establishing programs and facilities might have produced a critical shortage of officers.

Doctrinal publications and training aids.—Among the lessons learned from mass mobilization for World War I had been the need for training literature. Following the war, both the General Staff and the Army War College conducted extensive studies on its preparation and use. By 1930, four types of War Department training publications were being issued—training regulations, technical regulations, training manuals, and field manuals. In practice, field manuals were most frequently used in military instruction. During the 1930's, the volume of training literature was expanded by the publication of new manuals and regulations designed to explain the use of new weapons and organizations. Finally, in

1938, the existing training literature was simplified by eliminating training regulations and replacing them with revised and expanded field manuals. Such revision became necessary, in any event, when the far-reaching organizational changes of 1939-40 and the new weapons and materiel being furnished under the rearmament program made nearly all field manuals obsolete. Revision of the old manuals was well underway by the end of 1941, but for most of the emergency period, training facilities had to either depend on obsolete manuals or create their own materials.

Responsibility for the revision of training literature was not vested in a single agency but was distributed among the service schools and special boards. Directives for the revision of field manuals made it clear that simplicity was as important an objective as bringing the material up to date; lecture-style writing, duplication, and complexity were to be eliminated at all costs. Most of the actual writing was done by the faculties of the Command and General Staff School and the service schools, in the belief that people who were experienced in teaching and instructional methods would be able to write better training manuals than specialists in a given subject. Despite dissatisfaction at the slowness of the work, and the difficulty of coordinating the work of different service schools to avoid duplication and contradiction, the policy of decentralized preparation continued throughout the war.

Supplementing written manuals and doctrinal publications were a wide variety of training aids. After World War I, Army service schools had developed an increasing number of devices, including charts, films, filmstrips, tables, mockups, and models, and other aids to add depth to ideas created by written and spoken words. Instructors in service schools had come to depend heavily on such devices, but with manuals, they were often not readily available in the early stages of expansion. When funds became available in increasing amounts after 1940, the training aids program was expanded, and by the middle of the war, maps, films, and filmstrips were available in ever increasing quantities. Eventually, the resources and experience of the motion picture industry were harnessed to the production of training aids. Throughout the war, however, many of the auxiliary tools of training were produced by small units, either for special purposes or because of individual inspiration on the part of unit commander, in training aids shops that were established down at least as far as the regimental level.

Before 1940, training schedules did not conform to any rigid pattern. Small units at company level and above usually prepared a master schedule for the entire year that included mandatory training subjects, but the sequence and hours allotted to them were left to the discretion of the unit commander and were subject to the availability of time and facilities. The Protective Mobilization Plan, however, included in its subsidiary plans a provision for mobilization training programs, which prescribed time allotments for training subjects in a desired sequence. The mobilization training programs, which were issued for each arm and service late in 1940, were rigid training schedules, allowing only such changes as were made necessary by local conditions. Experiences of the war were reflected by successive changes of the mobilization training programs and by changes in the length of the training period. The overall length of the replacement training program, for instance, varied from 13 weeks to 17, to 8, to 14, back to 13, and again to 17, usually to meet

a heavy demand for replacements in theaters of operations. The mobilization training programs standardized training and were useful to inexperienced officers. At times, however, they were not flexible enough to allow experienced officers to take advantage of their ingenuity and professional skill.

As teaching programs, mobilization training programs were in turn supplemented by subject schedules, which were, in effect, a syllabus for subjects specified in mobilization training programs. Prepared by the branch schools, these schedules consisted of an outline of the subject, instructions on how it was to be taught, and lists of required training aids and equipment necessary or desirable for a particular lesson. Training programs were also supplemented by a variety of devices by which higher commanders could influence the conduct of training. War Department training circulars were used to institute changes in training manuals until a given manual could be revised, and similar directives were published by subordinate commands. Many of these communications established broad training policies, emphasized current deficiencies, and prescribed special training. In sum, a body of regulations was created that not only outlined the training to be given but also specified its conduct and content.

Although mobilization made on-the-job training impractical, the Army continued to emphasize "learning by doing" in its training programs, disguised by the cumbersome phrase "applicatory training." In practice, methods of instruction emphasized five basic principles: preparation, explanation, demonstration, application, and examination. The technique was efficient for mass transmission of a limited body of knowledge but was often limited by the availability of equipment and training aids, particularly in the early stages of mobilization. To overcome this handicap, training centers frequently had to pool resources and utilize training committees composed of officers and noncommissioned officers specially trained for some phase of instruction. Testing, at all stages of instruction, was used to measure the effects of training.

The Administration of Training

Until the fall of France, the Army within the continental United States was administered through nine geographic divisions known as corps areas. Commanders of corps areas not only controlled the "housekeeping" functions of the Army in the Zone of Interior but also were responsible for the training programs of the arms and services, except for those activities directly under branch control. In theory, a framework of four army areas was superimposed on this structure, which, in case of hostilities, would become responsible for tactical training and operations. In the event of mobilization, plans called for the activation of a General Headquarters to command the field forces in army areas.

The headquarters envisioned by Army planners was created and injected into the Army command structure on 26 July 1940. When activated, General Headquarters consisted of a Chief of Staff and a small group of officers selected to perform its initial function—the supervision and training of tactical ground forces in the continental United States. On 3 August 1940, Brig. Gen. (later Lt. Gen.) Lesley J.

McNair was appointed to command General Headquarters. A second step toward a wartime organization was taken in October 1940, when command of the four field armies was separated from that of the corps areas.

In theory, responsibility for the several phases of training was clearly delineated in the General Headquarters concept. Commanders of corps areas and the chiefs of the arms and services continued to exercise their preemergency control of the basic training of personnel in their spheres of responsibility and in the newly activated replacement training centers. General Headquarters was designed to take over when these commanders had completed their responsibility and to train the units filled by graduates of replacement training centers. In garrison, troops remained under the jurisdiction of corps area and post command, but in the field, command and support became the responsibility of General Headquarters. Ideally, the system should have created four independent field armies capable of prompt and effective tactical movement, but in practice, the ideal was never achieved. Army commanders were never fully liberated from the responsibility for post command, the delegation of training responsibility remained incomplete, and General Headquarters remained subject to War Department General Staff, G-4, in matters of supply. Until March 1941, when replacement training centers began to function, newly activated units of the forces under General Headquarters command were filled with selectees directly from civilian life. Much of General Headquarters energy was consumed in training raw recruits, tactics, discipline, and the use of weapons, instead of the advanced unit training for which it was intended.

The duties of General Headquarters were, for the most part, of a general nature. Seven officers were assigned to General Headquarters in August 1940, and as late as June 1941, as few as 23 were on its staff. General McNair's energy and ability enabled him to translate the Chief of Staff's strong views on the necessity of step-by-step training into action, as well as the traditional Army view that training should begin from the ground up. But aside from these accomplishments, General Headquarters ambiguous position and limited strength made it a difficulty to function as intended. When the addition of command and planning responsibilities in the summer of 1941 brought it into conflict with the War Plans Division, the War Department began to consider reorganization.⁴¹

The Reorganization of March 1942

The Army reorganization of March 1942, which served as the basis for Zone of Interior administration throughout the war, was the product of conflicts produced by overlapping responsibilities under the existing War Department structure and the increasing administrative burden on the Chief of Staff created by Army expansion. After a lengthy period of study, reorganization was effected by Executive order on 9 March 1942.⁴²

⁴¹ (1) Greenfield, Kent Roberts, Palmer, Robert R., and Wiley, Bell I.: *The Organization of Ground Combat Troops. United States Army in World War II. The Army Ground Forces.* Washington: U.S. Government Printing Office, 1947. (2) Millett, John D.: *The Organization and Role of the Army Service Forces. United States Army in World War II. The Army Service Forces.* Washington: U.S. Government Printing Office, 1954.

⁴² See footnote 41 (2).

Under the new organization, only a limited number of officers had direct access to the Chief of Staff, including the General Staff and the three chiefs of Zone of Interior administrative agencies. The General Staff was to be composed of a small group of officers who would assist the Chief of Staff in strategic planning and coordinate the activities of theater commanders with Zone of Interior agencies. Zone of Interior administration would be accomplished through three commands reporting directly to the Chief of Staff: Army Air Forces, Army Ground Forces, and Army Service Forces. The new air command had its own general and administrative staffs and the responsibility for training and equipping air units both for independent operations and for combined exercises. Army Ground Forces became responsible for organizing and training ground combat troops previously controlled by General Headquarters and absorbed most of the functions controlled by the previously semiautonomous chiefs of the combat arms. Army Service Forces was charged with relieving the fighting arms of the problems of supply, procurement, and housekeeping administration. Because the Chief of Staff was determined that no more than three commands in the United States would report to him, Army Service Forces assumed all responsibilities which did not fit into the structure of Army Air Forces and Army Ground Forces, including the technical services. The Medical Department, as one of the technical services, now reported directly to the Commanding General, Army Service Forces, instead of to the Chief of Staff.⁴³

In addition to its mission of supply and procurement, Army Service Forces was charged with routine administrative and housekeeping duties, including certain Armywide functions, such as "preliminary training, manpower mobilization, and labor relations; operation of reception centers, replacement training centers, and training schools for the supply arms and services; technical training of individuals, basic training of service troops, and technical training of service units; and the furnishing of ASF personnel to the Army Air and Ground Forces, theaters of operations, and overseas forces * * *."⁴⁴ To carry out this mission, Army Service Forces was given control of those installations responsible for administrative and housekeeping duties, including the corps areas, and many installations which had previously been under the control of the chiefs of the arms and services. To emphasize this change, the title of the corps areas was changed to Service Commands, Army Service Forces. To facilitate administrations, all Army field installations in the Zone of Interior were placed under four categories of control. Those under the direct control of Army Service Forces, including supply and training facilities, and all named general hospitals, except the Army Medical Center, were categorized as class I installations and placed under the commanding generals of service commands. Class II installations were those where Army Ground Forces units were stationed, and Army Service Forces duties were confined to housekeeping and administration. Class III installations were those similarly occupied by Army Air Forces units. Class IV installations were those that, because of their technical nature, remained under the direct command of a supply or administrative service.

⁴³ Initially called SOS (Services of Supply), the name of the command was changed to ASF (Army Service Forces) by War Department General Orders No. 14, 12 Mar. 1943. It is best known by this designation, which will be used hereafter.

⁴⁴ See footnote 41 (2), p. 28.

In this redistribution of authority, The Surgeon General not only lost direct control of most of the Medical Department's exempted installations but also lost a great deal of control over the activities of the Air Surgeon and the medical service he commanded.⁴⁵

The reorganization of 1942 placed a capstone on the structure of command and control which had gradually been evolving since the introduction of the General Staff system. Throughout the interwar period, as part of the special staff, the chiefs of the technical services had acted as technical advisers to War Department General Staff, G-3, in matters of troop training. Well before 1939, The Surgeon General had become established as the final source of technical doctrine for the training of medical troops, and the War Department had charged the Surgeon General's Office with the responsibility for developing programs for the individual and unit training of all medical troops, as well as preparing Medical Department training materials for publication. The Surgeon General continued to be the ultimate source of training doctrine and official War Department training guides and materials for all medical soldiers throughout the war. The War Department reorganization of March 1942, which reduced the staff level of the chiefs of technical services and placed them under the Commanding General of Army Service Forces, modified only administratively The Surgeon General's responsibility for the formulation of Medical Department training doctrine, program guides, and instructional materials. Before the reorganization, The Surgeon General discharged this responsibility as an agent of the War Department; after the reorganization, he discharged it as an agent of the Commanding General, Army Service Forces.⁴⁶

In contrast with the control of technical doctrine, The Surgeon General's command relationship to the staffs of installations training medical troops was seriously modified by the reorganization of 1942. During the interwar period and the first 2 years of the emergency, direct command of the facilities and staff for training medical troops was divided between corps area commanders and The Surgeon General. Corps area commanders had immediate jurisdiction over the training of medical soldiers at all posts, camps, and stations that were not reserved for The Surgeon General by War Department directive. At the beginning of the limited emergency, the exempted stations consisted of the Medical Field Service School; Army Medical Center, including Walter Reed General Hospital; the other four named general hospitals; and medical supply depots.⁴⁷ Commanding officers of exempt installations were directly responsible to The Surgeon General for all administrative and supervisory activities affecting training. They were responsible to corps area commanders in matters of supply, communication, courts-martial, and the discipline and military bearing of their troops. Because all service school courses were conducted at either the Medical Field Service School or the Army Medical Center, The Surgeon General had direct control over all such courses. Control of the basic training of recruits was shared by The Surgeon General and the commanders of corps areas; recruits at exempted stations were trained by their commanders, and

⁴⁵ See footnote 6 (2), p. 5.

⁴⁶ Army Regulations No. 170-10, 10 Aug. 1942.

⁴⁷ Army Regulations No. 170-10, 10 Oct. 1939.

others were trained under corps area jurisdiction. As the Army expanded to meet emergency and wartime needs, facilities for training medical troops were dramatically expanded. Changes in the command authority over Medical Department training facilities were so frequent and diverse that they must be reviewed by category to be meaningful.

Control of basic training.—In the interwar years, the initial training of a Medical Department recruit was usually accomplished on-the-job at the dispensary or hospital to which he was assigned. Compared with basic training during the war, little emphasis was placed on drill and field training. When Selective Service began to bring large numbers of new men into the Medical Department, recruits were sent from reception centers either to Medical Department field units, which were activated in increasing numbers after July 1940, or to the Medical Replacement Training Centers, which began being activated in February 1941.⁴⁸

The Surgeon General's relationship to the Medical Replacement Training Centers had a checkered history. The first centers, established at Camp Lee and Camp Grant in January 1941 and at Camp Barkeley in November 1941, were corps area installations,⁴⁹ even though plans for the centers were developed in the Office of The Surgeon General. In December 1941, these centers were designated exempt stations and placed under command of The Surgeon General.⁵⁰ Camp Joseph T. Robinson, Ark., established in January 1942, operated under a different command relationship to The Surgeon General for a period of 8 months, being placed under the control of the Chief of Infantry for administration and The Surgeon General for training.⁵¹

The War Department reorganization of March 1942 made no immediate change in The Surgeon General's relationship to the Medical Replacement Training Centers at Camps Lee, Grant, and Barkeley, which were exempted stations, but the center at Camp Robinson became an installation of the newly created Army Ground Forces when that command absorbed the functions of the Chief of Infantry. In July 1942, the Surgeon General's Office requested that the center at Camp Robinson be placed on exempted status to eliminate the "long and circuitous procedure of securing concurrences before ordering personnel in and out of this center."⁵² The request was not approved, and Camp Robinson remained under the administrative control of Army Ground Forces until August 1942, when it became a class I installation of Army Service Forces.⁵³ Meanwhile, in June, the Medical Replacement

⁴⁸ See footnote 5, p. 3.

⁴⁹ (1) Letter, The Adjutant General to Commanding Generals, Second thru Ninth Corps Areas; Commanding General, GHQ, Air Force; Commanding Officer, Edgewood Arsenal, Md.; and Commanding Officer, Aberdeen Proving Grounds, Md., 13 Jan. 1941, subject: Replacement Centers. (2) Letter, The Adjutant General to Commanding Generals, Seventh and Eighth Corps Areas; Chief Signal Officer; The Surgeon General; and Chief of Infantry, 23 Oct. 1941, subject: Activation of Replacement Training Centers.

⁵⁰ (1) Telegram, The Adjutant General to Commanding Generals, Medical Replacement Training Centers, Camp Grant, Ill., Camp Lee, Va., and Camp Barkeley, Tex., 20 Dec. 1941. (2) See footnote 6 (2), p. 5.

⁵¹ Letter, The Adjutant General to Commanding Generals, Third, Sixth, Seventh, and Eighth Corps Areas, Infantry Replacement Training Centers; Chief of Infantry; and The Surgeon General, 3 Jan. 1942, subject: Constitution and Activation of Medical Replacement Training Center, Camp Joseph T. Robinson, Ark.

⁵² Memorandum, The Surgeon General for Director of Training, Services of Supply, 6 July 1942, subject: Exempted Status Medical Replacement Training Center, Camp Joseph T. Robinson, Ark.

⁵³ Memorandum No. W170-1-42, The Adjutant General, 22 Aug. 1942, subject: Status of the Medical Replacement Training Center, Camp Joseph T. Robinson, Ark.

Training Center at Camp Lee was transferred to Camp Pickett,⁵⁴ and, in August, the exempted stations also became class I installations under the newly created service commands of Army Service Forces.⁵⁵

By this reorganization, the Medical Department lost direct command of the Medical Replacement Training Centers and was required to exert its influence through channels. Throughout the war, the formulation of doctrine remained a prerogative of The Surgeon General, along with the authority to draft training programs. Doctrine and training programs could be forwarded to the Medical Replacement Training Centers directly through the Commanding General, Army Service Forces, who retained direct control over these areas. The selection, assignment, and relief of staff and faculty personnel were similarly retained by the headquarters of Army Service Forces, and in December 1942, regulations were loosened to allow direct communication between the chiefs of technical services and training activities in matters of program, doctrine, and staff assignments. With the exception of the responsibility for faculty and staff assignment, which was transferred to service command jurisdiction in April 1943, these policies remained in effect until after the end of the war.⁵⁶

Control of units in training.—At the beginning of the limited emergency, only five medical field organizations were in existence. Of these, only the 1st Medical Regiment was under the direct command of The Surgeon General, and that because it was assigned to the Medical Field Service School as a demonstration unit. The other four units were responsible to the commanders of corps areas. Activation of new medical field units did not get underway until the middle of 1940, following the callup of National Guard units and the inauguration of Selective Service. Because these units were attached or assigned to corps, armies, and divisions for training, they came under the control of General Headquarters. The exceptions to this procedure were a few numbered general hospitals activated at full strength. Until the reorganization of 1942, The Surgeon General, as a member of the War Department Special Staff, was as responsible for the training of a medical battalion or an evacuation hospital, which would later have been classified as an Army Ground Forces-type unit, as he was with those later classified as Army Service Forces-type units, such as numbered general or station hospitals. The Surgeon General was frequently called upon for guidance by the commanders of both field and support units, and his representatives inspected both types of units.⁵⁷

The War Department reorganization of March 1942 radically modified this supervision by placing certain types of medical units under Army Ground Forces, others under Army Air Forces, and still others under Army Service Forces for training.⁵⁸ Control was complicated by The Surgeon General's new status, as far as

⁵⁴ Radiogram, Commanding General, Medical Replacement Training Center, Camp Pickett, Va., to The Surgeon General, 21 June 1942.

⁵⁵ See footnote 46, p. 30.

⁵⁶ Army Regulations No. 170-10, 24 Dec. 1942.

⁵⁷ (1) See footnotes 9 (2), p. 6; and 39 (1), p. 23. (2) Letter, The Adjutant General to Commanding Generals of all Armies, Army Corps, Divisions, Corps Areas, and Departments; Commanding General, GHQ Air Force; Chief of Staff, GHQ; Chiefs of Arms and Services; Chief of the Armored Force; and Commanding Officers of Exempted Stations, 14 Jan. 1941, subject: Organization, Training and Administration of Medical Units.

⁵⁸ War Department Circular No. 59, 2 Mar. 1942.

unit training was concerned, as an agent of the Commanding General, Army Service Forces, and the elevation of the Ground Surgeon and the Air Surgeon to the same level of organizational hierarchy. Under the new system, the Office of The Surgeon General retained as much influence over those units assigned to the Army Service Forces as it had in peacetime when these units were controlled through the War Department or General Headquarters and corps area commanders, but its relationship to the training of medical units assigned to Army Ground Forces or Army Air Forces became more remote. While The Surgeon General still formulated training doctrine and official instructional materials for all medical units, he no longer inspected units assigned to Army Ground Forces and Army Air Forces. The War Department reorganization of 1942 thus reduced the staff level on which The Surgeon General functioned as a training agent, and, in so doing, removed from his control large numbers of medical troops during their unit's training period.

The division of control of unit training among the three major commands did not seriously affect The Surgeon General's control of the basic training of medical troops. Recruits and selectees assigned directly to Medical Department field units between September 1940 and mid-1941, before the opening of replacement training centers, received all the basic training they were likely to receive before the reorganization. Their training was a responsibility of either exempted units under direct command of The Surgeon General or field units under corps area command and General Headquarters. Although the Medical Replacement Training Center at Camp Robinson was under the control of Army Ground Forces for a short period, it too was placed under Army Service Forces for the duration of the war in August 1942. Except for those men assigned directly to units in the initial stages of mobilization, all enlisted members of the Medical Department received basic training from training camps administered as class I installations of Army Service Forces, whether they were ultimately destined for assignment to Army Service Forces or Army Ground Forces.⁵⁹

Command of schools.—On 1 July 1939, only two Medical Department installations provided academic training: the Medical Field Service School, and the Medical Department Professional Service Schools, including the Medical, Dental, and Veterinary Schools at the Army Medical Center. In the course of the war, the number of schools was expanded heavily to meet requirements for technically trained personnel. Throughout the war, Medical Field Service Schools and the three professional service schools at the Army Medical Center remained under the direct command of The Surgeon General. Mobilization plans called for the establishment of enlisted training schools at exempted installations, which would have remained under direct control, and all but two of the 13 schools established between April 1941 and July 1942 were, at their inception, directly administered by the Medical Department. The exceptions were the Enlisted Technician's School at Station Hospital, Fort Sam Houston, Tex., and the Army School of Roentgenology at the University of Tennessee College of Medicine, Memphis, Tenn., neither of which was located at an exempted station. In July 1942, the newly created service commands, which superseded the older corps area commands under the Army

⁵⁹ Annual Report, Training Division, Operations Service, Office of The Surgeon General, fiscal year 1943.

Service Forces, absorbed most of the Medical Department's exempted stations and removed all but the Medical Field Service School and the Army Medical Center from The Surgeon General's direct control. Following the reorganization, the Office of The Surgeon General continued to exercise direct control over training programs and doctrine but was unable to exercise jurisdiction over personnel and administration at schools falling under the authority of the service commands.

Activities of the Training Division, Office of The Surgeon General

Within the Office of The Surgeon General, administrative authority over The Surgeon General's training responsibilities was delegated to the Training Division, which developed all Medical Department training programs; supervised the preparation of technical manuals, training films, and other training aids; formulated plans for Medical Department replacement centers and schools; supervised the activation of training installations; and inspected schools, units, and training centers for which The Surgeon General had supervisory responsibility. On 1 July 1939, the Training Division was actually a subdivision of the Planning and Training Division, staffed by one officer, as it had been since its creation in 1921. In spite of an increasing workload, growth of the subdivision was slow. It was not until January 1940 that the staff was increased to two officers, and when the United States entered World War II, the subdivision was staffed by only three officers. In February 1942, the Training Subdivision achieved division status, but there was no change in personnel until June 1942, when its staff was increased to five officers.

In August 1942, the Training Division was reorganized to parallel the structure of the Army Service Forces Training Division. Originally it had consisted of an Enlisted Branch, an Officer Branch, and a Publication Branch. Thereafter, it contained a Replacement Training Branch, a School Branch, a Training Doctrine Branch, and a Unit Training Branch. The Replacement Training Branch and the School Branch prepared plans for the inauguration of Medical Replacement Training Centers and Medical Department schools, recommended overhead personnel allotments and changes in the staff, wrote appropriate mobilization training programs, and inspected the installations involved. The Unit Training Branch was created to prepare programs for Medical Department communications zone installations, which were an Army Service Forces responsibility, and, in addition, recommended officer personnel for these units and evaluated their proficiency. The Training Doctrine Branch supervised the preparation of technical manuals, field manuals, training films, filmstrips, posters, and graphic training aids. In May 1944, the Replacement Training Branch and the Unit Training Branch were renamed the Regular Training Branch and the Readiness and Requirements Branch to conform with terminology used in the Office of the Director of Military Training, Army Service Forces, but the changes were in name only. The basic structure created by the reorganization of August 1942 remained in effect throughout the war.⁶⁰

⁶⁰ (1) See footnote 6 (2), p. 5. (2) Annual Report, Training Division, Operations Service, Office of The Surgeon General, fiscal year 1944.

CHAPTER II

Medical, Dental, Veterinary, and Sanitary Corps Officers

World War II did not produce radical changes in the pattern of training Medical, Dental, Veterinary, and Sanitary Corps officers. Expanding activities increased specialization and division of labor and intensified the specialization of training. Programs were divided into components that could be expanded into separate courses; other courses were shortened, and the pace of training was accelerated. New courses were added to provide officers with skills that had been traditionally acquired through informal training. Medical specialists required for the treatment of wounds and diseases uncommon in peacetime medical practice also required special training. When the increasing demand for physicians resulted in a transfer of nontechnical duties to MAC (Medical Administrative Corps) officers, some areas of training were deleted from the program. Training facilities were expanded from the Medical Field Service School, Carlisle Barracks, Pa., and the Army Medical Center, Washington, D.C., to include general hospitals, medical depots, civilian institutions, replacement training centers, and officer replacement pools. Despite these changes, however, the division of training into tactical and technical programs continued throughout the war; the addition of new facilities and courses reflected the Medical Department's expansion, and not a change in direction.

PERIOD OF FLUX: 1939-41

Continuing the Peacetime Program: September 1939-September 1940

Regular Army training

Aside from increasing emphasis on field medical service, the first year of the war in Europe produced few substantive changes in Medical Department training. The expansion of the Army that accompanied the limited emergency proclamation, and the conversion to triangular divisions that followed, allowed the Medical Department to organize field medical detachments for four divisions, four medical battalions, and an additional medical regiment. Activation of these units during the winter of 1939-40 was complicated both by the preponderance of recruits and by the relative inexperience of many of the officers who had been detached from hospitals to command them. At best, their performance in the spring maneuvers of 1940 was described as "creditable," and led to the observation: "The inexperience in all echelons of command in the use of these units showed the necessity of having in

being all of the tactical medical elements of mobile forces in order that all may be trained in respective responsibilities and cooperative action."¹

To provide basic field training for newly commissioned officers, and to complete the basic training of Regular Army officers who had not yet attended the Medical Field Service School, the Officers' Basic Course was shortened from 5 to 3 months, and offered twice annually. The change permitted a modest expansion: in contrast to the largest class in the preceding 5 years, 81 officers who graduated in 1935, 111 student-officers completed the basic course in 1940.²

An unusual opportunity to experiment with basic officer training developed in 1940, when the War Department directed the MFSS (Medical Field Service School) students to participate in the spring corps and army maneuvers.³ To prepare the basic officers' class for maneuvers, Lt. Col. (later Brig. Gen.) Charles B. Spruit, MC, recommended altering the course schedule to concentrate formal instruction in the month preceding maneuvers. "I am firmly convinced that the experience these * * * officers would obtain by actual participation in the greatest peacetime maneuver the Army has ever had, will be of far greater value to the service and to them than the solution of any number of map problems or participation in the field exercises at Indiantown Gap."⁴

After an initial period of instruction at Carlisle Barracks, students from the Medical Field Service School participated in both corps and army exercises. During the corps phase, at Fort Benning, Ga., half of the students were assigned to medical battalions, and half to regimental medical detachments. To give students a greater understanding in all echelons of support, assignments were reversed during the army phase of maneuvers, which were held in the Sabine River area of Louisiana. Eight members of the faculty, assigned as special medical observers and control officers, accompanied the class. Although reports on the performance of MFSS students were enthusiastic, particularly when contrasted to that of medical unit officers who had received no formal training, the maneuvers produced conflicting recommendations for future training. The Surgeon General supported Colonel Spruit's opinion that "the sending of these two classes to the Army maneuver was justified."⁵ The Medical Field Service School, however, took the position that, despite the value of the maneuvers, the time could have been better spent in independent medical exercises at Indiantown Gap, Pa., within a reasonable distance of Carlisle Barracks. Five weeks had been too short to prepare students for field exercises, and the time

¹ Annual Report of The Surgeon General, U.S. Army, 1940. Washington: U.S. Government Printing Office, 1941.

² (1) Annual Report of The Surgeon General, U.S. Army. Washington: U.S. Government Printing Office, 1935. (2) See footnote 1.

³ Letter, The Adjutant General, War Department, to The Surgeon General, U.S. Army, 25 Mar. 1940, subject: Courses of Instruction at Special Service Schools, 1940-41.

⁴ Memorandum, Lt. Col. Charles B. Spruit, MC, Chief, Training Subdivision, Planning and Training Division, Office of The Surgeon General, for Col. Albert G. Love, MC, Chief, Planning and Training Division, Office of The Surgeon General, 5 Jan. 1940, subject: Training at Carlisle as Affected by Coming Course and Army Maneuvers in the South.

⁵ (1) Letter, Lt. Col. Charles B. Spruit, MC, Chief, Training Subdivision, Planning and Training Division, Office of The Surgeon General, to The Surgeon General, U.S. Army, 14 June 1940, subject: Third U.S. Army Maneuvers, Army Phase. (2) Annual Report of The Surgeon General, U.S. Army, 1941. Washington: U.S. Government Printing Office, 1941.

spent on maneuvers was disproportionate.⁶ The school prevailed, and future maneuvers were confined to facilities adjacent to Carlisle Barracks.

Aside from these experiments with basic field training, few other changes were introduced into the training program for Regular Army officers. The basic graduate courses at the Army Medical Center were shortened by a month, but the number of students remained constant. The advanced course at the Medical Field Service School was lengthened by a month to provide special instruction in training methods for senior officers. In December 1939, advanced graduate courses at the Army Medical Center, scheduled to begin in February 1940, were canceled because officers could not be spared to attend them.⁷ Revision of the MFSS extension courses, instituted in 1939 as a 4-year plan to concentrate efforts on preparing young Reserve and National Guard officers for service in-grade, eliminated the special extension course for Regular Army officers preparing for promotion to lieutenant colonel or colonel. More elementary courses were still open to them, but only eight Regular Army officers enrolled.

National Guard and Reserve officers

The first year of the limited emergency produced as few changes in the training of Reserve and National Guard officers as it had in the Regular Army program. Until both elements were called to active duty in the fall of 1940, summer training camps and correspondence courses continued to provide the bulk of their training. In common with the Regular Army, Reserve components were trained with an increasing emphasis on field medical service. In addition to the usual basic- and unit-training camps held at the Medical Field Service School in the summer of 1939, summer camp training in field sanitation was conducted for 79 officers at newly constructed demonstration areas at Jefferson Barracks, Mo.; Camp Bullis, Tex.; and Fort Ord, Calif. Previously, sanitary demonstration areas were available only at Carlisle Barracks. To school National Guard units in the problems of cold weather operations, supplemental field training was required between October 1939 and January 1940. Basic- and unit-training camps were again held in the summer of 1940. Field training was supplemented as usual by extension courses, which were still in the process of being revised, and more than 11,000 officers of the Reserve and National Guard enrolled in them between June 1939 and June 1940. During the same period, one National Guard officer enrolled in the Army Veterinary School course in forage inspection.

The program of extension courses for field grade officers, dropped from the Regular Army program, continued to be available to senior officers in Reserve components. The usual fall advanced course, offered between 15 September and 28 October 1939, was attended by 25 officers. The following May, 14 officers in a special course for National Guard officers were unexpectedly given the opportunity to participate in the Third U.S. Army maneuvers in Louisiana, where they were able to gain practical experience as officers in various echelons of medical support.

⁶ Technical Report of Activities of the Medical Field Service School, Carlisle Barracks, Pa., fiscal year 1940.

⁷ Letter, Col. James E. Baylis, MC, Executive Officer, Office of The Surgeon General, to The Adjutant General, War Department, 27 Nov. 1939, subject: Advanced Course, Medical Department Professional Service Schools, School Year 1939-40.

Schools outside the Medical Department

Between September 1939 and September 1940, two Medical Corps officers of the Regular Army attended the Army War College, Washington, D.C.; one attended The Infantry School, Fort Benning, Ga.; three attended the Army Industrial College, Washington, D.C.; and four attended the Command and General Staff School, Fort Leavenworth, Kans. One VC (Veterinary Corps) officer, Regular Army, attended the Chemical Warfare School, Edgewood Arsenal, Md. The number of Regular Army MC (Medical Corps) officers attending the School of Aviation Medicine, Randolph Field, Tex., increased from 10 to 17, reflecting the emphasis at the beginning of the limited emergency on expanding the Air Corps. Eight MC Reserve officers also completed this course, and an additional 51 qualified for entrance by completing a required extension course. Twenty-eight Regular Army officers attended a variety of courses at 15 universities and foundations, and the Reserve officers continued to attend civilian institutions under the Skinner Plan.⁸

Growth and Transition: September 1940–September 1941

Activation of the Army's Reserve and National Guard components, and passage of the Selective Training and Service Act, accelerated training in the Medical Department as well as throughout the Army. Between September 1940 and the end of the summer of 1941, when the tours of men called to active duty were extended for an additional year, attention focused on providing maximum training within the additional year. Because a high proportion of Medical Department officers called to active duty had previous training, distinctions between programs for Regular Army, Reserve, and National Guard officers were eliminated, and schools concentrated on refresher training designed to prepare them for special duties in the Army of the United States. Existing special service schools were expanded, and new schools were opened to provide specialized training. Officers completing resident courses of instruction in the special service schools of the Medical Department and Medical Corps officers completing courses of instruction at service schools other than Medical Department schools for fiscal year 1941 are shown in the tabulation which follows:

	<i>Schools¹</i>	<i>Number</i>
Special schools:		
Medical Field Service School, Carlisle Barracks, Pa.....		2,119
Army Medical Center, Washington, D.C.....		247
Army and Navy General Hospital, Hot Springs, Ark.....		62
Letterman General Hospital, San Francisco, Calif.....		44
Fitzsimons General Hospital, Denver, Colo.....		94
William Beaumont General Hospital, El Paso, Tex.....		12
Station Hospital, Fort Sam Houston, Tex.....		35
Veterinary Meat Inspection Course, Chicago, Ill.....		114
Total.....		2,727

⁸ See footnote 1, p. 36.

*Schools¹ (Continued)**Number*

Other schools:

School of Aviation Medicine, Randolph Field, Tex.....	237
The Infantry School, Fort Benning, Ga.....	0
Army Industrial College, Washington, D.C.....	12
Command and General Staff School, Fort Leavenworth, Kans.....	12
Total.....	261

¹ Annual Report, Training Subdivision, Planning and Training Division, Office of The Surgeon General, fiscal year 1941, p. 16.

The expansion of medical officer strength, from approximately 2,000 to more than 14,000 during the first year of partial mobilization, produced far-reaching changes in Medical Department Special Service Schools. Based on the assumption that previous training equipped officers from Reserve components for general duties, plans formulated by The Surgeon General called for establishment of refresher courses to prepare officers for the assumption of special duties. All officers assigned to tactical units were to receive a 1-month refresher course at Carlisle Barracks. Those assigned for duty at hospitals were to attend schools set up at general hospitals, under The Surgeon General's direct control, and the remainder were to be assigned to special courses offered at the Army Medical Center and other installations.⁹

To provide basic training for newly commissioned medical officers, the last 3-month basic course was offered at the Medical Field Service School in the fall of 1940, and 73 officers were graduated.¹⁰ Beginning in December, a 1-month refresher course for Reserve and National Guard officers was substituted for the regular basic-training program. Because officers were needed to staff enlisted replacement training centers, emphasis had to be shifted from the tactical training planned for this course by The Surgeon General's Protective Mobilization Plan of 1939, to preparing Reserve officers to serve as instructors for the increasing numbers of enlisted men being brought into the Army by selective service. Emphasis on training instructors continued until April 1941, when the program was reoriented to tactical training. During August, a special 1-month course for instructors was again offered, followed by a month-long course given at the replacement training centers, to provide replacements for Reserve officers who wished to be relieved or rotated from training assignments at the end of their year of active duty, and to provide instructors for the expansion of training facilities. By shortening courses and expanding facilities, the Medical Field Service School was able to increase its training capacity

⁹ (1) Letter, The Surgeon General, U.S. Army, to The Adjutant General, War Department, 6 Sept. 1940, subject: Medical Department in Mobilization, inclosures thereto. (2) Letter, The Adjutant General, War Department, to The Surgeon General, U.S. Army, 15 June 1940, subject: Courses at Special Service Schools. (3) Letter, Col. James E. Baylis, MC, Executive Officer, Office of The Surgeon General, U.S. Army, to The Adjutant General, U.S. Army, 24 June 1940, subject: Courses at Medical Department Special Service Schools, inclosures thereto.

¹⁰ Goodman, Samuel M.: History of Medical Department Training, U.S. Army, World War II. Volume III. A Report on the Training of Medical Officers, 1 July 1939-30 June 1944. [Official record.]

by June 1941, from approximately 100 officers the previous year to more than 500 officers each month.¹¹

In addition to transforming the basic officer training program, activation of the Reserves and the National Guard produced other changes in the MFSS program. Special courses previously offered to officers of Reserve components were dropped from the program, including the advanced course offered for field grade officers. Thereafter, officers of all components were eligible for the same courses. With the exception of the summer camp held for ROTC (Reserve Officers' Training Corps) students in June 1941, all summer camps were eliminated.¹²

During the first year of mobilization, modifications in the programs of the three Medical Department Professional Service Schools at the Army Medical Center to meet demands for increased training produced a transition to the installation's wartime role as a center for technical training. The Army Medical School basic graduate course, which had been reduced from 3 to 2 months the previous year, was shortened to a single month in the fall of 1940, and subsequently discontinued. The professional specialist courses, which had long provided on-the-job training in clinical and laboratory procedures, were similarly eliminated after the last class of 20 graduated. The advanced graduate course, which had not been offered the previous year, was again suspended. These programs were replaced by a series of refresher courses, ranging in length to a maximum of 3 months, in surgery, clinical medicine, ophthalmology and otorhinolaryngology, roentgenology, and photoroentgenology. The special graduate course at the Army Dental School was again offered. The Army Veterinary School conducted special graduate courses in clinical pathology, and offered the usual courses in forage inspection. Both the Army Medical and Dental Schools participated in the Medical Department's administrative refresher training program. By June 1941, the facilities of the Professional Service Schools at the Army Medical Center had been expanded from a capacity of 100 officers the previous year, to more than 100 officers each month.¹³

Partial mobilization proved a mixed blessing for the Medical Department, simultaneously providing much needed manpower and increasing the demand for medical services. As graduates of accredited professional schools, MC Reserve officers were considered qualified both by training and by experience to care for the sick and injured, but few of those who entered the Army, after September 1940, had

¹¹ (1) The Surgeon General's Protective Mobilization Plan of 1939, with annexes. (2) Annual Report, Training Subdivision, Planning and Training Division, Office of The Surgeon General, fiscal year 1941. (3) Letter, Maj. E. D. Liston, MC, Acting Executive Officer, Office of The Surgeon General, U.S. Army, to The Adjutant General, War Department, 23 June 1941, subject: Additional Officers at Replacement Training Centers, inclosures thereto. (4) Letter, The Adjutant General, War Department, to Chief of Staff, General Headquarters; Commanding Generals, First, Second, Third, and Fourth U.S. Armies, 12 Dec. 1940, subject: Attendance at the Medical Field Service School, Carlisle, Pa. (5) Letter, Brig. Gen. Albert G. Love, Assistant Chief, Planning and Training Division, Office of The Surgeon General, to The Adjutant General, War Department, 22 Jan. 1941, subject: Training of Officer Cadres for Medical Replacement Centers, Camp Lee, Va. (6) Immediate Action Letter, Maj. E. D. Liston, MC, Acting Executive Officer, Office of The Surgeon General, U.S. Army, to The Adjutant General, War Department, 23 June 1941, subject: Additional Officers at Replacement Training Centers, inclosures thereto.

¹² (1) See footnote 5 (2), p. 36. (2) Special Report of the Medical Field Service School: Personnel Trained—Graduates of School Courses, 1921-41.

¹³ (1) Annual Report of Technical Activities, Medical Department Professional Service Schools, Army Medical Center, Washington, D.C., fiscal year 1940. (2) Letter, The Adjutant General, War Department, to The Surgeon General, U.S. Army, 31 July 1940, subject: Courses at Special Service Schools. (3) Annual Report of the Training Subdivision, Planning and Training Division, Office of The Surgeon General, fiscal year 1941.

any detailed knowledge of the administration of Army hospitals. Recognizing the need for training Reserve officers in administrative procedures before assigning them to hospitals, The Surgeon General authorized the Army Medical Center (Dental and Medical Schools), each of the named general hospitals, including William Beaumont, El Paso, Tex.; Army and Navy, Hot Springs, Ark.; Fitzsimons, Denver, Colo.; and Letterman, San Francisco, Calif.; and Station Hospital, Fort Sam Houston, Tex., to conduct refresher courses in hospital administration. Under this program, 50 officers could be assigned monthly to each installation to under-study jobs to which they would subsequently be assigned. On-the-job training would thus be available to Reserve officers in positions ranging from forage inspector and mess officer to commanding officer of a general hospital. Maximum capacity reached 300 per month when the program was placed in full operation on 1 April 1941, but sometimes full utilization was not possible because officers could not be spared from their duties to attend these schools.

By the end of June, about 340 officers, or slightly more than 1 month's capacity, had graduated. The following year, facilities were expanded to include 14 named general hospitals, with a capacity of 700 officers per month. Shortly thereafter, when the supply of Reserve officers had been exhausted, the refresher courses became a part of the Officer Pool Program and were offered to newly commissioned officers. Even later, when MAC officers began to replace MC officers in administrative positions, many of them received pool training in administration. Despite its changing title, its function remained the same, and a 30-day period of on-the-job training in hospital administration became a permanent feature of the World War II program.¹⁴

Except for this increase in size, other facets of the training program for MC officers remained unchanged. The program for revising extension courses continued, and 12,764 officers enrolled during the fiscal year. This was only a slight increase over the previous year's enrollment of 12,645, but its size is significant in view of the number of Reserve and National Guard officers who had been called to active duty during the year. At the same time, the facilities of civilian institutions continued to be used for the advanced training of selected MC officers. Between July 1940 and July 1941, 25 officers attended courses ranging in length from 5 days to 1 year at 10 civilian institutions. As a result of priority placed on expansion of the Air Corps, attendance at the School of Aviation Medicine increased more than tenfold in 1941. In contrast to the 17 officers who graduated as flight surgeons in 1940, 237 graduated in 1941. Attendance at the Army Industrial College and the Command and General Staff School also expanded, and 12 Medical Department officers graduated from each school.¹⁵

¹⁴ (1) Smith, Clarence McKittrick: *The Medical Department: Hospitalization and Evacuation, Zone of Interior, United States Army in World War II. The Technical Services.* Washington: U.S. Government Printing Office, 1956. (2) See footnote 5 (2), p. 36. (3) Annual Report, Training Division, Operations Service, Office of The Surgeon General, fiscal year 1942. (4) Annual Report of Technical Activities, Medical Department Professional Service Schools, Army Medical Center, Washington, D.C., fiscal year 1941. (5) Letter, Col. Larry B. McAfee, MC, Executive Officer, Office of The Surgeon General, U.S. Army, to the Commanding General, Letterman General Hospital, San Francisco, Calif., 7 Nov. 1940, subject: Training of Medical Department Personnel. (6) Letter, Col. Larry B. McAfee, MC, Executive Officer, Office of The Surgeon General, U.S. Army, to The Adjutant General, War Department, 14 Dec. 1940, subject: Allocation of Training Facilities at Special Service Schools.

¹⁵ See footnotes 1 and 5 (2), p. 36.

Additional opportunities for training were provided for VC officers by the inauguration of a course in milk and dairy hygiene at the Chicago Quartermaster Depot, Chicago, Ill. Veterinary officers had traditionally inspected milk and meat purchased locally as part of their regular duties, but late in 1940, Quartermaster plans for the establishment of a market center program to insure a steady flow of perishable foods and cushion the impact of military demand on the market created a need for veterinary officers specializing in meat and dairy inspection. Following discussions between Lt. Col. Will C. Griffin, VC, depot veterinarian at the Chicago Quartermaster Depot, and Lt. Col. (later Brig. Gen.) Raymond A. Kelser, VC, Chief, Veterinary Corps, permission was obtained on 1 November 1940 for the Veterinary Division to conduct classes at the depot.

Under the agreement, staff and equipment for the course were supplied by the Medical Department, while classrooms and laboratory space were provided by the depot. The first class of 17 officers convened on 25 November 1940, and classes continued to be offered through 1946. By the end of 1946, the class had been conducted 52 times, with 1,038 graduates, including more than 100 officers of the Army Air Forces. Originally a 4-week program, it was extended to 5½ weeks in June 1944. After the reorganization of 1942, the school operated as a class IV installation of the Quartermaster Corps.¹⁶

THE WAR YEARS: 1941-45

When the United States entered World War II, the program for training medical, dental, and veterinary officers was accelerated. Because of changes made necessary by the near depletion of the pool of officers with previous training, and the decision to retain men called up after September 1940 for an additional year of service, few discontinuities were produced by the transition to war. Basic training was readjusted to prepare officers newly commissioned from civilian practice for military service, and the officer pool program was expanded. Advanced military instruction was provided by the addition of special cadre and medicomilitary courses. On the assumption that civilian physicians were technically competent to perform routine medical duties, the basic and advanced graduate courses at the Army Medical Center, begun during the limited emergency, were suspended. In their stead, the facilities of the Army Medical Center and a number of civilian medical schools were harnessed to retrain physicians with noncritical skills in specialties essential to the war effort or to the rehabilitation of the wounded. Through the ASTP (Army Specialized Training Program), efforts were also made to expand the supply of physicians available for military service by sending eligible enlisted men to medical school.

¹⁶ (1) Medical Department, United States Army. *United States Army Veterinary Service in World War II*. Washington: U.S. Government Printing Office, 1961. (2) Risch, Erna, and Kieffer, Chester L.: *The Quartermaster Corps: Organization, Supply, and Services*. Volume I. *United States Army in World War II. The Technical Services*. Washington: U.S. Government Printing Office, 1953.

Basic Military Training

War brought vast numbers of a new type of officer into the Medical Department. Before the war, Medical, Dental, and Veterinary Corps officers were, in most cases, career soldiers with varying lengths of service. Even after September 1940, when the Reserve and National Guard were called to active duty, members of these corps had some degree of military training. By late 1941, the Medical Department's pool of trained reserves had been nearly exhausted. Yet between December 1941 and August 1945, the Medical Corps alone expanded from approximately 11,000 to nearly 47,000.¹⁷ Those who were not drawn directly from civilian practices were recruited upon the completion of their internships, and few, if any, had previous military experience. As a result, the demand for basic-training facilities mushroomed.

The disproportionate concentration of the Army's wartime strength increases in the first year of hostilities increased pressure on the Medical Department's basic-training facilities, and produced expedient measures that might have been avoided by more uniform growth. Estimates of the troop strength required to defeat the Axis, formulated immediately after Pearl Harbor, projected a need for over 200 divisions, or more than 10 million men, by mid-1944. The troop basis for 1942, approved by the Secretary of War on 15 January as a guide for the organization and activation of units, required the Army to bring its strength to 71 divisions with a total of 3.6 million men by 1 January 1943. By September, the 1942 troop basis had been increased to an even 5 million men. Since estimates of total troop requirements were later reduced, the troop basis of 1942 required well over half of the soldiers mobilized during World War II to be trained during the first year of the war.¹⁸

As its share of the troop basis, the Medical Department was required to raise its strength from 16,219 officers in January 1942 to 39,894 by 1 January 1943.¹⁹ By the end of 1942, the Medical Department had narrowly missed meeting the goals set by the War Department. In the process, however, it was necessary to abandon the prewar pattern of sending every newly commissioned officer to the Medical Field Service School and to combine basic training with a variety of military specialty programs at many installations.

Where and how an individual MC, DC, VC, or SnC (Sanitary Corps) officer was given basic training depended, in large measure, upon his ultimate assignment. Because of The Surgeon General's policy that, as far as possible, junior officers who had not acquired a medical specialty would be given basic tactical training and assigned to the field forces, the facilities of the Medical Field Service School were reserved for younger officers. Members of affiliated units, limited-service personnel, and older, more highly specialized officers were usually trained at pools established at installations, ranging from general hospitals and Medical Replacement Training

¹⁷ Medical Department, United States Army. *Personnel in World War II*. Washington: U.S. Government Printing Office, 1963.

¹⁸ Kreidberg, Marvin A., and Henry, Merton G.: *History of Military Mobilization in the United States Army, 1775-1945*. Washington: U.S. Government Printing Office, 1955. (DA Pamphlet 20-212.)

¹⁹ Memorandum, Brig. Gen. Larry B. McAfee, Assistant to The Surgeon General, U.S. Army, Chief, Operations Service, for the Director of Training, Services of Supply, 7 May 1942, subject: A Study in Preactivation Training of Commissioned Officers, inclosure thereto.

Centers to supply depots, and under the control of headquarters ranging from ASF (Army Service Forces) service commands to AGF (Army Ground Forces) and AAF (Army Air Forces) commanders.

Training facilities at the Medical Field Service School and the Professional Service Schools were allocated by The Surgeon General, through the War Department, to the Army Service, Ground, and Air Forces, which in turn assigned officers within their command.²⁰ As a result, an MC, DC, VC, or SnC officer assigned to the Air, Service, or Ground Forces might receive his basic training at a medical pool within that command or, if he was considered eligible for duty in a tactical unit, at the Medical Field Service School. A medical officer assigned to the Army Air Forces, for example, might receive his initial training at either the Medical Field Service School or the pool established for medical units and installations of the Air Forces at the Gulf Coast Air Corps Training Center, Randolph Field, Tex. Thus, the basic military training given a Medical Department officer included a standard body of military knowledge, but the location and type of installation at which it was received were varied.

Medical Field Service School

Throughout the war, as in the prewar era, the Medical Field Service School provided basic training for the largest single number of officers in the Medical, Dental, Veterinary, and Sanitary Corps. Until the beginning of the limited emergency, the standard period of training in medical field service and in the functions of the combat arms had been 5 months. To provide military training for the large number of officers on active duty, who had previously been unable to attend the course, and to meet the requirement to train a small number of officers added to the Medical Department after the eruption of war in Europe, the course had been compressed to 3 months, and offered twice a year.

Following the activation of the Reserve and National Guard, the course was condensed to a single month of instruction, and facilities were expanded to offer "refresher" training to a large number of officers with previous military training. Because of the exhaustion of reserve pools, refresher training was suspended after the graduation of the Seventh Refresher Course, which was conducted between 4 and 29 August 1941, to train additional officers for duties at replacement training centers. Beginning in September 1941, a 2-month course, designated simply as the "Officers' Course," was introduced to train newly commissioned officers in the principles and methods of medical field service.²¹

With variations in length, this condensed version of the 5-month, prewar "Basic Course" continued to be offered throughout the war. On 6 July 1942, the course was shortened to a single month, to take advantage of June graduations and double the output of trained officers. The change was not welcomed by authorities at the Medical Field Service School, who felt that a minimum of 8 weeks was required for orientation to field medicine. Under a 4-week program, too much time

²⁰ A Report on the Status of Training in the Medical Department, U.S. Army, 24 Sept. 1942.

²¹ Technical Report of Activities of the Medical Field Service School, Carlisle Barracks, Pa., fiscal year 1942.

was spent in teaching subjects required by the War Department to standardize instruction at all special service schools. Six months later, when combined pressure from the Air and Ground Forces for a greater share of the school's output resulted in its being expanded, the course was lengthened to 6 weeks. Beginning with the 19th class, on 3 January 1943, the program was revised and quotas were rearranged to allow a new class of 500 to begin every 2 weeks.

With three basic courses running concurrently, the capacity of the school was increased to allow the graduation of 1,500 officers during every 6-week period. By a series of expedients, which included closing the MAC Officer Candidate School at Carlisle Barracks on 27 February 1943, to provide housing for the expanded basic course, the Medical Department was able to provide basic training for most newly inducted officers, and to reduce the number of those inducted in 1942 without benefit of MFSS training. Even then, one special 6-week class had to be authorized at the ASF Training Center, Camp Barkeley, Tex., in January 1944, when the demand for training exceeded existing facilities. Enrolled were 856 officers. With this exception, the 6-week Officers' Basic Course continued to be offered at Carlisle Barracks until February 1945, when reduced demand for officers allowed the course length to be restored to 8 weeks. Between December 1940 and 2 August 1945, when the 69th course was completed, slightly more than 25,000 officers graduated. Graduates of the Medical Field Service School Officers' Basic Course for fiscal years 1921-45 were as follows:²²

<i>Years</i>	<i>Number</i>
1921-40.....	1,369
1940-41.....	2,119
1941-42.....	1,692
1942-43.....	7,358
1943-44.....	9,298
1944-45.....	4,620

Officer pool training

The inability of Army Special Service Schools to provide basic training for all officers in the event of mass mobilization, and the obvious need to reserve those facilities for officers qualified for tactical duties, had long been a matter of concern to War Department planners. Early in 1941, the Medical Department arrived at a partial solution to the problem by activating refresher courses at general hospitals that allowed Reserve officers, who had the equivalent of basic training when called to active duty, to understudy their counterpart in a hospital's administrative structure for a period of 1 month. Courses were offered at six hospitals, each with a

²² (1) See footnotes 10, p. 39; 12 (2), p. 40; 19, p. 43; and 21, p. 44. (2) Annual Report, Medical Field Service School, Carlisle Barracks, Pa., fiscal year 1943. (3) Memorandum, Lt. Col. F. B. Wakeman, MC, Chief, Training Division, Operations Service, Office of The Surgeon General, for the Personnel Division, Surgeon General's Office, 22 May 1942. (4) Letter, Col. John A. Rogers, MC, Executive Officer, Office of The Surgeon General, to the Commanding General, Services of Supply, 10 Apr. 1942, subject: Special Courses, Medical Field Service School. 1st indorsement thereto, dated 11 Apr. 1942. (5) Annual Report, Medical Field Service School, Carlisle Barracks, Pa., 1945. (6) Annual Report, Army Service Forces Training Center, Camp Barkeley, Tex., fiscal year 1944. (7) Annual Report of The Surgeon General, U.S. Army. Washington: U.S. Government Printing Office, 1922. (8) Technical Report of Activities of the Medical Field Service School, Carlisle Barracks, Pa., fiscal year 1944.

capacity of 50 students per month, but because of the urgent demand for the technical and tactical service of medical officers, the program was never fully utilized.

Within a week after Pearl Harbor, however, the War Department turned its attention to the problem of officer filler and loss replacement training. On 19 December 1941, orders were issued to the chief of each ground arm and service to establish pool training for unassigned officers without delay at special service schools, branch replacement training centers, and War Department overhead installations under the direct control of the chief of the arm or service. These pools were to be designed to provide "suitable preparatory training" to each individual before permanent assignment and to furnish a source of replacements for troop units and training centers.²³

Early in 1942, plans were formulated by the Medical Department for the establishment of officer replacement pools within the Zone of Interior at a number of installations and under a variety of commands, including all named general hospitals except Darnall, Danville, Ky., all medical replacement training centers, medical supply depots, medical sections of general depots, and the Gulf Coast Air Corps Training Center. Pools were assigned the threefold mission of providing instruction to qualify officers for their first permanent assignment, of furnishing officers qualified to attend courses training medical specialists at service schools and civilian institutions, and of acting as the primary source of officer filler and loss replacements. Officers destined for Medical Department tactical units (later designated "AGF type" units) were assigned to either pool at one of the medical replacement training centers, each of which had a capacity for 100 officers, or the Medical Field Service School, which was authorized a pool of 150 officers. Officers assigned to the Air Forces were sent to the Gulf Coast Air Corps Training Center, which had a pool of 200 officers; those assigned to professional units of the field forces or fixed Zone of Interior installations (later designated "ASF type" units) were trained in pools of 50 established at named general hospitals, which were the successors to the administrative refresher courses established for Reserve officers in 1940. Pools for training 50 officers in medical supply and procurement were established at medical supply depots and the medical sections of general depots.

Early plans directed that officers would be assigned to pools for a minimum of 3 months, but these were soon changed to allow the period in pools to vary from an extremely short period up to 4 months. Formal course outlines were developed to give newly commissioned officers a basic knowledge of the Army and military subjects, but most of the instruction was provided through on-the-job training. Programs varied with the type of installation at which a pool was located, and commanders were instructed to integrate students in their commands and to train them so that they could furnish either a qualified pool officer or a previously trained

²³ (1) Memorandum, Brig. Gen. Wade H. Haislip, Assistant Chief of Staff, War Department General Staff, for the Chief of Staff, 15 Dec. 1941, subject: Pool of Officer Replacements, inclosures thereto. (2) Letter, The Adjutant General, War Department, to Chief of Each Ground Arm or Service; Chief of the Armored Force; and Chief of Staff, General Headquarters, 19 Dec. 1941, subject: Officer Filler and Loss Replacements for Ground Arms and Services. (3) See footnote 5 (2), p. 36.

officer whom the student would replace within the command whenever a filler or replacement was requested.²⁴

Full use of officer pools was not possible until after June 1942, when a large number of young officers who had graduated from medical school in 1941, and spent the intervening year in internships, were called to active duty. By the time these officers became available, pools had been established with a total capacity of 1,500 officers. Shortly after June 1942, an additional pool was established at the New York Port of Embarkation.

With varying size and location, pool training continued to be conducted throughout the war. Its importance as a primary source of basic training for medical, dental, and veterinary officers declined late in the war, however, because of the decreasing numbers of such officers available for military service, the expanding capacity of the Medical Field Service School, and the increasing use of MAC officers to perform nonmedical duties. The decentralized agencies that administered pools frequently assigned officers for indefinite and varying periods, sometimes assigned them there only for administrative purposes, and often failed to distinguish between MC and MAC officers in annual reports; for these reasons, it is not possible even to estimate the numbers of MC, DC, VC, and SnC officers who received pool training. It is probable, however, that nearly every junior officer passed through a pool at some time during World War II, and in two areas, supply and administration, it was the only source of training available.

The operation of pools is typified by the Medical Department Replacement Pool which began operations on 8 June 1942 at Camp Barkeley. Between that date and 30 June 1943, the 4-week refresher course was conducted for 528 officers. After completing this course, 359 officers were assigned to temporary duty in Medical Department training battalions at Camp Barkeley, pending permanent assignment.

The program of instruction in the 4-week pool course included a general study of administration, field sanitation, and organization and operation of medical field units. Two officers of the Medical Replacement Training Center cadre at Camp Barkeley were assigned to supervise the pool, prepare schedules, conduct classes, and make necessary reports. Regular classes conducted in the training battalions and in the Officer Candidate School at the center were open to pool officers, whose schedules were arranged to allow them to take advantage of the varied activities available at Camp Barkeley. Special classes were also conducted for pool officers by instructors at the camp. During their period of temporary duty with medical battalions, pool officers were given the opportunity to observe experienced instructors, and were assigned teaching duties. After June 1943, the number of officers passing through the Camp Barkeley pool declined, as the supply of available

²⁴ (1) Memorandum, Maj. F. B. Wakeman, MC, Chief, Training Division, Operations Service, Office of The Surgeon General, for The Surgeon General, 3 Jan. 1942, subject: Training of Officer Filler and Loss Replacements for Ground Arms and Services. (2) Letter, Lt. Col. John A. Rogers, MC, Executive Officer, Office of The Surgeon General, U.S. Army, to The Adjutant General, War Department, 15 Jan. 1942, subject: Officer Filler and Loss Replacements in the Medical Department. 1st indorsement thereto, dated 7 Feb. 1942. (3) Letter, Lt. Col. John A. Rogers, MC, Executive Officer, Office of The Surgeon General, U.S. Army, to Commanding Generals, All Medical Replacement Training Centers; Commanding Officers, All General Hospitals; and All Medical Supply Depots, 27 Feb. 1942, subject: Officer Filler and Loss Replacements for the Ground and Air, Arms and Services.

officers diminished. Only 99 officers received pool training, compared with 528 the previous year.²⁵

An unusual curriculum, typifying the diversity of the officer pool program, was the course in medical supply procedures at the St. Louis Medical Depot, St. Louis, Mo. Between 1922 and 1924, the Medical Department had operated a separate Medical Supply Training School at the New York General Depot, New York, N.Y. Thereafter, medical supply officers were usually assigned to a 2-year tour at the New York General Depot, followed by a year in the Surgeon General's Office, and then completed their training with a 1-year course at the Army Industrial College. During the 1920's, between three and five officers completed this training each year, but during the 1930's, only two medical supply officers were enrolled annually.

In response to wartime demand for an increasing number of medical supply officers, a separate Medical Department school was reestablished in April 1942. Initially, this course consisted of 2 weeks of informal, on-the-job training, organized to give the student officer a few days' practical experience in the supervision of each of the St. Louis Medical Depot's divisions and branches. This drastic reduction in course length was based on the assumption that supply officers would be drawn from the ranks of civilians with medical supply experience, who would require only token orientation to military procedures. Administration of the course was the responsibility of the Officers' Orientation School, established at the St. Louis Medical Depot for that purpose. In August 1942, the course was lengthened to 4 weeks and given permanent status.

As the war assumed global proportions, it became increasingly apparent that officers in charge of supplies needed more thorough orientation to the procedures involved in transferring supplies from the Zone of Interior to combat areas. On 1 March 1943, the course was assimilated into ASF supply training programs reorganized to provide 3 months of training in three phases, and redesignated the "ASF Depot Course." The first phase of this new program was conducted at the Quartermaster School, Camp Lee, Va., where officers received 30 days of orientation to Army supply procedures. The 1-month training program at the St. Louis Medical Depot became phase II of the new program. Phase III consisted of 30 days of practical work at one of several medical supply depots within the Zone of Interior. Course capacity was expanded to 100 officers.

While these developments were taking place, other courses were established at the St. Louis Medical Depot for Medical Department enlisted personnel. On 3 June 1943, the administrative organization at the St. Louis Medical Depot, responsible for supervising all of these courses, was formally designated the "Medical Supply Services School," and the Officers' Orientation School was absorbed as the Officers' Supply Division of the newly created school.²⁶

Following this reorganization, the Medical Supply Services School continued to provide training for the duration of the war without major changes in its curriculum.

²⁵ (1) Annual Report, Army Service Forces Training Center, Camp Berkeley, Tex., fiscal year 1944. (2) Circular Letter No. 48, Office of The Surgeon General, U.S. Army, 23 May 1942.

²⁶ (1) Annual Report, Training Division, Operations Service, Office of The Surgeon General, fiscal year 1943. (2) Annual Report, Army Service Forces, Medical Supply Services School, St. Louis Medical Depot, St. Louis, Mo., fiscal year 1944. (3) Annual Report, Medical Supply Services School, St. Louis Medical Depot, St. Louis, Mo., fiscal year 1943. (4) Medical Department, United States Army. Medical Supply in World War II. Washington: U.S. Government Printing Office, 1968.

The first class of officers to enroll in phase II of the new program entered the school on 5 April 1943, and before the end of June, a total of 495 officers had completed this phase. Between June 1943 and June 1944, a total of 412 officers completed this phase of instruction and were sent to the medical sections of ASF depots for phase III of the ASF Depot Course. Thirty-eight officers completed courses in equipment maintenance, and nine completed courses in optical repair, which had been inaugurated at the school. Between June and September 1944, when it was dropped from the program, four officers graduated from the 6-week course for supervisors of optical repair shops. By June 1945, 46 more officers had graduated from the 16-week equipment maintenance course, and an additional 178 had graduated from phase II of the depot course.²⁷ The tabulation which follows shows the total number of male Medical, Dental, Veterinary, and Sanitary Corps officers graduating from service school courses from July 1939 to August 1945.

<i>Training¹</i>	<i>Number</i>
Officers Basic Course.....	25,972
Cadre Course (Special).....	526
Medical and Field Sanitary Inspectors.....	888
Chemical Warfare Medical Dept. Officers Course.....	1,836
Quartermaster School, ASF Depot Course, Phase I.....	516
ASF Depot Course, Phase II (Med).....	1,195
ASF Depot Course, Phase III.....	42
Equipment Maintenance.....	93
Optical Repair.....	13
Meat and Dairy Hygiene.....	862
Clinical Pathology, Veterinary Officers (Special).....	14
Forage Inspection.....	67
Tropical Medicine.....	1,708
Anesthesiology.....	292
Electroencephalography.....	48
Maxillofacial Plastic Surgery.....	233
Roentgenology.....	802
Military Neuropsychiatry.....	841
Operation of Red Cross Blood Donor Center.....	46
Malariology.....	260
Medical and Surgical Care of Battle Casualties in Forward Areas.....	179
Adjutant General's School.....	276
Army Industrial College.....	15
Army War College.....	2
Command and General Staff School.....	246
Engineers School.....	52
Ordnance School.....	10
Food and Nutrition.....	145

¹ (1) Training Division, Office of The Surgeon General, 8 Jan. 1948. (2) Goodman, Samuel M.: History of Medical Department, Training U.S. Army World War II. Volume III. A Report of the Training of Medical Officers, 1 July 1939-30 June 1944. [Official record.] A small number of MAC officers may be included in some courses.

²⁷ (1) Annual Report Training Division, Operations Service, Office of The Surgeon General, fiscal year 1944. (2) Annual Report, School Branch, fiscal year 1945. In Annual Report, Training Division, Operations Service, Office of The Surgeon General, fiscal year 1945. (3) Memorandum, Maj. Walter H. Potter, SnC, Chief, Specialties Branch, Supply Planning and Specialties Division, Supply Service, Office of The Surgeon General, for the Chief, Operations Service, Surgeon General's Office, 28 July 1943, subject: Training of Opticians for Optical Repair Sections of Medical Depot Companies. (4) Memorandum, Col. F. B. Wakeman, MC, Director, Training Division, Operations Service, Office of The Surgeon General, to Commandant, Medical Supply Services School, St. Louis Medical Depot, St. Louis, Mo., 13 Aug. 1943, subject: Training of Medical Department Officers in Maintenance of Medical Equipment.

Pools also provided special instruction for groups which were difficult to fit into the regular program. Women, for example, were not commissioned in the prewar Army, and there were no programs for training female Medical Department officers. After Congress authorized the commissioning of women doctors in April 1943, 76 female physicians were commissioned in the Medical Corps. About one-third of this group was placed on active duty without formal training. Beginning in October 1943, however, all newly commissioned women doctors were sent to the Medical Department Replacement Pool at Lawson General Hospital, Atlanta, Ga., where they received an orientation to military life. Fifty-five women, or approximately two-thirds of all women accepted in the Medical Corps, were trained at this pool. In addition to pool training, three women doctors were sent to the Tropical Medicine Course; four were sent to the School of Military Neuropsychiatry, at Lawson General Hospital; and six, to various courses in anesthesiology.²⁸

A special pool for Negro officers was established at Fort Huachuca, Ariz., on 8 June 1943. This action was taken following publication of a War Department policy, in January 1943, requiring Negro officers to be assigned in groups. Ostensibly, officers assigned to the pool were to continue their technical training "until such time as group assignment to a Medical Department unit or installation" became effective. Since the commandant of the Medical Field Service School, Brig. Gen. Addison D. Davis, refused to allow more than 25 Negro officers to attend the school at one time, the pool also proved useful for holding newly commissioned Negro officers until they could be accepted under the quota.²⁹

Extension courses

Throughout the interwar years, the Special Service School extension program, administered through corps areas, was a major part of the Army's training program for Reserve and National Guard officers. This series of progressive subcourses, designed to expand the officer's grasp of the fundamentals of military knowledge and qualify him for promotion, was participated in by more Reserve and National Guard officers than any other form of training. Even after September 1940, when these officers were called to active duty, enrollment in extension courses offered through the Medical Field Service School continued unabated. Revision of the program to incorporate changes in doctrine and equipment, begun in the late 1930's and scheduled for completion in 1942, continued throughout 1941.

By the time the United States entered World War II, most of these revisions had been completed, and the revised Army Extension Courses were thought to be

²⁸ (1) See footnote 17, p. 43. (2) Goodman, Samuel M.: *History of the Training of Medical Department Female Personnel*, 1 July 1939 to 31 December 1944. [Official record.]

²⁹ (1) War Department Circular No. 132, 8 June 1943. (2) Annual Report, Office of the Director, Medical Division, Fort Huachuca, Ariz., 1943. (3) Memorandum, Col. Frank B. Wakeman, MC, Director, Training Division, Operations Service, Office of The Surgeon General, to Director of Training, Services of Supply, 10 Mar. 1943, subject: Training Pool for Colored Medical and Dental Officer Personnel. (4) Memorandum, Lt. Col. Durward G. Hall, MC, Assistant to Director, Reserve Division, Personnel Service, Military Personnel Division, Office of The Surgeon General, for Col. Howard T. M. C. Wickert, Chief, Planning Division, Operations Service, Office of The Surgeon General, 20 Mar. 1943. (5) Memorandum, Maj. E. R. Whitehurst, MAC, Assistant to Director, Reserve Division, Personnel Service, Military Personnel Division, Office of The Surgeon General, to the Chief of Military Personnel, Surgeon General's Office, 16 Feb. 1943, subject: Assignment of Colored Medical and Dental Personnel.

the most up-to-date source of information on doctrine, tactics, technique, and procedure available. Because most Reserve and National Guard officers were on active duty by the end of 1941, the War Department General Staff, G-3, Operations and Training, recommended, and received approval from the Chief of Staff, that operation of corps area extension courses be suspended and that extension course material be diverted to field force units for use in unit troop schools. Orders for the suspension of corps area extension schools for the duration of the war were issued early in February 1942, and all officers then enrolled in classes were required to complete them by 1 April. Special Service Schools were directed to continue their revisions of course material.

By August, however, reports that unit troop schools were not using the extension courses because they were too cumbersome for the accelerated pace of wartime training were confirmed by training inspections of four newly activated divisions, and G-3 decided to relieve the service commands from the burden of directed use. In the future, G-3 declared, the War Department would handle extension courses as it handled other areas of training, confining itself to announcing policies and outlines of broad objectives, and allowing the commanding generals of the service commands to determine the manner in which the objectives would be achieved. When a poll of the service commands revealed that only the Army Air Forces desired the continued preparation and revision of extension course material, the War Department directed the Special Service Schools to suspend their revision of extension courses for the duration of the war. The service commands were directed to continue their distribution of extension material until stocks were exhausted, and to revise courses that might prove useful in training their respective commands.

By the end of 1942, the prewar extension program was decentralized and, for all practical purposes, suspended for the duration of the war.³⁰

Specialized and Advanced Military Training

The program of basic training provided at the Medical Field Service School and replacement pools was supplemented by a variety of programs, either sponsored by, or available to, the Medical Department for training specialists qualified to protect the health of the Army in the field, or qualified for duties requiring specialized military skills.

³⁰ (1) Letter, Lt. Col. John A. Rogers, MC, Executive Officer, for The Surgeon General, U.S. Army, to the Commandant, Medical Field Service School, Carlisle Barracks, Pa., 8 Oct. 1941, subject: Revision of Army Extension Courses for the 1942-43 School Year. (2) War Department Training Circular No. 6, 2 Feb. 1942. (3) Letter, The Adjutant General, War Department, to All Corps Area Commanders, 3 Feb. 1942, subject: Suspension of Corps Area Extension School. (4) War Department Circular No. 198, 20 June 1942. (5) Letter, Col. C. H. Day, AGD, Assistant Ground Adjutant General, to Assistant Chief of Staff, G-3, 1 Aug. 1942, subject: Suspension of Preparation of Army Extension Courses. (6) Memorandum, Brig. Gen. I. H. Edwards, Assistant Chief of Staff, G-3, for the Commanding Generals: Army Ground Forces; Army Air Forces; and Services of Supply, 27 Aug. 1942, subject: Suspension of the Preparation of Army Extension Courses. (7) Memorandum, Brig. Gen. I. H. Edwards, Assistant Chief of Staff, G-3, for the Commanding Generals: Army Air Forces; Army Ground Forces; and Services of Supply, 29 Oct. 1942, subject: Suspension of the Preparation of Army Extension Courses. (8) Memorandum, Brig. Gen. I. H. Edwards, Assistant Chief of Staff, G-3, for The Adjutant General, 29 Oct. 1942, subject: Suspension of the Preparation of Army Extension Courses, inclosures thereto. (9) War Department Circular No. 361, 31 Oct. 1942.

Medical field and sanitary inspectors

Mass mobilization, accompanied by the rapid expansion of existing facilities, the creation of new military installations, and the induction of large numbers of men unfamiliar with techniques for avoiding the potential hazards of garrison and field life, produced threats to the health of the Army. By mid-1942, the problem was serious enough to prompt the War Department to call the attention of commanders of all grades to their responsibility for the enforcement of sanitary regulations, and to observe:³¹

* * * The incidence of food poisoning, diarrhea, and dysentery among troops last year, both in camps and on maneuvers, and the recurrence of similar outbreaks this year indicate that training in personal hygiene and sanitation has been neglected and that well established measures for the control of such diseases have not been intelligently enforced. Commanders of all grades, surgeons, and medical inspectors must realize that organizations which have difficulty controlling endemic intestinal diseases during training will have greater difficulty in the field, and it follows that the combat value of such units will be substandard. The recurrence of these diseases is indicative of inefficiency on the part of the responsible commanders and medical officers and lack of discipline in the units.

In response to War Department concern, a conference was held at the Medical Field Service School on 20 August 1942, between the commandant of the school, General Davis, and Lt. Col. (later Col.) Frank B. Wakeman, MC, the director of training at the Office of The Surgeon General, and their assistants, to discuss methods for improving sanitation in the Army. As a result of this conference, recommendations were sent to the War Department calling for the expansion of division cadres and post staffs to include a medical inspector, and the establishment of a special training program for such officers at the Medical Field Service School. The request for a special training program was argued on the grounds that a majority of Medical Corps officers were new to the service and not thoroughly trained in the requirements of military sanitation. The block of instruction included in the basic orientation course could not be expanded to qualify officers for duties as medical inspectors without hampering their training in other military subjects. The course proposed by the committee was to be 1 month in length, with a capacity of 50 officers each month, preferably senior captains of the Medical Corps, to begin in November 1942. In response to these recommendations, the Medical and Field Inspectors' Course was authorized on 9 September 1942, and classes began on 2 November.³²

In general, the course established in the fall of 1942 followed the outlines suggested by the Wakeman-Davis Committee. Of 192 hours of course work, 102 were devoted to military sanitation, including such diverse subjects as barracks sanitation, insectborne diseases, food inspection, waste and rubbish disposal, water

³¹ War Department Circular No. 277, 20 Aug. 1942.

³² (1) Letter, Brig. Gen. Addison D. Davis, Commandant, Medical Field Service School, Carlisle Barracks, Pa., to The Surgeon General, U.S. Army. Attention: Plans and Training Division, 29 Aug. 1942, subject: Medical Inspectors' Course, Medical Field Service School, Carlisle Barracks, Pa. (2) Memorandum, Col. John A. Rogers, MC, Executive Officer to The Surgeon General, U.S. Army, for the Director of Training, Services of Supply, 4 Sept. 1942, subject: Course of Instruction for Medical Inspectors. (3) Memorandum, Brig. Gen. C. R. Huebner, GSC, Director of Training, Services of Supply, for The Surgeon General, U.S. Army, 9 Sept. 1942, subject: Course of Instruction for Medical Inspectors.

and sewage treatment, and venereal disease control. The balance was devoted to studying tactics and administration related to the duties of a medical inspector. Quotas were distributed among the service commands, defense commands, and Air and Ground Forces. Courses continued to be offered throughout the war, with few changes in content.

Standards of admission, however, were gradually eroded by the growing shortage of physicians. Originally, only senior captains in the Medical Corps, who had completed the MFSS Officers' Basic Course, were to be admitted, but in time, the regulations were rewritten by authorities outside the Medical Department's control, and lieutenants, newly commissioned captains, SnC officers, and MAC officers were sent to the course. In August 1943, the course was lengthened to 5 weeks to allow a greater amount of basic training and field experience. Reports from the field indicated that SnC and MAC officers were being successfully utilized as medical inspectors. By June 1945, at the completion of the 24th class, 892 officers had graduated.³³

Chemical Warfare School

The development of a formal course of instruction in chemical warfare was one of the few radical innovations in the Medical Department officer training program. Before the war, a few officers had been sent to Edgewood Arsenal for training each year, but for most officers, knowledge of defense against chemical agents was confined to a few hours of cursory instruction received in the MFSS Officers' Basic Course.

Early in 1941, The Surgeon General instructed the Medical Research Division at Edgewood Arsenal to prepare tables of organization and equipment for a gas medical battalion that was to be activated to care for gas casualties. Seizing this opportunity, the chief of the Medical Research Division, Lt. Col. (later Col.) William D. Fleming, MC, reported that such a battalion would be of little use unless its medical personnel received more instruction in chemical warfare and chemical warfare medicine than was currently available, and submitted one of the Medical Research Division's periodic recommendations for the establishment of a formal course of instruction.³⁴ Work on a course and text began, and almost a year later, the course outline was submitted to the Office of The Surgeon General. In August 1942, the Medical Corps Officers' Course, to be given at the Chemical Warfare School, was approved by the War Department, and classes began in September.

³³ (1) See footnotes 22 (2) and (5), p. 45. (2) Essential Technical Medical Data, U.S. Army Forces, South Atlantic, for April 1944, dated 4 May 1944. (3) War Department Circular No. 99, 9 Mar. 1944. (4) Letter, Col. R. W. Bliss, MC, Assistant to The Surgeon General, U.S. Army, as Chief, Operations Service, to the Director of Military Training, Army Service Forces, 3 Aug. 1943, subject: Training of Medical and Field Sanitary Inspectors. 1st indorsement thereto, dated 8 Aug. 1943. (5) Letter, Brig. Gen. Addison D. Davis, Commanding General, Medical Field Service School, Carlisle Barracks, Pa., to The Surgeon General, U.S. Army. Attention: Col. F. B. Wakeman, MC, Training Division, 28 Apr. 1943, subject: Sixth Medical Inspectors' Course, Medical Field Service School, Carlisle Barracks, Pa., inclosures thereto.

³⁴ (1) Letter, Lt. Col. William D. Fleming, MC, Chief, Medical Research Division, Chemical Warfare Service, Edgewood Arsenal, Md., to The Surgeon General, War Department, 25 Mar. 1942, subject: Special Training in Treatment of Chemical Casualties, inclosure thereto. (2) Letter, Lt. Col. William D. Fleming, MC, Chief, Medical Research Division, Chemical Warfare Service, Edgewood Arsenal, Md., to The Surgeon General, War Department, 31 Mar. 1942, subject: Instruction of Medical Officers in Care of Gas Casualties.

This course of instruction to train Medical Department officers in the identification of chemical warfare agents, in decontamination, and in prevention and care of chemical warfare casualties covered a 4-week period. Originally, plans called for five classes of 100 officers each, to begin on 7 September 1942, but before the fifth class had graduated, the course was extended indefinitely. Officers attending the course were selected from the Army Service, Air, and Ground Forces, and from the Office of The Surgeon General.

The teaching staff of the Chemical Warfare School provided technical instruction in agents, materiel, and weather factors, while members of the Medical Research Division presented courses in the physiological effects of agents, pathology, treatment, and medical service. Veterinary Corps officers enrolled in the course were offered an alternate program in the protection, care, and treatment of animal casualties, and the contamination and decontamination of food. A similar adjustment in content was made in May 1943 for SnC officers, who were given special instruction on the decontamination of water. In July 1944, the course was shortened to 3 weeks by the elimination of many hours devoted to basic military subjects. Before the course was discontinued at the end of the 29th class in December 1944, approximately 2,000 officers received instruction at the Chemical Warfare School. A majority were MC officers, but the Sanitary and Veterinary Corps were well represented, and in 1944, the course was even attended by 48 naval officers.³⁵

Special Cadre Course for divisional officers

Providing qualified officers with the ability to organize, activate, and train new divisions was a major problem for all of the arms and services. Prewar planners had counted on being able to strip installations of their Regular Army personnel to provide cadre for the first 8 months of mobilization. At the end of 8 months, it was assumed they would be able to select cadre for future activations from among superior trainees. During the limited mobilization following passage of selective service, unit activations followed this pattern. It was not until after the outbreak of war that formal training was provided for Medical Department officers by the inauguration of the Special Cadre Course for divisional officers at the Medical Field Service School. Under this program, it was planned that, approximately 2 months before the activation of a division, a maximum of 13 medical officers assigned to the medical battalion and medical detachments supporting the division would be enrolled in the Special Cadre Course for 4 weeks of intensive training. The course

³⁵ (1) Cochran, Rexmond C.: History of Research and Development of the Chemical Warfare Service in World War II. Volume 30. Medical Research in Chemical Warfare. Historical Branch, Chemical Corps School, Edgewood Arsenal, Md., 1 Mar. 1947. [Official record. Office of the Chief of Military History.] (2) Annual Report, School Branch, fiscal year 1945. In Annual Report, Training Division, Operations Service, Office of The Surgeon General, fiscal year 1945. (3) Memorandum, Brig. Gen. Alexander Wilson, C.W.S., Chief, Field Service, Chemical Warfare Service, to the Commanding General, Services of Supply, 20 July 1942, subject: Chemical Warfare School, Medical Corps Officers' Course. (4) Letter, The Adjutant General, War Department, to The Surgeon General, U.S. Army, 4 Aug. 1942, subject: Chemical Warfare School, Medical Corps Officers' Course. (5) Annual Report, Training Division, Operations Service, Office of The Surgeon General, fiscal year 1943. (6) Memorandum, Lt. Col. Charles H. Moseley, MC, Deputy Director, Training Division, Office of The Surgeon General, for Lt. Col. John R. Wood, Medical Research Laboratory, Edgewood Arsenal, Md., 10 May 1943. (7) Memorandum, Col. John A. Rogers, MC, Executive Officer to The Surgeon General, U.S. Army, for Director of Training, Services of Supply, 29 Sept. 1942, subject: Chemical Warfare School, Medical Corps Officers' Course.

was designed to instruct them in methods of training and administration, and in the principles of first- and second-echelon medical support, to allow them to function efficiently in their newly activated divisions and inform them of duties during unit activation. The first Special Cadre Course began on 26 January 1942, and by the end of June, 138 officers, representing 11 divisions, had graduated.

Included in this total were 22 newly commissioned Negro officers assigned to the 93d (Negro) Infantry Division, and to the Station Hospital, Fort Huachuca, who did not participate in the regular program of instruction. A special outline of instruction was designed for these officers, who attended the Medical Field Service School between 9 March and 4 April 1942.³⁶ The curriculum prepared for these officers contained a greater concentration on basic military subjects than that prepared for regular cadre courses, a procedure which was probably not necessary for the Reserve officers assigned to the 93d (Negro) Infantry Division, but was essential for the training of the cadre of the Negro station hospital, a group of handpicked Negro physicians, which had already become the subject of national controversy.

The controversy arose out of a series of conferences held between representatives of the Office of The Surgeon General and the Negro counterpart of the American Medical Association, the National Medical Association, beginning on 14 October 1940, as a result of pressure by Negro professional and political organizations for integration and greater participation in the war effort. At this time, patients at fixed Army hospitals were completely integrated, but professional service in these installations was the exclusive prerogative of white physicians. Negro physicians were confined to field installations providing first- and second-echelon medical service for Negro units.

Among the demands of the National Medical Association was the complete integration of professional staffs, to relieve a greater number of Negro physicians from duty as regimental surgeons (unflatteringly characterized as "first aid surgeons" by the National Medical Association). Members of the association demanded an equal opportunity to enhance their careers by participating in advanced training programs and to gain the specialized medical and administrative experience available to physicians assigned to station and general hospitals.³⁷ While sympathetic to demands for increased participation in higher echelon medical service, Maj. Gen. James C. Magee opposed any integration of professional services until integration of the Army became a War Department policy, because professional integration of military hospitals would result in white patients being forced to accept treatment by Negro physicians.³⁸

No minutes were kept of the first meeting, but representatives of the Office of The Surgeon General emerged believing that the National Medical Association

³⁶ See footnote 21, p. 44.

³⁷ (1) Press release, National Medical Association Incorporated, "Reply of the National Medical Association to the Purported Press Release of the Honorable Secretary of War, USA, 20 Feb. 1942." (2) Letter, Eleanor Roosevelt to Maj. Gen. James C. Magee, The Surgeon General, U.S. Army, dated 1 Mar. 1943, inclosure thereto. (3) Memorandum, Col. Albert G. Love, MC, Chief, Planning and Training Division, Office of The Surgeon General, to Maj. Gen. James C. Magee, The Surgeon General, U.S. Army, 14 Oct. 1940.

³⁸ Minutes, Meeting, Re Use of Negro Doctors, Nurses, and Dentists by Medical Department, 7 Mar. 1941.

agreed that the use of Negro physicians in mixed wards was impracticable, and that a satisfactory substitute for professional integration could be provided by establishing segregated Negro wards in hospitals with a large number of Negro patients, or possibly, a hospital devoted exclusively to Negro patients.³⁹ Following the conference, the Office of The Surgeon General began to consider establishing separate Negro hospitals at Fort Huachuca; Savannah Ordnance Depot, Savannah, Ga.; and the Wilmington Anti-Aircraft Firing Center, Wilmington, Del. Separate Negro wards were established at Fort Bragg, N.C., and Fort Livingstone, La. The general plan of segregating Negro patients for the benefit of Negro physicians received War Department approval.⁴⁰

Late in December 1940, Judge William H. Hastie, the dean of the Howard University Law School, Washington, D.C., who had recently been appointed Civilian Aide to the Secretary of War on Negro Affairs, was given the power to comment or concur before final decision, on all matters of policy pertaining to Negroes.⁴¹ Establishment of an all-Negro hospital was postponed until it could be justified by the concentration of sufficient numbers of Negro personnel; in the interim, members of the National Medical Association began to express discontent with plans for Negro medical service.

At a conference in March 1941, attended, among others, by Judge Hastie and Dr. (later Colonel, MC) Midian O. Bousfield, a leading member of the National Medical Association, Judge Hastie took issue with a member of the National Medical Association, who insisted that the association had not accepted the Medical Department's plan. As Judge Hastie explained it, the National Medical Association was willing to concede the necessity of segregated wards in the South, where local customs would be hostile to the integration of a professional staff, but felt it would be unfortunate if the practice were extended to other areas. Dr. Bousfield expressed the opinion that anything short of complete integration would be inconsistent with the concept of democracy.⁴²

When plans for an all-Negro hospital were revived early in 1942, however, and Dr. Bousfield was recommended by the Procurement and Assignment Service, a civilian agency, as the most qualified member of the National Medical Association to recruit a hospital staff, he accepted the responsibility. When his name was urged upon the Medical Department by Judge Hastie's office, he also accepted command of the new hospital.⁴³ In a letter to members of the National Medical Association,

³⁹ (1) See footnote 37(3), p. 55. (2) Letter, Maj. Gen. James C. Magee, The Surgeon General, U.S. Army, to Dr. A. N. Vaughn, President, National Medical Association, 18 Oct. 1940.

⁴⁰ (1) Letter, Col. Larry B. McAfee, MC, Executive Officer to The Surgeon General, to The Adjutant General, War Department, 25 Oct. 1940, subject: Plan for Utilization of Negro Officers, Nurses, and Enlisted Men in the Medical Department's 1940-41 Military Program. 1st indorsement thereto, dated 15 Nov. 1940. (2) See footnote 38, p. 55.

⁴¹ Letter, The Adjutant General, War Department, to the Chiefs of Arms and Services, and Divisions of War Department General Staff, 18 Dec. 1940, subject: Policies Pertaining to Negroes.

⁴² (1) See footnote 38, p. 55. (2) Memorandum, William H. Hastie, Civilian Aide to the Secretary of War, to The Surgeon General, U.S. Army, 17 Mar. 1941, inclosure thereto.

⁴³ (1) Memorandum, Lt. Col. Howard T. Wickert, MC, Assistant Chief, Planning Division, Operations Service, Office of The Surgeon General, for General McAfee, Chief, Operations Service, Office of The Surgeon General, 16 Jan. 1942. (2) 2d indorsement, Brig. Gen. Larry B. McAfee, Assistant to The Surgeon General, Chief, Operations Service, Office of The Surgeon General, to The Adjutant General, War Department, 19 Jan. 1942. (3) Informal Action Sheet, Brig. Gen. Larry B. McAfee, Assistant to The Surgeon General, Chief, Operations Service, Office of The Surgeon General, to The Adjutant General, War Department, 1 May 1942.

Dr. Bousfield announced:⁴⁴

* * * I have just returned from a conference in the Surgeon General's Office in Washington. A station hospital of 672 beds is to be organized immediately at Camp Huachuca, Ariz., with a complete complement of Negro doctors. Except for being a completely segregated unit, it is a victory for the protest against the exclusion of Negro doctors. Much more important, it gives protection to our best physicians in two ways: It prevents them from being drafted into the ranks, and gives great protection by being assigned to a station hospital, which will not be disturbed unless the country is bombed or successfully invaded. The men will likely not see active service with the fighting forces. A complete division is to be trained at Huachuca.

* * * * *
 An immediate response will indicate the interest of the members of the National Medical Association in the control of an opportunities [sic] of additional training to be obtained in this large hospital, as well as in this successful issue of our protests.

Neither the establishment of an all-Negro hospital nor Dr. Bousfield's letter was long in drawing hostile fire. An announcement by Secretary of War, Henry L. Stimson, that the Fort Huachuca hospital was to be established, purportedly at the request of the National Medical Association, was immediately repudiated by that organization. In its formal reply to the Secretary's press release, the association stated that Dr. A. N. Vaughn, president of the National Medical Association, refused to endorse the plan, and that they would not subscribe to any form of racial segregation.⁴⁵ The Medical Department responded by informing the Secretary of War, through The Adjutant General:⁴⁶

* * * The point at issue appears to be the purported statement that the Negro association officials specifically requested the present arrangement for the utilization of Negroes in the Medical Service. Actually they have consistently insisted on integration of Negro doctors with white doctors. This had not been done. War Department policy for their use does not contemplate it. However, through patient segregation it has been possible to broaden the Negro doctors' service in the Medical Department, and it has been the impression that the manner in which it was being done, that is, separate departments in these hospitals in which the Negro patient population would justify it and complete Negro staffed hospitals for Negro cantonments, was most satisfactory to the association officials, short of complete integration.

Despite the National Medical Association's protests, it appears that the Medical Department, limited by War Department policy on integration, had acted in good faith to expand the professional activities of Negro physicians, even though it meant changing previous policies of separating patients by disease and substituting segregation by race. Dr. Vaughn had been informed of this policy immediately following the conference of October 1940, and Judge Hastie had endorsed the policy of segregated wards for the benefit of physicians, at least in the South, in March 1940.⁴⁷

⁴⁴ Letter, Dr. M. O. Bousfield, Chairman, National Medical Association Procurement and Assignment Service, to All State and Local Societies of the National Medical Association, 12 Mar. 1942.

⁴⁵ See footnote 37 (1), p. 55.

⁴⁶ (1) Memorandum, Brig. Gen. Larry B. McAfee, Assistant to The Surgeon General, U.S. Army, Chief, Operations Service, Office of The Surgeon General, to The Adjutant General, War Department, 16 Mar. 1942, subject: Secretary of War's Press Conference on Use of Negro Doctors. (2) 2d indorsement, Brig. Gen. Larry B. McAfee, Assistant to The Surgeon General, U.S. Army, Chief, Operations Division, Office of The Surgeon General, to The Adjutant General, War Department, 9 Mar. 1942.

⁴⁷ See footnote 39 (2), p. 55.

Subsequently, both Judge Hastie and Dr. Bousfield, an outspoken opponent of hospital segregation, collaborated with the Medical Department in establishing the Fort Huachuca Station Hospital. Dr. Bousfield was later censured by the National Medical Association for his part in the affair, and his inappropriate recruiting effort also drew expressions of resentment. Others expressed the fear that Dr. Bousfield's geographic origin would result in the choice of too many physicians from the Middle West.⁴⁸ In any event, the special course for the cadre of the 93d (Negro) Infantry Division and the Fort Huachuca Station Hospital began on a sour note. Preparation of a special outline was justified by the lack of prior experience and training on the part of officers selected for the hospital. Apparently, the course proceeded without incident, and all 22 officers were graduated with satisfactory ratings. No further segregated Special Cadre Courses were held.⁴⁹

Special Cadre Courses continued to be offered regularly until July 1943, when the program was terminated. In April 1943, the capacity of the program was expanded from 50 to 100, to allow cadres from nondivisional units to attend. During its more than 2 years of operation, 560 officers graduated from the course.⁵⁰

Schools outside the Medical Department

In addition to courses already discussed at the Chicago Quartermaster Depot and the Edgewood Arsenal Chemical Warfare School, a number of courses were available at Army schools not controlled by the Medical Department. Between July 1941 and July 1942, 46 Medical Department officers were sent to the Command and General Staff School. Twelve MAC officers and three MC officers graduated from the Adjutant General's School, Fort Washington, Md., and a few attended the 2-week Camouflage Course at Fort Belvoir, Va. The following year, 132 completed courses at the Command and General Staff School, 81 completed courses at the Adjutant General's School, 43 completed the Camouflage Course, and four completed the Ordnance Automotive Maintenance Course at the Ordnance School, Atlanta, Ga. Between July 1943 and the end of June 1944, 52 officers graduated from the Command and General Staff School, 180 graduated from the Adjutant General's School, four completed the Camouflage Course, and six completed the Ordnance Automotive Maintenance Course. After June 1944, no officers were reported attending these courses.⁵¹

⁴⁸ (1) Letter, Brig. Gen. Larry B. McAfee, Assistant to The Surgeon General, U.S. Army, Chief, Operations Service, Office of The Surgeon General, to Dr. S. H. Freeman, Secretary, Board of Trustees, National Medical Association, Inc., 7 May 1942. (2) Letter, Dr. W. Harold Branch to The Surgeon General, U.S. Army, 6 Apr. 1942. (3) Letter, Brig. Gen. Larry B. McAfee, Assistant to The Surgeon General, U.S. Army, Chief, Operations Service, Office of The Surgeon General, to Dr. W. Harold Branch, 22 Apr. 1942. (4) Letter, Maj. Gen. J. A. Ulio, The Adjutant General, to Dr. R. M. Hedrick, Chairman, Board of Trustees, National Medical Association, Inc., 9 Mar. 1942.

⁴⁹ (1) Letter, Maj. E. R. Whitehurst, MAC, Assistant to Director, Reserve Division, Personnel Service, Military Personnel Division, Office of The Surgeon General, to the Commandant, Medical Field Service School, Carlisle Barracks, Pa., 25 Nov. 1942, subject: Training of Negro (sic) Medical Officers. 1st indorsement thereto, dated 30 Nov. 1942. (2) Letter, Brig. Gen. Addison D. Davis, Commandant, Medical Field Service School, to The Adjutant General, U.S. Army, 8 Apr. 1942, subject: Special School Report, Special (93d (Negro) Infantry Division) Course 1942, inclosure thereto.

⁵⁰ See footnote 22 (2) and (8), p. 45.

⁵¹ See footnote 14 (3), p. 41; 26 (1), p. 48; and 27 (1), p. 49.

Specialized Technical Training

Training officers for tactical and administrative duties was a serious problem, but equally important was the task of providing physicians, dentists, and veterinarians with the specialized technical training required for medical support of an army of 8 million, employed in a global war. The distribution of technical skills in prewar medicine, geared to diseases common to the continental United States and a small number of industrial accidents, was inadequate to provide medical service for an army beset with combat casualties and exotic diseases, and a civilian population whose industrial activities were accelerated.

Within the American medical profession, only a handful of men had any familiarity with tropical medicine, and the number of thoracic surgeons, neurosurgeons, and similar specialists was small compared to the number required for the rehabilitation of war casualties. At the same time, such specialists as general surgeons, obstetricians, and pediatricians were available in numbers greater than the Army could use. To produce the specialists it needed, the Medical Department instituted a series of technical courses designed to retain physicians with redundant skills. Facilities for these courses were provided by expanding existing programs, establishing new service schools, and harnessing civilian institutions. In sum, the redistribution of technical skills to meet wartime requirements was one of the largest and most significant training problems encountered by the Medical Department in World War II.

Civilian institutions

The Medical Department had used the facilities of civilian institutions to provide specialized training for selected officers since 1920. Throughout the interwar years, the Medical Corps officers sent annually for specialized training had proved invaluable in keeping the Medical Department in contact with professional trends. Faced with the problem of training large numbers of officers in professional specialties at the beginning of the war, the Medical Department again turned to civilian institutions for assistance.

On 23 January 1942, the Office of The Surgeon General asked the Division of Medical Sciences of the National Research Council to recommend medical colleges equipped to provide instruction in general surgery, orthopedic surgery, thoracic surgery, maxillofacial plastic surgery, neurosurgery, clinical pathology, roentgenology, and anesthesiology.⁵² The council was also asked to recommend the length of each course, and to draft outlines of instruction. On 11 April 1942, the Office of The Surgeon General requested that epidemiology, venereal disease control, tropical medicine, and sanitary engineering be added to the list.⁵³

⁵² (1) Informal Memorandum, Maj. F. B. Wakeman, MC, Assistant to The Surgeon General, Chief, Training Division, Operations Service, Office of The Surgeon General, to Lt. Col. Joseph R. Darnall, MC, Professional Service, Surgeon General's Office, 23 Jan. 1942. (2) Letter, Maj. Robert G. Prentiss, Jr., MC, Director, Technical Division, Operations Service, Office of The Surgeon General, to Dr. Lewis H. Weed, Chairman, Division of Medical Sciences, National Research Council, 23 Jan. 1942. (3) 41 Stat. 786.

⁵³ Letter, Lt. Col. Roger G. Prentiss, Jr., MC, Director, Technical Division, Operations Service, Office of The Surgeon General, to Dr. Lewis H. Weed, Chairman, Division of Medical Sciences, National Research Council, 11 Apr. 1942.

Working in cooperation with the Office of The Surgeon General, committees of the National Research Council accepted the project and estimated the number of officers required in each specialty. The project was approved by the Army Service Forces in June 1942, and before the end of the month, facilities were available at 22 civilian institutions for courses in eight specialties. Classes could not begin until September 1942, however, because of a shortage of officers available to attend them.⁵⁴ In the interim, 57 officers were sent to the Mayo Foundation, Rochester, Minn., and to The Johns Hopkins University, Baltimore, Md., for specialized training.⁵⁵

By September 1942, the supply of officers had increased sufficiently so that it was possible to begin most of the courses planned earlier in the year. On 28 September 1942, courses were opened in 12 specialties at 15 civilian institutions. On 2 January 1943, the program was expanded to include seven additional institutions. By June 1943, 2,067 officers had enrolled, and 2,014 had graduated.⁵⁶

In the fall of 1943, most of the courses at civilian institutions were canceled. By June 1944, training was confined to a basic course in neurosurgery at the University of Pennsylvania, Philadelphia, Pa., and to courses in anesthesiology, general surgery, internal medicine, physical therapy, and roentgenology at the Mayo Foundation. Between June 1943 and June 1944, the number of officers completing courses in civilian institutions was reduced to 944.⁵⁷ The following year, enrollment in civilian institutions was reduced even further. In March 1945, the courses in general surgery and internal medicine were canceled. Twelve-week courses in neuropsychiatry at Columbia and New York Universities, located in New York, N.Y., were used to supplement training at the Army School of Military Neuropsychiatry, Mason General Hospital, Long Island, N.Y. A total of 381 officers completed courses between June 1944 and June 1945.⁵⁸

A variety of factors were responsible for the abrupt reduction of training at civilian institutions in the fall of 1943. Chief among these were a renewed shortage of medical officers and a change in policies governing the use of civilian facilities. In September, The Surgeon General reported that he did not have enough physicians in the Army Service Forces to man hospital units scheduled for overseas movement the following January, and the Medical Department began to study the possibility of a wider use of MAC officers in a semiprofessional capacity.

The movement of hospitals to the overseas theaters dramatically reduced the pool of officers available for advanced technical training. Coupled with this development was a change in policies governing the use of civilian institutions. Early in 1943, the War Department began to insist on the maximum utilization of existing

⁵⁴ (1) See footnotes 14 (3), p. 41; and 26 (1), p. 48. (2) Memorandum, Brig. Gen. Larry B. McAfee, Acting The Surgeon General, for the Commanding General, Sixth Service Command, 22 Feb. 1943, subject: Medical Department Training Facilities in the Sixth Service Command. (3) Letter, Col. John A. Rogers, MC, Executive Officer to The Surgeon General, U.S. Army, to Dr. Lewis H. Weed, Chairman, Division of Medical Sciences, National Research Council, 18 May 1942. (4) Memorandum, Col. John A. Rogers, MC, Executive Officer to The Surgeon General, U.S. Army, for the Director of Training, Services of Supply, 22 May 1942, subject: Attendance of Military Personnel at Civilian Educational Institutions. 1st indorsement thereto, 3 June 1942.

⁵⁵ See footnote 14 (3), p. 41.

⁵⁶ See footnote 26 (1), p. 48.

⁵⁷ See footnote 27 (1), p. 49.

⁵⁸ See footnote 35 (2), p. 54.

schools, and the Medical Department began to emphasize the use of military facilities. Officers in the Training Division were unhappy about this policy, but they began to transfer programs to facilities under military jurisdiction.⁵⁹ The Army School of Malariology at Fort Clayton, C.Z., is a case in point: one of the purposes of establishing this school was to bring instruction completely under Army control. Similarly, the course in anesthesiology was terminated at all civilian institutions except the Mayo Foundation, and transferred to named general hospitals.⁶⁰ The only new courses at civilian institutions after September 1943 were added because the urgent requirement for military neuropsychiatrists overtaxed the facilities of the School of Military Neuropsychiatry at Mason General Hospital. Columbia and New York Universities were therefore selected to conduct a 3-month course beginning in April 1944. The course was not repeated.⁶¹

General hospitals

To supplement courses developed along National Research Council guidelines at civilian institutions, special courses in anesthesiology and neurosurgery were established at a number of general hospitals. Five general hospitals began to offer a 3-month course in anesthesiology in January 1943. Because these courses were intended merely to increase the total number of specialists being trained, they essentially duplicated those being offered at civilian schools.⁶² The neurosurgical program, however, was designed to supersede the original civilian course. Dissatisfaction with the programs at civilian institutions, particularly those at the University of Illinois, Chicago, Ill., and the Columbia University Neurological Institute, resulted in the restructuring of the entire program.⁶³

The new two-phase course was established on 26 April 1943. Phase I of the program consisted of 4 weeks of instruction at Columbia University, in the anatomy and physiology of the nervous system, with emphasis on surgical application. During the second phase, students were assigned, singly or in pairs, to neurosurgical centers throughout the country for 60-day periods of practical training. In contrast with the previous program, the practical phase was conducted entirely at military hospitals, where apprentice neurosurgeons saw cases typical of those they would encounter in military practice. On 17 January 1944, the theoretical phase of instruction was shifted to the University of Pennsylvania. It remained there until suspended early in 1945, after the supply of general surgeons available for special training had been

⁵⁹ See footnotes 14 (1), p. 41; and 17, p. 43.

⁶⁰ (1) Annual Report, Army School of Malariology, Fort Clayton, C.Z., fiscal year 1944. (2) Letter, Col. F. B. Wakeman, MC, Director, Training Division, Operations Service, Office of The Surgeon General, to the Director of Military Training, Army Service Forces, 26 Nov. 1943, subject: Courses in Anesthesiology.

⁶¹ (1) Memorandum, Col. F. B. Wakeman, MC, Director, Training Division, Operations Service, Office of The Surgeon General, for Director of Military Training, Army Service Forces, 9 Mar. 1944, subject: Training of Neuropsychiatrists. (2) Memorandum, Brig. Gen. R. W. Bliss, Chief, Operations Service, Office of The Surgeon General, for Commanding General, Army Service Forces, 21 Mar. 1944, subject: Training of Neuropsychiatrists.

⁶² (1) Memorandum, Col. F. B. Wakeman, MC, Director, Training Division, Operations Service, Office of The Surgeon General, to Director of Training, Services of Supply, 13 Nov. 1942, subject: Courses in Anesthesiology. (2) Letter, Maj. Gen. James C. Magee, The Surgeon General, U.S. Army, to the Commanding Officer, Tilton General Hospital, Fort Dix, N. J., 20 Nov. 1942, subject: Training in Anesthesiology.

⁶³ Personal Diary, Lt. Col. R. Glen Spurling, MC, Chief, Neurosurgical Section, Walter Reed General Hospital, Washington, D.C., entry dated 15 Mar. 1943.

exhausted and the needs of the Medical Department had been met. Approximately 245 neurosurgeons were trained during the war, about half through the 3-month program at civilian institutions, and half under the joint military-civilian program.⁶⁴

Army schools

Tropical and military medicine.—Before World War II, graduates of American medical schools were seldom trained to cope with tropical diseases. Recognizing this deficiency, the Subcommittee on Tropical Diseases of the National Research Council recommended, on 9 May 1941, that the Army and the Navy develop programs in tropical medicine. Specifically, they recommended that the services send officers to the Tropics for special training, and that they utilize the facilities of the Tulane University School of Medicine, New Orleans, La., and the School of Tropical Medicine, San Juan, P.R. The subcommittee stood ready to assist the services in developing facilities, and in preparing programs of instruction.⁶⁵

Following a meeting between representatives of The Surgeon General and the Subcommittee on Tropical Diseases on 15 May 1941, the Medical Department agreed to draw up an outline for a course to be offered at the Army Medical Center and to explore the possibility of conducting a course at Tulane University, and another in the Tropics.⁶⁶ Recommendations for the course at the Army Medical Center were approved in June 1941, and classes began in August. The first classes were of 4 weeks' duration, but by the end of the year, course length was extended to 8 weeks to permit the addition of basic subjects in military medicine, including clinical and surgical medicine, preventive medicine, ophthalmology, otolaryngology, roentgenology, dentistry, and veterinary medicine. The title of the course was changed to Tropical and Military Medicine, and the course became, in effect, a substitute for the suspended advanced graduate course, with a heavy emphasis on tropical diseases.⁶⁷ The Surgeon General justified these changes on the basis of "insistent requests of station, corps, and army surgeons that some basic instruction other than that in tropical medicine be given to the officers who had the opportunity to attend the school."⁶⁸

Courses were designed to provide both lectures and laboratory instruction in tropical and parasitic diseases. Content was adjusted from time to time to prepare officers for current or future areas of operation. Instructors were Medical Department officers from the Army Medical School, Walter Reed General Hospital, Washington, D.C., and The Surgeon General's office, as well as specialists from other Government and civilian institutions. Lecturers were provided by the

⁶⁴ Medical Department, United States Army. *Surgery in World War II. Neurosurgery. Volume I.* Washington: U.S. Government Printing Office, 1958.

⁶⁵ Minutes, Meeting, Subcommittee on Tropical Diseases, Division of Medical Sciences, National Research Council, 9 May 1941.

⁶⁶ Minutes, Meeting, Re Special Training in Tropical Diseases, 15 May 1941. [Between representatives of The Surgeon General and the Subcommittee on Tropical Diseases, Division of Medical Sciences, National Research Council.]

⁶⁷ See footnote 10, p. 39.

⁶⁸ Letter, Maj. Gen. James C. Magee, The Surgeon General, U.S. Army, to Lt. Col. Leon A. Fox, MC, Office of the Division Engineer, Caribbean Division, New York, N.Y., 14 Oct. 1941.

Department of Agriculture, the U.S. Public Health Service, the U.S. Navy, the Rockefeller Foundation, and several universities.

Beginning with the 11th course, in January 1943, staff members of medical schools in the United States and Canada were enrolled in the course under the sponsorship of the American Association of Medical Colleges and financed by a grant from the John and Mary R. Markle Foundation. Seventy-two faculty members of colleges, graduates of this program, were prepared to present instruction to students who might subsequently enter the armed services.

The course was originally designed for a maximum of 30 students. By July 1942, the demand for officers with a background in tropical medicine was intense, and by November, enrollment had increased to 106 students. Peak enrollment of 222 was reached in January 1943. Courses continued throughout the war, ending with the graduation of the 23d class in September 1945. A final course of 4 weeks was given in October 1945, with special emphasis on tropical diseases in the Far East. During the war, 1,882 students graduated. Of these, 1,741 were Medical Corps officers, 25 were Sanitary Corps officers, and one was a Women's Army Corps officer. Other graduates included 16 from the U.S. Public Health Service, six from other U.S. Government services, and 83 officers from Allied Nations.⁶⁹

To adjust to the requirements of global war, the course in tropical and military medicine was supplemented by programs emphasizing the control of tropical diseases. During 1942, while the use of civilian institutions for teaching medico-military subjects was still in the planning stages, steps were taken to insure a more adequate emphasis on the control of tropical diseases. The course for medical and field sanitary inspectors was inaugurated at the Medical Field Service School, and a course in tropical medicine at Tulane University similar to the one conducted at the Army Medical Center was incorporated into plans for the utilization of civilian institutions. Instruction on tropical diseases was incorporated into the courses in clinical laboratory and in epidemiology that were to be part of the program at civilian medical schools.⁷⁰

In June 1942, members of the Office of The Surgeon General and its civilian consultants began to discuss the possibility of having the Tennessee Valley Authority conduct a 2-week field course in malaria control at Wilson Dam, Ala.⁷¹ Finally, in December 1942, plans were developed for sending small groups of Medical Department officers to hospitals, stations, and dispensaries along the Pan American Highway in Costa Rica, for 1 to 4 months of practical experience in control of tropical diseases.⁷²

Late in 1942, these plans began to be translated into programs. On 10 August

⁶⁹ Annual Report, Technical Activities, Medical Department Professional Service Schools, Army Medical Center, Washington, D.C., fiscal year 1946.

⁷⁰ (1) See footnote 26 (1), p. 48. (2) Letter, The Adjutant General, War Department, to Commanding General, Caribbean Defense Command, 19 Aug. 1943, subject: Army School of Malariaology, Fort Clayton, C.Z., indorsements thereto.

⁷¹ Letter, Lt. Col. Paul F. Russell, MC, Chief, Tropical Diseases and Malaria Control Section, Epidemiology Division, Preventive Medicine Service, Office of The Surgeon General, to Dr. W. A. Sawyer, Director, International Health Division, the Rockefeller Foundation, 9 July 1942.

⁷² Memorandum, Col. F. B. Wakeman, MC, Director, Training Division, Operations Service, Office of The Surgeon General, to the Director of Training, Services of Supply, 29 Dec. 1942, subject: Applicatory Training in Tropical Diseases.

1942, the field course in malariology was inaugurated at the Tennessee Valley Authority. This course was conducted until 31 October 1942, when it was replaced by a similar course of 3 weeks' duration, conducted by the Florida State Board of Health, in cooperation with the International Health Service of the Rockefeller Foundation, at Pensacola, Fla. By June 1943, 207 officers had graduated from these field courses. Courses in epidemiology and in clinical laboratory began operation in September 1942. In February 1943, the course in tropical medicine at Tulane University was opened, and by June, it had graduated 42 officers. In March 1943, four officers were sent to Costa Rica for field work in malariology along the Pan American Highway.⁷³

By mid-1943, it had become obvious that field programs in tropical diseases, particularly malariology, were too widely scattered for efficient control and that no site in the United States was completely satisfactory for field work in malariology.⁷⁴ In September, the Office of The Surgeon General proposed the establishment of a service school to provide instruction in malariology on the Pacific side of the Canal Zone. The site was chosen because all types of malaria control were used in the area



FIGURE 4.—Army School of Malariology, Fort Clayton, C.Z.

⁷³ (1) Report of the Activities of the Epidemiology Branch for 1942. *In* Annual Report of Activities of Preventive Medicine Division for 1942. (2) Annual Report, Tropical Disease Control Division, Preventive Medicine Division, 1943. (3) See footnote 26 (1), p. 48. (4) Medical Department, United States Army. *Preventive Medicine in World War II*. Volume VI. Communicable Diseases. Washington: U.S. Government Printing Office, 1963, pp. 22–24.

⁷⁴ See footnote 73 (4).

and because it was close to such agencies as the Canal Zone Health Department and the Gorgas Institute.⁷⁵

The Office of The Surgeon General recommended that the Army School of Malariology be activated on 1 January 1944, but the opening was postponed until late in the month because of construction delays and difficulties in acquiring personnel. The 4-week course conducted by the school included instruction in survey and reconnaissance, epidemiology, parasitology, entomology, engineering principles of malaria control, larvicides and insecticides, malaria discipline and individual protective measures, clinical malaria, and antimalarial drugs. Between January and June 1944, 70 students graduated, and the following year, the course was completed by 172 students. The field course in Florida was terminated when the Army School of Malariology opened (fig. 4).⁷⁶

The Army School of Roentgenology.—Before the war, the subject of roentgenology was included in several programs at the Army Medical Center. After many of these programs were suspended in 1940 and 1941, roentgenology was elevated to the status of a formal course. The new 4-week course, designed to prepare junior grade MC officers to operate X-ray equipment, began on 5 January 1942. Course capacity was 50 students each month.⁷⁷

To make room at the Army Medical Center for an expansion of the course in tropical and military medicine, the roentgenology course was transferred to facilities leased in Memphis from the University of Tennessee, and established as the Army School of Roentgenology in December 1942. The first class at the new location enrolled early in January 1943. Class length was extended to 6 weeks, and course capacity was increased to 100. The course continued to be conducted throughout the war. Peak enrollment was reached in 1943, and gradually declined in following years. Course length increased as enrollment fell off, reaching 12 weeks by April 1944, and members of the staff devoted more time to research. Between January 1942 and June 1945, approximately 857 officers graduated.⁷⁸

The School of Military Neuropsychiatry.—Psychiatry became a permanent part of the practice of military medicine during World War I, but in common with other medical specialties, it fell victim to the attrition of peace and depression. In 1940, only 35 officers of the Regular Army Medical Corps were assigned to psychiatric positions, and only four of these were certified by the American Board of Psychiatry and Neurology.⁷⁹ Mobilization and war, however, produced a constantly growing demand for specialists to screen inductees and treat the psychiatric casualties of training and combat.

It was not until 6 months after the beginning of the war, in the face of mounting patient loads, that the Neuropsychiatry Branch (later the Psychiatry Consultants Division) of the Surgeon General's Office became aware of the national shortage of

⁷⁵ See footnote 70 (2), p. 63.

⁷⁶ See footnote 35 (2), p. 54; and 60 (1), p. 61.

⁷⁷ (1) Medical Department, United States Army. *Radiology in World War II*. Washington: U.S. Government Printing Office, 1966. (2) See footnote 14 (3), p. 41.

⁷⁸ (1) Annual Report, Army School of Roentgenology, Memphis, Tenn., fiscal year 1944. (2) Annual Report, Army School of Roentgenology, Memphis, Tenn., fiscal year 1945. (3) See footnote 77 (1).

⁷⁹ Medical Department, United States Army. *Neuropsychiatry in World War II*. Volume I. Zone of Interior. Washington: U.S. Government Printing Office, 1966.

trained psychiatrists, and the need for an intensive training program. Many MC officers assigned to the psychiatric sections of hospitals had had no contact with psychiatric patients since their internship, and even qualified psychiatrists required specialized training to cope with the administrative aspects of military neuropsychiatry. All officers had to be acquainted with Army regulations governing psychiatry, disposition procedures, and testimony before boards and courts-martial. Most had to be prepared for practice under field conditions and the problems of forward areas.⁸⁰

Early in September 1942, the Neuropsychiatry Branch recommended the establishment of a training program, and on 9 October, the Office of The Surgeon General officially requested the authorization for a 4-week course in military neuropsychiatry. Lawson General Hospital was suggested as the site because of its large psychiatric service. The request was approved on 27 October 1942, and on 2 January 1943, the new service school began operation.⁸¹

The School of Military Neuropsychiatry, Lawson General Hospital, began with a staff of four MC officers in existing hospital buildings. The program, consisting of 187 hours of instruction, was designed to orient psychiatrists to the military aspects of their speciality. About two-thirds of the program was devoted to lectures, seminars, and clinical presentations in neurology and psychiatry, and the balance was devoted to administration and military orientation. A total of 308 students graduated from the 11 courses conducted at Lawson General Hospital.⁸²

In October 1943, the school was moved to Mason General Hospital, which had been designated as a specialized treatment hospital for neuropsychiatric casualties. In the spring of 1944, it became apparent that the shortage of trained psychiatrists would continue indefinitely, and the program was redesigned to provide 12 weeks of intensive training for medical officers who had no previous psychiatric experience. With the exception of two "fill in" courses, all subsequent classes were subjected to a total of 600 hours of instruction with a heavy emphasis on orienting physicians to psychiatry. It was at this time that the program temporarily expanded to include courses at Columbia and New York Universities. Both of these universities conducted three such courses, and 227 officers graduated. The School of Military Neuropsychiatry continued to offer classes until 22 December 1945, graduating 692 officers. The total graduates for the military school at both of its locations were exactly 1,000, about two-thirds of whom had no previous background in psychiatry.⁸³

The Professional Service Schools at the Army Medical Center.—Before the war, Medical Department technical training was conducted almost exclusively

⁸⁰ See footnote 79, p. 65.

⁸¹ (1) Menninger, Brig. Gen. William C.: Education and Training in Neuropsychiatry. [Official record.] (2) Memorandum, Col. John A. Rogers, MC, Executive Officer, Office of The Surgeon General, U.S. Army, for Director of Training, Services of Supply, 9 Oct. 1942, subject: Intensive Course of Instruction in Military Neuropsychiatry. (3) Memorandum, Brig. Gen. C. R. Huebner, GSC, Director of Training, Services of Supply, for the Commanding General, Fourth Service Command, 27 Oct. 1942, subject: Establishment of a School for Military Neuropsychiatry.

⁸² (1) Annual Report, School of Military Neuropsychiatry, Lawson General Hospital, Atlanta, Ga., fiscal year 1943. (2) Annual Report, School of Military Neuropsychiatry, Mason General Hospital, Long Island, N.Y., fiscal year 1944.

⁸³ See footnote 79, p. 65.

at the Professional Service Schools at the Army Medical Center. Many courses were suspended at the beginning of the war, and others, such as the course in roentgenology, were transferred to make room for expansion of the course in tropical medicine. The few that remained throughout the war were usually conducted by either the Army Dental School or the Army Veterinary School.

In the prewar era, training in plastic and maxillofacial plastic surgery was provided by the Army Medical School through its professional specialists courses. In August 1941, after these courses had been suspended, the Army Medical School and the Army Dental School joined in cooperative efforts to organize a 4-week course to prepare medical and dental officers to serve on maxillofacial surgical teams. The new course opened on 1 September 1941, and continued to be offered until September 1943, graduating 209 officers. Late in 1942, the length of the course was extended to 6 weeks. Between September 1942 and August 1944, training in maxillofacial plastic surgery was also conducted at civilian institutions.⁸⁴

A new 4-week course in the preparation of blood plasma and the operation of plasma centers was inaugurated at the Army Medical Center in April 1942. The program provided on-the-job training in laboratory techniques and the operation of donor centers. The course continued to be given to a small number of officers throughout the war.⁸⁵

In 1941, the Army Veterinary School reported that some instruction in meat and dairy hygiene was being given to officers of the Sanitary Corps undergoing training for duty as nutrition officers. The program was designed to orient officers to the production, preparation, and distribution of meat for military use. Instruction was informal, consisting of 6 weeks of conferences and demonstrations. Because of space limitations, the Food and Nutrition Course was transferred to the Army Medical School on 10 June 1942, where it remained until February 1945 when it was transferred to the Medical Nutrition Laboratory in Chicago. The number of officers attending the course was always small and was not consistently reported. By the end of the war, course length had been extended to 9 weeks, and the capacity was six officers.⁸⁶

The course in forage inspection, described earlier, was one of the few peacetime courses that continued for the duration of the war. The 1-month Refresher Course in Forage Inspection was authorized on 31 July 1940, as a substitute for the National Guard officers' course and a partial substitute for the Basic Graduate Course for VC officers. Temporarily suspended in June 1942, it was reestablished in March 1943 and continued until after V-J Day. It was conducted 21 times, and 66 officers graduated.⁸⁷

In June 1940, the Veterinary Division of the Surgeon General's Office recommended the establishment of a course in clinical pathology for officers assigned to Medical Department laboratories. A few months later, a 3-month course designated

⁸⁴ (1) Annual Report, Technical Activities, Medical Department Professional Service School, Army Medical Center, Washington, D.C., fiscal year 1942. (2) See footnotes 26 (1), p. 48; and 27 (1), p. 49. (3) Medical Department, United States Army. *United States Army Dental Service in World War II*. Washington: U.S. Government Printing Office, 1955.

⁸⁵ See footnote 10, p. 39.

⁸⁶ See footnotes 35 (2), p. 54, and 84 (1).

⁸⁷ See footnote 16 (1), p. 42.

as the Special Graduate Course in Clinical Pathology was established. The course included 454 hours of instruction and laboratory experience in bacteriology, parasitology, serology, and food chemistry.⁸⁸

On-the-job training for specialized teams.—Early in 1942, the Medical Department formally recognized the need to prepare specialized teams to operate at medical field installations. Small groups such as surgical teams, composed of an operating surgeon and his assistant, an anesthetist, a nurse, and a surgical technician, required practice to integrate their skills and function efficiently. Other specialties in which the teams were required included treatment of shock, splinting, thoracic surgery, maxillofacial plastic surgery, and neurosurgery. On 27 February 1942, all hospitals with a capacity of 500 or more beds were directed to establish team training programs before 1 April.⁸⁹ Formal course outlines were not required, and instruction was to be integrated with the routine duties of personnel at the hospitals. Once the program was established, it became a continuous feature of hospital-level training, although statistics were not reported by the Medical Department.⁹⁰

The School of Aviation Medicine.⁹¹—The priority placed on air defense during the initial phases of the limited emergency brought with it an early expansion and acceleration of the training program at the School of Aviation Medicine. In May 1940, Gen. H. H. Arnold, chief of the Army Air Corps, estimated that during the next year 50,000 physical examinations, in addition to routine examinations, would be required to screen the trainees needed for Air Corps expansion. To train physicians to conduct examinations, he recommended, through The Surgeon General, that the training program for the School of Aviation Medicine under the Protective Mobilization Plan be put into effect on 15 July 1940. His recommendation was approved, and in mid-1940, the basic course at the school was shortened from 3 months to 6 weeks.

During the year it remained in effect, the accelerated course had mixed results. Designed to train Army medical officers as aviation medical examiners, the program was confined to theoretical and clinical instruction in medical specialties, and training time was increased from 43 to 50 hours a week. Between 1 July 1940 and 1 July 1941, approximately 240 medical examiners graduated. That number was adequate, but instructors at the school believed that 6 weeks was not enough time to provide thorough training, and reports from the field confirmed this opinion. At the end of the year, class length was restored to 12 weeks, and the capacity of the school was expanded.

Beginning in April 1942, the course was split into two phases of 6 weeks each. During the first phase, students attended conferences, lectures, demonstrations, and

⁸⁸ (1) See footnote 84 (1), p. 67. (2) Letter, Lt. Col. Ralph B. Stewart, VC, Director, Army Veterinary School, Army Medical Center, Washington, D.C., to the Assistant Commandant, Army Medical Center, Washington, D.C., 3 Aug. 1940, subject: Special Course of Instruction in Veterinary Laboratory Procedure, attachment thereto.

⁸⁹ Letter, The Adjutant General, War Department, to the Commanding Generals of All Corps Areas, Chief of the Air Force, and the Commanding Officers of All Named General Hospitals, 27 Feb. 1942, subject: Training of Auxiliary Surgical Groups.

⁹⁰ See footnote 10, p. 39.

⁹¹ This section is based on Link, Mae Mills, and Coleman, Hubert A.: Department of the Air Force. Medical Support of the Army Air Forces in World War II. Washington: U.S. Government Printing Office, 1955.

clinics at the School of Aviation Medicine. In the second phase, they were sent to special branch schools established at Aviation Cadet Classification Centers for practical training. By assigning students to other stations for half of the course, authorities at the school hoped to double its capacity, and to use students to conduct physical examinations during half of their training. During this period, classes expanded from a capacity of 100 to approximately 320.

Since the classification centers at which the second phase of the medical examiners' course was conducted were initially designed for the examination of cadets, they were not ideally equipped for classes in medical, administrative, and tactical procedures. Training was further complicated by a lack of uniformity in branch school programs. One school, for example, conducted a 3-week course in hospital administration similar to the refresher and pool courses at ASF hospitals. To overcome these difficulties, the Air Surgeon directed a committee to study the training and to recommend a standardized program of instruction, in mid-September 1942. The committee decided that the second phase should be divided into three subcourses of 2 weeks each. During one period, the student was to be assigned to conduct physical examinations on the examining line, and rotated from station to station in the line so that he performed each part of the examination on aircrew applicants. In the second period, he was to conduct psychological studies of aviation cadets, and during the third, he was to be assigned to the station hospital to study medical subjects. The schedule was put into effect in November 1942, but as late as April 1943, branch schools had failed to achieve the desired level of standardization.

On 7 October 1943, the Aviation Medical Examiners' Course was shortened from 12 to 9 weeks, and the branch schools were closed. Between May 1942 and October 1943, 1,020 students had graduated from the San Antonio, Tex., branch school, 666 from the Santa Ana, Calif., branch, and 1,092 from the Nashville, Tenn., branch. After October 1943, all training for aviation medical examiners was conducted at the School of Aviation Medicine. On 31 July 1944, the course was lengthened to 11 weeks to permit the reestablishment of flight training, expand the time devoted to medical studies, and provide students with a free afternoon each week.

During the course of World War II, the School of Aviation Medicine expanded its curriculum to embrace many subjects which had previously been confined to schools under the direct control of The Surgeon General. Traditionally, medical officers assigned to the Army Air Corps had received their training in military medicine, tactics, and administration at the Medical Field Service School, and then attended the School of Aviation Medicine to be trained as aviation medical examiners and eventually become flight surgeons.⁹² During 1941, when the course was compressed into 6 weeks of intensive training, main emphasis was placed on conducting physical examinations at classification centers and on related subjects, such as cardiology and physical diagnosis. After December 1941, mounting criticism of the officers graduating from the course brought a shift in emphasis

⁹² Aviation medical examiners became qualified as flight surgeons after a specified period of time, usually 1 year, on duty with the Army Air Forces. The period needed to qualify varied during the war and could be modified by the amount of flight time accumulated by an officer.

toward military medicine and administration. By March 1942, the commandant of the school was able to report:

* * * The course at the School of Aviation Medicine has materially changed since October, as we are stressing the practical aspects of field duty more and more and the physical examination is only of material interest to those who are assigned to classification centers and replacement centers. To be sure 64 examinations are made but they are few and far apart except at the centers mentioned. We have added tropical medicine, field sanitation and hygiene, first aid, shock treatment, low pressure chamber work and other features to our curriculum. Furthermore, some compulsory exercise and drill have been added.⁹³

In November 1942, a Department of Military Medicine was added to the school and made responsible for instruction in the organization and functions of the Army Air Forces, field sanitation and hygiene, chemical warfare, supply and administration, and field exercises. By October 1943, a 6-day bivouac had been added. During the same period, training in medical specialties was increased, and beginning in April 1944, a policy of sending all MC officers assigned to the Army Air Forces to the School of Aviation Medicine was adopted. Finally, after July 1944, officers eligible for service in theaters of operations were assigned to the Tactical Unit Surgeon's Course at the AAF School of Applied Tactics, Orlando, Fla., to be trained in tactics, military aspects of medicine, and administration.

The trend toward incorporating tactical, medicomilitary, and administrative subjects into the curriculum of the School of Aviation Medicine paralleled developments in Special Service Schools and other ASF training programs. The course in tropical medicine, for example, integrated administrative and tactical subjects into the technical curriculum early in the war. Similar developments took place at the Medical Field Service School itself, in the course for medical field and sanitary inspectors, and in pools established at medical installations. The underlying cause of this duplication of efforts lay in the inability of the Medical Field Service School to provide basic training for all Medical Department officers as soon as they reported for duty.

Programs for Negro flight surgeons were also a problem. During the first year of the war, the School of Aviation Medicine was able to keep Negroes from attending by enrolling them in extension courses. Three Negro officers enrolled in the extension course graduated in February 1943. When this policy was brought to the attention of the Secretary of War by Judge Hastie in January 1943, the policy was changed to provide equal standards for admission. The first Negro officers graduated from the course in March 1943.

Mid-War Additions to the Medical Department Program

By late 1943, the pace of unit activations had slowed and training efforts were reduced in the main to providing replacements. At this point, planners began to turn their attention to adjustments in the training process, special courses for special situations, and eventually, to planning for the cessation of hostilities. During the last 2 years of the war, a series of courses was added to the program whose only common denominator was being established to meet special needs.

⁹³ See footnote 91, p. 68.

Anesthesiology for portable surgical hospitals.—A special course in anesthesiology for portable surgical hospitals was conducted from 7 August to 4 September 1943. The object of this special course was to provide personnel trained to use the limited anesthetic equipment allotted to portable surgical hospitals. The course was conducted at Halloran General Hospital, Staten Island, N. Y., Nichols General Hospital, Louisville, Ky., and the station hospitals at Fort Bragg and Camp Breckinridge, Morganfield, Ky. A total of 12 officers graduated.⁹⁴

The Army Ground Forces refresher course.—In December 1943, the commanding general of the Army Ground Forces requested that the Medical Department establish a refresher course in medical and surgical treatment of battle casualties in forward areas for officers assigned to medical detachments and divisional medical battalions. In response, the Office of The Surgeon General developed a 4-week program of on-the-job training at named general hospitals. Forty-eight hours' training time was devoted to each of four subject areas: Amputations and fractures, neurosurgery and anesthesiology, neuropsychiatry and medicine, and roentgenology and chest and abdominal surgery. The training consisted of reviewing the case histories of battle casualties, making ward rounds with the chiefs of hospital services, and participating in the weekly clinical conferences of staff sections and the general staff of hospitals.

The first 4-week AGF Refresher Course in First and Second Echelon Medical and Surgical Care was initiated on 29 April 1944 at the following general hospitals: Bushnell, Brigham City, Utah; Percy Jones, Battle Creek, Mich.; Walter Reed; Brooke, San Antonio, Tex.; and McCloskey, Temple, Tex. Courses continued until November 1944, when the program was discontinued.⁹⁵

Electroencephalography.—In July 1944, a 4-week course was established at Walter Reed and Mason General Hospitals to train officers in the operation and interpretation of electroencephalographs. Each course had a capacity of four students. Subsequently, similar courses were established at Brooke General Hospital and DeWitt General Hospital, Auburn, Calif. By the end of June 1945, a total of 35 students had graduated.⁹⁶

Orientation for female S_NC officers.—In November 1944, a 2-week course was established at Billings General Hospital, Indianapolis, Ind., for newly commissioned members of the Women's Army Corps (detailed to the Sanitary Corps) as bacteriologists, biochemists, or serologists. By the time the course was terminated in March 1945, 31 officers had graduated.

⁹⁴ (1) Letter, Col. Charles H. Moseley, MC, Deputy Director, Training Division, Operations Service, Office of The Surgeon General, U.S. Army, to the Director of Military Training, Army Service Forces, 21 July 1943, subject: Special Course in Anesthesiology. (2) See footnote 27 (1), p. 49. (3) Letter, The Surgeon General, U.S. Army, to the Commanding Officer, Nichols General Hospital, Louisville, Ky., 28 July 1943, subject: Special Training Course in Anesthesiology.

⁹⁵ (1) Letter, Commanding General, Army Ground Forces, to Commanding General, Army Service Forces, 4 Dec. 1943, subject: Course of Instruction for Medical Officers, indorsements and inclosure thereto. (2) Memorandum, Col. Floyd L. Wergeland, MC, Director, Training Division, Operations Service, Office of The Surgeon General, U.S. Army, for Director of Military Training, Army Service Forces, 13 Apr. 1944, subject: Refresher Course for Medical Corps Officers of the Army Ground Forces, indorsement and inclosure thereto. (3) See footnote 35 (2), p. 54.

⁹⁶ Memorandum, Lt. Col. Chas. H. Moseley, MC, Deputy Director, Training Division, Operations Service, Office of The Surgeon General, U.S. Army, to Director of Military Training, Army Service Forces, 26 June 1944, subject: Applicatory Training of Medical Corps Officers in Electroencephalography.

Refresher courses for Medical Department officers.—At the beginning of World War II, many Regular Army officers had been transferred from professional duties to administrative posts, where their administrative skills and experience could be used to guide the Medical Department's expansion. By late 1944, large numbers of medical, dental, and veterinary officers had already served long periods in administrative or semiprofessional assignments. When peace returned and the Army was demobilized, many would be returned to clinical duties.

Plans for refresher training to bring Medical Department officers up to date with developments in their specialties were approved in the fall of 1944, and on 17 November, a "Guide for the Professional Refresher Training of Medical Corps Officers" was approved. This guide was used as background material for 12 weeks of on-the-job refresher training for MC officers in general medicine and general surgery. By early 1945, 48 general hospitals were participating in the program. By June 1945, 176 MC officers had completed the refresher course. In April and May 1945, guides for refresher training were approved for DC and SnC officers, and courses were established for them at general hospitals.

THE ARMY SPECIALIZED TRAINING PROGRAM⁹⁷

Between 1943 and 1945, 29,730 enlisted men were assigned to ASTP (Army Specialized Training Program) units at civilian schools to be trained as physicians, dentists, and veterinarians, and approximately 4,900 enlisted men were assigned to ASTP units at colleges and universities for preprofessional training. Before the program was terminated in July 1946, 16,429 enlisted men graduated from professional schools and became available for appointment as officers in the Medical Department.⁹⁸

World War I Precedents

The World War II Army Specialized Training Program had antecedents in World War I. Following the passage of the Selective Service Act of 1917, medical schools sought to have students exempted from induction on the ground that their value to the Armed Forces would be greater if their education were continued through graduation. A prolonged war might even produce a serious shortage of physicians. Medical students were not exempted, but by the end of August 1917, the Army had made it possible for full-time medical, dental, and veterinary students entering the service to be assigned to the Medical Enlisted Reserve Corps in an inactive status to continue studies at their own expense. Students could retain their inactive status through residency if their academic progress was satisfactory. The program was placed under the supervision of The Surgeon General.⁹⁹

⁹⁷ Except as otherwise noted, this section is based on Fitts, Francis M.: *Training in Medicine, Dentistry, and Veterinary Medicine, and in Preparation Therefor, Under the Army Specialized Training Program, 1 May 1943 to 31 Dec. 1945.* [Official record.]

⁹⁸ See footnote 17, p. 43.

⁹⁹ *The Medical Department of the United States Army in the World War.* Washington: Government Printing Office, 1923, vol. I.

By March 1918, 60 percent of the medical students in recognized schools of medicine had entered the Enlisted Reserve Corps. Those not under military jurisdiction consisted of aliens, the physically disqualified, registrants deferred because of dependents, overage students, and those who had not reached age 21. Statistics are not available for dental and veterinary students. In August 1918, enlistments and transfers to the Enlisted Reserve Corps were discontinued because SATC (Students' Army Training Corps) was established. That fall, all members of the Enlisted Reserve except those serving hospital internships were called to active duty and transferred to SATC units established at the schools in which they were enrolled. Since these trainees were discharged shortly after the armistice, little information on this experiment is available. Despite provisions for the voluntary continuation of professional studies, the eagerness of that generation to participate in the war effort resulted in a serious reduction of the number entering or continuing their studies.

Neither program made specific provisions for preprofessional students. Those preparing for medical, dental, and veterinary schools had no protection beyond general enrollment in the Students' Army Training Corps. Since the age of induction was not lowered from 21 to 18 until 31 August 1918, failure to assure a continuous flow of students into professional schools created no serious military problems. Had the war continued for several years, however, a shortage of physicians, dentists, and veterinarians might have developed.

National Emergency Programs

Between wars, little thought appears to have been given to providing uninterrupted training for professional and preprofessional students. It was not until after the declaration of a limited national emergency in 1939, when educators became concerned that medical students who had earned Reserve commissions outside the Medical Department as undergraduates might be mobilized as line officers, that the question received formal consideration.¹⁰⁰

In April 1940, as a result of a study of medical officer procurement, the War Department made it possible to transfer full-time medical, veterinary, and dental students with Reserve commissions to the MAC Officers' Reserve during mobilization. On 28 August 1940, the day after Congress authorized limited mobilization, the transfer was put into effect by War Department directive.¹⁰¹

Under the Selective Training and Service Act of September 1940, students were exempted from the draft until July 1941, but residents and interns were required to seek occupational deferments from their local boards. While such

¹⁰⁰ Letter, The Adjutant General, War Department, to Each Corps Area and Department Commander; Each Chief of Arm or Service, 17 Apr. 1940, subject: Special Mobilization Procedures for Procurement of Medical Department Reserve Officers Who Are Students in Approved Medical Schools.

¹⁰¹ (1) Letter, Col. James E. Baylis, MC, Executive Officer to The Surgeon General, to The Adjutant General, War Department, 9 Aug. 1940, subject: Special Mobilization Procedures for Procurement of Medical Department Reserve Officers Who Are Students in Approved Medical Schools. 1st indorsement thereto, 3 Sept. 1940. (2) Letter, The Adjutant General, War Department, to Each Corps Area and Department Commander; Each Chief of Arm or Service, 28 Aug. 1940, subject: Special Mobilization Procedures for Procurement of Medical Department Reserve Officers Who Are Students in Approved Medical Schools. (3) See footnote 100.

deferments were usually granted, they could not be guaranteed. In May and June 1941, the War Department authorized the appointment of full-time juniors and seniors in approved schools of medicine to the Medical Administrative Corps, and postponement of their call to active duty. A year later, similar appointments were authorized for students in the two lower classes and for students who had been accepted for the next entering class. After completing their studies, these officers were to be transferred to either the Medical, Dental, or Veterinary Corps.

By February 1943, when the program was discontinued, commissions in the Medical Administrative Corps were held by 13,108 medical, 5,838 dental, and 1,116 veterinary students. The Navy provided a similar program, and by March 1943, when the National Selective Service recommended that local boards defer full-time students in these fields, there were few physically qualified male students who had not enrolled in the wartime Reserve. This change in policy by the Selective Service proved of value, however, for it also extended deferments to preprofessional students who were accepted for approved professional studies and would complete their undergraduate work within 24 months.¹⁰²

Students in other fields had less extensive opportunities to continue their education. In May 1942, the War Department authorized the voluntary enlistment of college students in the Enlisted Reserve Corps, with the understanding that they were to be exempted from active service as long as the military situation permitted. Medical, dental, and veterinary students could not participate in this program, but preprofessional students who had not yet been accepted by a professional school were able to take full advantage of it.¹⁰³

The War Department Program¹⁰⁴

The decision to initiate the military college training program grew out of the War Department's recognition that lowering the selective service age to 18 would cut off the supply of college-trained men. The armed services could not afford the luxury of allowing a large proportion of the Nation's military manpower to spend 4 years engaged in studies not necessarily vital to the war effort, but neither could they afford to destroy their source of college-trained men who could serve as officers and technicians. Planners also had to consider the impact of reducing the draft age to 18 on the Nation's colleges and universities.

In January 1942, and again in July, representatives of the Nation's colleges met at conferences sponsored by the American Council on Education, to discuss the effect of war on higher education. In both instances, statements were issued urging the Government to make maximum use of college facilities, to grant Federal aid to accelerate training, and to draft plans for using the resources of educational institutions in the war effort. Anticipating that both industry and educators would

¹⁰² See footnote 17, p. 43.

¹⁰³ Letter, The Adjutant General, War Department, to Corps Area and Similar Commanders, 25 May 1942, subject: Preinduction Training in Colleges and Universities, inclosures thereto.

¹⁰⁴ This section is based on "History of Military Training, Army Specialized Training Program, Army Service Forces, From Its Beginning to 31 Dec. 1944, With Supplement to 30 June 1945." [Official record.]

oppose reducing the draft age to 18, the War Department began to make plans for an Army-Navy college training program.

On 25 September 1942, the Commanding General, ASF, was directed to prepare a detailed plan for an Army college training program. On 13 November, the President signed an amendment to the Selective Service Act, reducing the draft age to 18, and on 17 December, the Secretaries of the War and Navy Departments announced an Army-Navy college training program. The programs announced by the two secretaries became the Army Specialized Training Program and the Navy College Training Program commonly known as the V-12.

Basic policies guiding ASF planning for the Army Specialized Training Program were developed during a series of conferences between representatives of the War Department and American colleges and universities. Guidelines for the program were incorporated into the memorandum of 25 September 1942, directing the Commanding General, ASF, to develop detailed plans for the Army Specialized Training Program. The number of men to be trained, and their fields of specialization, were to be determined by the Army's needs. Trainees were to be selected from the Army at large, on the basis of previous academic training, the results of scholastic aptitude and achievement tests, and the qualities of leadership demonstrated during military service. Selection was to be preceded by basic military training. During their college training, men assigned to the program were to be on an active-duty status, organized, administered, and disciplined under a cadet system. The curriculum, the duration of training, and the number of men in each course were to be determined by the Army.

In exceptional cases, cadets who were selected for service in nonmilitary activities were to be transferred to the Reserve, for employment in civilian status, subject to recall to active duty. Recommendations were also included for the kinds and levels of instruction, the acceleration of academic training, and the selection of trainees. The detailed plan based on these guidelines was developed by the Personnel Division, ASF, after further conferences.

The final plan for the Army Specialized Training Program, released by the Secretaries of War and Navy on 17 December 1942, modified many of the guidelines in the memorandum of 25 September. Medical and dental students, and members of the Enlisted Reserve Corps, were exempted from basic military training. Selection was placed under the control of the War Department and was to follow the general guidelines for selecting officer candidates. Enlisted men over the age of 22 were eligible only for advanced training. Trainees were to be privates, seventh grade, and given military training under a cadet system, concurrent with their academic training. Academic standards were to be formulated after consultation with the U.S. Office of Education and the American Council on Education. Men in training were to undergo continuous screening, and failing trainees were to be promptly relieved and reassigned.

Graduates of the program were to be selected for further training at an officer candidate school, recommended for ratings as technical noncommissioned officers, or returned to troops. Responsibility for the operation of the program was assigned to the Army Service Forces. A memorandum from the Secretaries, submitting the

plan for the President's approval on 3 December 1942, stipulated that not more than 150,000 men would be trained by the Army at any one time, of whom 40,000 would be medical, dental, veterinary, premedical, and pre dental students.

Special provisions were included for members of the Enlisted Reserve Corps and the Reserve Officers' Training Corps, and medical, dental, and veterinary students who held Reserve commissions in the Medical Administrative Corps, to insure that their previous training would be utilized, and that there would be no discrimination against them. It was considered discriminatory to deprive them of opportunities for further training, or to require them to continue at their own expense. Premedical and pre dental students in the Enlisted Reserve Corps were to be called to active duty at the end of the first full term beginning in 1943, and detailed to continue their studies. Medical, veterinary, or dental students commissioned in the Medical Administrative Corps were given the opportunity to resign their commissions and enlist as privates to continue their studies at Government expense. Premedical students not in the Enlisted Reserve Corps, if inducted through selective service, were to be placed on inactive duty until the end of the first full term beginning in 1943, and were then to be called to active duty. Thereafter, they could be assigned to the Army Specialized Training Program for further medical or premedical training, or to other military duties.

Between its establishment late in 1942, and its termination in 1946, the Army Specialized Training Program underwent continuous change. Of major importance were fluctuations in the program's size. At the beginning, ceiling strength was set at 150,000. By September 1943, the Army Specialized Training Program had reached a strength of approximately 124,000 trainees and was still growing. On 16 September, however, the War Department let it be known that the program would probably be reduced, and on 1 November 1943, the Secretary of War directed that total enrollment be reduced to 95,000 by 30 June 1944, and to 40,000 by the end of December. The program reached a peak strength of 140,000 in January 1944, when plans for reduction to prescribed ceilings were put into effect. On 10 February 1944, the Chief of Staff, War Department General Staff, sent a strongly worded memorandum to the Secretary of War, recommending a drastic reduction of ceilings to a maximum of 30,000. On 16 February, the War Department General Staff, G-1, Personnel, informed the Commanding General, ASF, that a ceiling of 30,000 ASTP trainees would become effective on 1 April. Those remaining in the program would consist entirely of advanced technical, preprofessional, and professional trainees.

In response to this directive, a plan, submitted on 25 February 1944, recommended that 25,000 professional and preprofessional medical, dental, and veterinary trainees be retained in the program, and that an additional 1,000 vacancies be reserved for soldiers who held acceptances from professional schools but were not yet enrolled in the Army Specialized Training Program. It also recommended that the Army Specialized Training Program include 2,000 foreign area and language trainees, 3,000 advanced engineering trainees, and a small group of men in other programs. Under this plan, total enrollment would have been reduced to 34,100. With revisions that reduced it to 30,000 trainees, the Secretary of War approved the plan on 28 February 1944. As a result of these decisions, medical, dental, and

TABLE 2.—*Summary of Army Specialized Training Program demands, by arms and services, January 1943–July 1944*

Arms and services	1943				1944		
	January	April	July	October	January	April	July
Army Air Forces.....			43,997	10,197	12,790	100	100
Army Ground Forces.....		46,995	55,985	40,520	40,520	2,350	2,350
Classified.....			3,156	3,156	3,156	955	955
Corps of Engineers.....	6,633	6,633	3,000	3,000	4,500	1,700	1,700
Chemical Warfare Service.....	1,683	1,683	500	500	500	50	50
Ordnance.....	1,650	1,650		900	900	645	645
Signal Corps.....	4,925	4,925	13,707	13,707	13,234	3,001	3,001
Transportation Corps.....			50	50			
Surgeon General.....	5,630	5,630	5,630	5,630	5,630	5,665	5,665
Adjutant General's Office.....	1,170	1,170	1,100	1,100			
Provost Marshal General.....	1,595	1,595	1,600				
Total.....	23,286	70,281	128,725	78,760	81,230	14,466	14,466

Source: History of Military Training, Army Specialized Training Program, Army Service Forces, From Its Beginning to 31 December 1944, With Supplement to 30 June 1945. [Official record.]

veterinary students were the largest single group of Army Specialized Training Program trainees after April 1944 as reflected in table 2.

Medical, Dental, and Veterinary Training

Army specialized training in medicine, dentistry, and veterinary medicine differed from other Army specialized training in a variety of ways.¹⁰⁵ Because study in these fields led to professional degrees, the program was longer and followed the regular curriculum of professional schools. Instead of adopting the standard 12-week ASTP cycle, many schools remained on the quarter or the semester. Provisions for physical and military training were different, and because most medical, dental, and veterinary students were on commutation of quarters and rations, there were differences in local administrative problems. Since most students in these fields had begun their professional or preprofessional training before the establishment of the Army Specialized Training Program, most of them were selected under other than ASTP procedures; and, while Medical Department officers connected with the program were fond of repeatedly saying that trainees were not "students in uniform" but "soldiers in college," the differences between standard Army specialized training and the Army Specialized Training Program in medical specialties was so marked that, in May 1943, a representative of the Army Specialized Training Division told participants at an ASF conference that contracts with medical schools fell into a separate category from standard ASTP contracts because "* * * we are putting professional students into uniform, we are not

¹⁰⁵ See footnote 97, p. 72.

putting soldiers into medical colleges. * * * most of these boys have had no military training at all; we are merely going to put a uniform on them and let them keep right on doing what they have been doing all the time."¹⁰⁶

The program in operation.—During the spring and summer of 1943, all members of the Enlisted Reserve Corps, who had reached age 18, were called for active duty. Upon completion of basic military training, they, and all other enlisted men in the Zone of Interior (except loss replacements and those in alerted units), were eligible for selection for the Army Specialized Training Program. Medical, dental, and veterinary students in approved schools, who were called to active duty as members of the Enlisted Reserve Corps or inducted through the Selective Service System, were not required to receive basic military training before assignment, but were processed through reception centers and immediately returned to the schools in which they were enrolled as members of the school's ASTU (Army Specialized Training Unit). Members of the Enlisted Reserve Corps who had been accepted for admission to a 1943 or 1944 professional school freshman class were also exempted from basic training and were granted the option of remaining on inactive status to complete prerequisites for admission. Those who did not elect to remain on inactive status were processed at reception centers and sent to a STAR (Specialized Training and Reassignment) unit for verification of their admission to professional schools, and for evaluation of their progress toward completing entrance requirements.

This information was forwarded to the Army Service Forces, which ordered the trainee to an Army Specialized Training Unit to complete his preprofessional training. Enlisted men with 1943 and 1944 acceptances, who had finished basic military training without completing their preprofessional training, were also sent to STAR units for classification and assignment. In short, the War Department did everything possible not to interrupt the professional and preprofessional training of potential physicians, dentists, and veterinarians.

Enlisted men who had completed their preprofessional training and been accepted by a professional school were assigned interim duties until they could be enrolled in a freshmen class. Such duties were performed on an "attached-unassigned" status at Medical Department installations within the service command in which the professional school was located, or in which the trainee was then stationed. The period of interim duties varied from 1 to 8 months.

By honoring the commitments of individual schools during 1943 and 1944, the War Department, in effect, delegated responsibility for selecting trainees to accredited medical, dental, and veterinary colleges. A major factor in this decision was the presence in the Army of a large number of enlisted men with premedical or predental training who had either failed to apply for acceptance at a professional school, or failed to gain admission. To avoid selecting these men at the expense of those already admitted, the Army agreed to accept the admissions of individual schools for freshman classes beginning in 1943 and 1944.

¹⁰⁶ Remarks of Lt. Col. Blake R. Van Leer, MC, at Army Service Forces Conference on Negotiation and Renegotiation Procedure for Training Unit Contracts for Securing Services and Facilities of Non-Federal Education Institutions, Omaha, Neb., 28 May 1943.

The number of men accepted by individual schools for classes beginning in 1943 and 1944 was estimated to be adequate to meet the Medical Department's 1946 and 1947 demand schedules. However, demand schedules for subsequent years could be met only by selecting and assigning enlisted men for training in medicine and dentistry. Satisfaction of the Medical Department's annual demand schedule for 4,200 physicians, 1,100 dentists, and 150 veterinarians required the reservation of 3,600 freshman medical school and 825 dental school vacancies in each 9-month cycle. Because of the disproportionately large number of enlisted men in veterinary training, additional training in this field was not required. To guarantee these vacancies, the War Department entered contracts with medical and dental schools to reserve 55 percent of the freshman medical capacity and 35 percent of the freshman dental capacity in each class beginning after 1 January 1945. The schools were advised that vacancies in 1945 freshman classes would no longer be filled by honoring the selections of individual institutions. Instead, representatives of medical and dental education would participate in the selection of enlisted men to fill Army-reserved freshman vacancies.

To fill its reserved vacancies, the Army was required to provide an average of 400 medical and 100 dental trainees each month. This level of enrollment could be maintained only by selecting trainees from those who had demonstrated their academic competence by completing two or three terms of the basic ASTP curriculum. Courses required for admission to medical or dental school could then be completed in three additional terms—a total period of 60 weeks. Assuming a loss in these three terms of only 15 percent, a monthly input of 625 trainees into term 3 of the preprofessional curriculum was necessary to meet the contract obligations for the utilization of freshman vacancies. While it was assumed that a number of potential candidates might be discovered in the Army at large, their numbers and qualifications were so uncertain that they could not be counted upon to furnish a continuous flow of trainees. Thus, plans for professional training after 1944 required continuation of the basic phase of the Army Specialized Training Program at a level sufficient to provide a choice of candidates for preprofessional training.

The basic phase of the Army Specialized Training Program was discontinued on 1 April 1944, and approximately 42,000 trainees enrolled in the basic program were assigned other military duties. Only those who had been selected from basic ASTP cycles ending in December, January, and February were transferred to the preprofessional program. On 18 April, ASF headquarters announced that the Army's share of classes entering medical schools during 1945 would be cut from 55 percent to 28 percent, and for dental schools, from 25 percent to 18 percent; no commitments were to be made for classes starting in 1946.¹⁰⁷

Meanwhile, the question of reducing the dental Army Specialized Training Program became involved with that of discharging dentists already in the service. In March 1944, the Dental Corps had reached its ceiling strength and was faced with the prospect of having more graduates than it needed. On 18 July, the War

¹⁰⁷ Memorandum, Brig. Gen. W. L. Weible, GSC, Director of Military Training, Army Service Forces, for The Surgeon General, 18 Apr. 1944, subject: War Department Policy Governing Training in Medicine and Dentistry under Army Specialized Training Program.

Department announced that training would be terminated. Only those who were seniors in July were able to continue, and the dental Army Specialized Training Program came to an end when they graduated in April 1945.

In May 1944, The Surgeon General approved the termination of the veterinary phase of the Army Specialized Training Program. Apparently, the Veterinary Division considered the program no longer necessary, since the Veterinary Corps was near its authorized strength, and having little difficulty in recruiting veterinarians from civilian practice.¹⁰⁸

The future of the medical phase of the Army Specialized Training Program was a matter of more concern to The Surgeon General. The collapse of Japan raised the problem of whether the Army should continue the program to meet civilian needs for doctors. Some War Department authorities feared the Army would be criticized for the lack of medical training during the war, while others believed that training should be confined to meeting the future needs of the Army. Maj. Gen. (later Gen.) Brehon B. Somervell, Commanding General, ASF, believed that the Army could not justify continuing expenditures and recommended that medical courses be terminated during the academic year 1945-46. The Surgeon General believed that young medical officers who had received their education at Government expense should be ordered to active duty as replacements for older medical officers with long periods of service.¹⁰⁹

Two months after the defeat of Japan, the Medical Department recommended that the program be continued as a source of replacements. In light of past difficulties in recruiting physicians for the Regular Army, it took a dim view of the loss of 5,000 medical officers that would result from terminating the program in June 1946. The Chief of Staff did not agree, and in November 1945, the War Department announced that the program would be terminated on 1 July 1946. With specified exceptions, those scheduled to graduate before 1 July 1946 were to be retained for service. Those scheduled for graduation after that date were to be separated from the program in March 1946. Upon separation, they were transferred to the Enlisted Reserve Corps in an inactive status and subject to recall if they failed to complete their studies. Those who were unable to continue their studies were transferred to other duties and discharged when they became eligible. The medical phase of Army Specialized Training Program came to an end a year after the dental and veterinary phases and permitted the Army to solve many of its postwar personnel problems. Total enrollment in professional courses, and their output, as a result of the Army Specialized Training Program, are summarized in table 3.

Peak enrollment was reached in March 1944, when 21,581 enlisted men were in training: 14,042 in medicine, 6,143 in dentistry, and 1,396 in veterinary medicine. Peak enrollment in preprofessional training was reached in April of the same year, when 4,093 enlisted men were enrolled. Precise figures for total enrollment in

¹⁰⁸ See footnote 17, p. 43.

¹⁰⁹ (1) Letter, Maj. Gen. I. H. Edwards, GSC Assistant Chief of Staff, G-3, to Prof. Philip Lawrence Harrison, Bucknell University, Lewisburg, Pa., 23 Aug. 1945. (2) Memorandum, Gen. Brehon B. Somervell, Commanding General, Army Service Forces, for Chief of Staff, U.S. Army, 4 Sept. 1945, subject: Future of Army Specialized Training Program. (3) Letter, Maj. Gen. Norman T. Kirk, The Surgeon General, U.S. Army, to the Honorable L. Mendel Rivers, House of Representatives, 16 Oct. 1945.

TABLE 3.—*The Army Specialized Training Program: Students of medicine, dentistry, and veterinary medicine assigned, separated, discharged, and transferred through curtailment of the program*

Student status	Medicine	Dentistry	Veterinary medicine
Assigned.....	20,336	7,734	1,660
Separated.....	15,216	3,031	679
By graduation.....	(13,373)	(2,458)	(598)
By failure.....	(1,045)	(472)	(41)
For other reasons.....	(798)	(101)	(40)
Curtailment.....	5,120	4,703	981
Discharged.....	(5,120)	(4,651)	(940)
Transferred.....		(52)	(41)

NOTE.—Figures in parentheses are subtotals.

Source: (1) Fitts, Francis M.: Training in Medicine, Dentistry, and Veterinary Medicine, and in Preparation Thereof, Under the Army Specialized Training Program, 1 May 1943 to 31 December 1945. [Official record.] (2) Letter, Col. Francis M. Fitts, MC (Ret.), to Col. John B. Coates, Jr., MC, Director, Historical Unit, U.S. Army Medical Service, 15 Nov. 1955.

preprofessional courses throughout the life of the program are not available, but approximately 3,500 were assigned to premedical, about 1,400 to predental, and an unknown number to preveterinary studies.¹¹⁰

Curriculum.—The curriculum adopted for enlisted men in engineering and in area language studies was designed to meet specific requirements of the arms and services. Many traditional college courses, oriented toward scientific or liberal arts degrees, were modified in content, duration, or emphasis to provide soldiers with special skills in the shortest possible time. College credits and academic degrees were secondary and had little military value. ASTP curriculums for medical, dental, and veterinary students were the exception because graduation from a professional school approved by the War Department was a prerequisite for commissioning. Since these schools had accelerated their programs by eliminating long vacations and holidays before the establishment of the Army Specialized Training Program, it was not even necessary to shorten the length of their programs. Contracts, therefore, merely stipulated that the ASTP trainees at these institutions would follow the contractor's standard curriculum under the accelerated program recommended by the national professional association of which it was a member. Schools were unofficially requested to remain in session 48 weeks of each calendar year, since no more than 30 days annual leave could be routinely granted to Army trainees.

Since the Army had accepted the standards of professional schools for graduation, it had little choice but to accept their standards for admission. Success of the preprofessional program, and in the long run, the professional program, depended upon graduates being acceptable for advanced training. Despite these limitations, the Army was able to make significant changes through standardization and acceleration. Standards for admission to accredited medical, dental, and veterinary

¹¹⁰ See footnote 17, p. 43.

schools had been formulated by professional associations, college accrediting associations, and the schools themselves, long before the establishment of the Army Specialized Training Program. The requirement for admission to medical schools was a minimum of 2 years of college work that included courses in English, physics, biology, and general and organic chemistry. Three years of college were recommended, and a number of medical schools required 4 years. A few required the degree of bachelor of arts or science. Schools were free to expand these requirements, and beyond meeting minimum standards, professional school admission requirements varied widely. Requirements for admission to schools of dentistry and of veterinary medicine were lower, but since only one preparatory curriculum could be adopted for the Army Specialized Training Program, the program had to meet medical school standards.

By the time the Army Specialized Training Program was established, college associations had already paved the way for standardization and acceleration by recommending that professional schools contribute to the war effort by accepting applicants who satisfied minimum requirements for admission. At the request of the Director, Army Specialized Training Division, The Surgeon General invited selected representatives of medical, dental, and veterinary education to a conference in January 1943. This committee recommended that the professional program consist of 30 term hours of required basic courses, and 60 term hours of electives. Required courses were to include 8 term hours of general chemistry, 4 term hours of organic chemistry, and 6 term hours each in English, physics, and biology. Electives were to be restricted to courses in qualitative and quantitative analysis, physical chemistry, comparative anatomy and embryology, psychology, economics, public administration, and a modern foreign language. Completion of the program required six ASTP terms, or a total of 72 weeks.¹¹¹ The recommendations of this committee were accepted by The Surgeon General and were adopted by the Army Specialized Training Division with only minor changes. The length of the program was reduced to five terms, and basic course requirements were increased to 8 hours in each subject.¹¹²

The War Department's decision to compress premedical training into a period of 60 weeks (five ASTP terms) was controversial. The Association of American Colleges contended that the curriculum was overaccelerated; it would result in physical and mental exhaustion, and enter trainees in professional programs before they had matured. Since the program could be completed in five terms if preprofessional students followed schedules comparable to those adopted for other ASTP trainees, however, the War Department did not feel that it could justify adding a sixth term. Sixty weeks of ASTP instruction was considered to be the equivalent of at least 64 weeks (2 academic years) of peacetime college work.

The sequence of courses under the Army Specialized Training Program was a marked departure from traditional patterns of training. Customarily, students in

¹¹¹ Letter, Brig. Gen. Larry B. McAfee, Acting The Surgeon General, to Officer in Charge of Army Specialized Training Program, 2 Jan. 1943, subject: Pre-Medical and Medical Education, inclosure thereto. Report of Advisory Committee on Medical Sciences Part of the Army Specialized Training Program.

¹¹² Army Service Forces Manual M 108, Catalog of Curricula and Courses, Army Specialized Training Program, March 1945.

preprofessional programs began specializing as early as their freshman year, with no assurance that they would eventually be admitted to a school of medicine or dentistry. There was no way to coordinate the number of preprofessional students with the number of vacancies in professional schools, and as a result, large numbers of students who had completed premedical programs annually competed for a limited number of medical school vacancies. The training of unsuccessful candidates was either wasted or adapted to other fields.

The Army attempted to avoid wasting talent and manpower by assigning all trainees to a common curriculum in which they studied English, physics, and general chemistry. Candidates for preprofessional training were then selected from among those who had proved their academic competence by completing the first two or three terms of the ASTP basic curriculum, or a year of college before entering the service.¹¹³ The number of trainees selected to complete the remaining course in the preprofessional curriculum was limited by the number of professional school vacancies reserved for the Army, with an allowance for dropouts and failures. Those who were not selected for preprofessional training were allowed to continue in other phases of the Army Specialized Training Program.

Selection of schools.—Selecting schools to participate in the medical phases of the Army Specialized Training Program was never a major problem, because the choice was limited to those accredited by the American Medical Association.¹¹⁴ By the time the Army Specialized Training Program was established, members of the Officers' Reserve Corps, the Medical Administrative Corps Reserve, and the Enlisted Reserve Corps were attending all of these schools except the Woman's Medical College of Pennsylvania, Philadelphia, Pa. Since the problems involved in transferring the academic credits of these men to a few select institutions were considered insurmountable, the Army chose to make arrangements for contract instruction at all approved medical, dental, and veterinary schools.

Race and religion presented special problems. Because of its policy of honoring the admissions of schools which had accepted students for classes beginning in 1943 and 1944, the Army was unable to reject Negroes who had been accepted by predominately white schools. This could be done only when the Army had full control of freshman vacancies. At the same time, many schools were worried that Army control of vacancies, and the Army procedure of assigning students by number instead of by name, would lead to unwanted integration. Col. Francis M. Fitts, MC, Director of Military Training, ASF, explained these problems and their solution at The Surgeon General's conference with chiefs of the medical branches of the service commands in mid-1943.¹¹⁵

* * * Negro trainees now accepted by Chicago or Harvard will be sent to those schools by which they had been accepted. When Chicago and Harvard reserve for the Army a certain percentage of vacancies we will not send Negro trainees there. That has been the point which has given some concern to some schools and is one which you cannot decide absolutely or say that an order will not be made; but if it is made, it will be rectified.

¹¹³ War Department Memorandum No. W350-112-43, Army Specialized Training Program Professional and Pre-professional Training General Information and Procedures for Selection of Personnel, 29 Apr. 1943.

¹¹⁴ See footnote 17, p. 43.

¹¹⁵ Report of The Surgeon General's Conference with Chiefs, Medical Branch of Service Commands, Washington, D.C., 14-17 June 1943.

As a result of these policies, enrollment in medicine and dentistry at Howard University and Meharry College, Nashville, Tenn., was limited exclusively to Negroes, and Negroes were not selected for other colleges unless they had already been admitted by the individual school. In any case, enrollment of Negroes was to be limited, because the Medical Department did not plan to expand its use of these officers, and needed only about 40 replacements a year for those already on active duty. With about 380 Negro medical students already enrolled in the Medical Administrative Corps, the Medical Department had a 10-year supply of replacements and believed it could not justify extensive training of this racial group. A small group of trainees were sent to Negro colleges late in 1944, but reservations for 1945 were canceled. Enrollment at the College of Medical Evangelists, Loma Linda, Calif., a Seventh-Day Adventist School, was similarly limited to members of that faith.¹¹⁶

The selection of colleges for preprofessional programs was more complicated. Reports compiled by the Association of American Medical Colleges, on the performance of freshman medical students admitted from more than 500 colleges and universities between 1931 and 1941, served as a basis for evaluation. The names of schools whose past performance and capacity indicated that they were capable of acceptably training a class of at least 50 preprofessional students were then submitted for clearance to the Joint Army-Navy Manpower Commission Committee for the Selection of Non-Federal Institutions. Final selection for participation in the preprofessional program required that total ASTP enrollment at the school, in all programs, be sufficient to allow the formation of an Army specialized training unit with a strength of 200 to 250 trainees.

The number of schools at which preprofessional programs could be established was limited by the number of students assigned to the program. Initial estimates called for the enrollment of 8,000 students, and the selection of 90 institutions for possible contracts. This estimate, however, was based on the assumption that enlisted men would be enrolled for preprofessional studies during their first term. The decision to enroll all ASTP trainees in a common program until the end of their second term reduced the number of men to be classified as preprofessional trainees to 5,400. This level of enrollment, which would have been reached in September 1944, allowed the establishment of preprofessional programs at 52 institutions.

Contracts.—Government contracts with colleges and universities for ASTP professional and preprofessional programs were negotiated through the service commands. In contracts with medical and dental colleges, the Government agreed to allow schools to continue training ASTP and Reserve students who were already enrolled, or who had been accepted for enrollment in classes beginning before 1945. In each class beginning in 1945 and subsequent years, the schools agreed to reserve a specified number of vacancies for Army trainees. By an agreement with the War Manpower Commission, the combined enrollment of ASTP and V-12 trainees after 1944 was limited to 80 percent of incoming freshman classes: 55 percent to the Army and 25 percent to the Navy. The remaining 20 percent was reserved for

¹¹⁶ See footnote 115, p. 83.

women and men who were not eligible for military service. Thirty-five percent of the capacity of dental schools was allocated to the Army, and 25 percent to the Navy. No contracts were made for the reservation of freshman vacancies in veterinary schools. The Army was required to give 60 days' notice if it was unable to fill reserved vacancies.

In April 1944, when the basic phase of the Army Specialized Training Program was discontinued, it became apparent that the Army would be unable to fill the freshman vacancies it had reserved. The number of men selected for professional training was only adequate to fill half of the vacancies reserved for 1945, and there would be no new trainees in subsequent years. Contracts were therefore revised to reserve only 28 percent of the capacity of medical schools, and 18 percent of the freshman dental capacity. The number of institutions under contract remained unchanged.

To compensate the school for the staff, facilities, equipment, and supplies it provided, the Government agreed to pay the equivalent of nonresident tuition for each trainee enrolled. Special provisions were made for a small group of schools whose normal tuition was significantly below the national nonresident average. The Army also agreed to pay incidental fees normally paid by students. No payment was made for registration fees, enrollment fees, and "good-faith" deposits. The textbooks, instruments, and supplies required by trainees were purchased by the Government and issued, or reissued, to trainees on receipt. Textbooks issued to freshman trainees remained in their possession until the completion of training. Instruments which could be obtained on a rental basis, such as microscopes, were not purchased. Instructional supplies and equipment which were not standard throughout the program were purchased for the Government through the contracting school, which was allowed a small handling charge.

The average monthly cost of professional training per trainee is shown in table 4.

Contracts for preprofessional training were similar to those for other ASTP programs. Payment was made on a cost basis computed for the rental and maintenance of facilities (classrooms, laboratories, dormitories, and messhalls) and for proportional salaries of faculty members actually engaged in the instruction of Army trainees. All contracts were subject to renegotiation each term.

The average monthly cost per trainee for instruction under the preprofessional curriculum was \$52.31.

TABLE 4.—Average monthly cost of professional training per trainee

Item	Medical	Dental	Veterinary medicine
Tuition and instructional fees.....	\$51.00	\$38.00	\$26.70
Textbooks and instruments.....	7.15	4.84	4.40
Instrument rental.....	4.32	18.26	2.40
Total.....	\$62.47	\$61.10	\$33.50

Preprofessional trainees were housed and messed by the contracting institution. In most medical, dental, and veterinary medicine schools, however, group housing and messing facilities could not be provided. Many medical and dental schools had no university housing and were located in densely populated metropolitan areas where common housing and messing were impractical. At other schools, the wide dispersion of trainees for clinical training during their junior and senior years made it undesirable. As a result, most ASTP medical, dental, and veterinary trainees were paid commutation allowances for quarters and rations. At schools in which group housing and facilities were available, many regulations, including restrictions on late study, had to be relaxed.¹¹⁷

Academic standards.—When the program was established, the Army accepted all enlisted men then enrolled in approved professional schools. It similarly accepted enlisted men who had been admitted to freshman classes entering approved schools in 1943 and 1944. Thus, for the first 2 years of the program, standards for selection were set by individual schools. Many of these students could not have been accepted under Army standards. The AGCT (Army General Classification Test) was given to all enlisted men when they came on active duty. A minimum AGCT score of 115, plus graduation from high school, were the prerequisites for assignment to the Army Specialized Training Program. When members of the Enlisted Reserve Corps and Medical Administrative Corps Reserve enrolled or accepted by medical, dental, and veterinary schools were called to active duty in mid-1943, nearly 9 percent of the Army trainees in medical schools, 22 percent in dental schools, and 18 percent in veterinary schools failed to achieve the AGCT score of 115. These percentages did not include students accepted by the two accredited Negro schools, where 35 percent of the medical students and over 60 percent of the dental students failed to achieve a qualifying score.¹¹⁸ Because of the Army's commitments, students accepted by individual schools for classes beginning in 1943 and 1944 had to be exempted from basic ASTP standards. Enlisted men assigned for preprofessional or for professional training by the Army, however, were required to meet minimum standards.

To remain in the professional program, trainees were required to meet the individual school's standards for continuation and graduation. Students were permitted to repeat courses only if failure was explained by illness, injury, or official Army orders. Failure in any subject, not satisfactorily explained by extenuating circumstances, resulted in separation from the program. Trainees so separated were ineligible for reassignment to the Army Specialized Training Program. The majority of the medical, dental, and veterinary trainees separated from the program, other than by graduation, were assigned to the Medical Department for further training and for service as medical soldiers.¹¹⁹ In setting standards for the preprofessional program, the Army accepted the policy established at a majority of the accredited professional schools and required an overall "C" average.

¹¹⁷ Army Service Forces Manual M 105, Army Specialized Training Programs, 3 Apr. 1944.

¹¹⁸ Compilation of the number of ASTP students at various universities who fell below the Army General Classification Test passing score of 115 by Medical Section, Curricula and Standards Branch, Army Specialized Training Division, 3 Sept. 1943.

¹¹⁹ See footnote 117.

The selection of the enlisted men for assignment to vacancies reserved by the War Department in classes beginning after 1944 required more elaborate procedures. In general, candidates were chosen from trainees completing term 2 and term 3 of the basic ASTP curriculum (B-1), who were then transferred to the preprofessional curriculum for the completion of their premedical training. Applicants for admission to the preprofessional program were required to pass a preliminary screening test known as the Aptitude Test for Medical Professions before they could be sent to unit classification boards for interviews.¹²⁰

The Aptitude Test for Medical Professions was prepared for the War Department by Drs. Fred A. Moss and Thelma Hunt under the direction of a committee of the Association of American Medical Colleges. Dr. Moss and this committee had previously designed and administered the Scholastic Aptitude Test for Medical Colleges (Medical Aptitude Test) which was used by the admissions committees of a majority of medical schools. The applicant's score on the Medical Aptitude Test had served as a basis for admission in conjunction with academic records, letters from professors, and personal interviews. The test had not been used extensively in the selection of dental students.

In the Army Specialized Training Program, the Aptitude Test for Medical Professions was used primarily to limit the number of candidates who would be presented to unit classification boards for interviews. Usually, minimum scores were set at a point that required boards to interview three times the number of candidates they would ultimately select. Representatives of contracting medical and dental schools within each service command served as consultants, and conducted ASTP classification board interviews to determine whether candidates were qualified and acceptable. After being interviewed, candidates were assigned to one of four categories: fully qualified and acceptable; acceptable, but not of the highest qualifications; acceptable; or not satisfactory and not acceptable. As far as possible, units were assigned from candidates classified as fully acceptable. Reports of qualified candidates in excess of unit quotas were forwarded to the Army Specialized Training Division.

Since preprofessional trainees were selected before they had taken courses in biology and in organic chemistry, a second screening was required in the final term (term 5) of the preprofessional curriculum. This second screening resulted in an elimination from the program of 173 enlisted men, or 7.2 percent of the 2,401 previously selected for training in medicine.

Because of the abrupt termination of all but a few special purpose programs in early 1944, only four groups of candidates were able to take the Aptitude Test for Medical Professions. Trainees in the first three groups tested were screened and selected for professional training by routine procedures. Since it was impossible to interview members of the group tested on 16 February 1944, before the basic program was brought to a conclusion, the 500 candidates with the highest scores were arbitrarily transferred and interviewed during their first term in the preprofessional program. Those found unacceptable for medical or dental training were offered the opportunity to study Japanese.

¹²⁰ Herge, Henry C.: *Wartime College Training Programs of the Armed Services*. Washington: American Council on Education, 1948.

Trainees who graduated in medicine and were commissioned in the Medical Corps, AUS, or the Medical Corps Reserve, were not called to active duty until they had completed their civilian hospital training. This training, in an inactive-duty status, consisted of 9 months of hospital internship for all, an additional 9 months as assistant residents for a maximum of one-third, and a further period of 9 months as residents for one-sixth of the original group. When called to active duty, they were assigned for 6 weeks' intensive field training at the Medical Field Service School, Carlisle Barracks, and 6 weeks of training in Army hospital procedures and administration in general hospitals in the Zone of Interior.

In 1945, The Surgeon General recommended that, effective on 1 April 1946, all medical officers still in an inactive status be called to active duty from previously authorized civilian hospital residencies and assistant residencies, and that those serving hospital internships be activated upon the completion of 12 months of intern training. This change in existing procedures was adopted, with the concurrence of the War Manpower Commission, to allow these positions to be filled by veterans whose hospital training had been interrupted.

Military and physical training.—All ASTP trainees, except those in medicine, dentistry, and veterinary medicine, were required to participate in 6 hours of military training and 5 hours of physical training. For men in the professional program, the military training requirement was reduced to 3 hours, and physical training was eliminated. These exemptions were granted because it was difficult to crowd an extra 9 hours of training into the accelerated programs of professional schools without using time needed by trainees for their studies. Moreover, almost every medical, dental, and veterinary school lacked the gymnasiums and athletic fields required for a physical training program. In units where such facilities were available, trainees were encouraged to engage in physical exercise. Military instruction outside the classroom was usually conducted in streets, vacant lots, and parks.

At first, military instruction was based on the program previously used by medical units of the Reserve Officers' Training Corps. Later, it was modified to be used both for enlisted men who had completed basic training and by those who had been assigned directly to the Army Specialized Training Program. In July 1944, a program of branch immaterial training was established to allow students to be trained by nonmedical officers.¹²¹ Under this program, branch training was given to students in a 6-week course at the Medical Field Service School, followed by 6 weeks of training at a Zone of Interior hospital after they had been commissioned and served their hospital internship.

EDUCATIONAL TECHNIQUES AND PROBLEMS

Despite their number and variety, Medical Department training programs shared many common techniques and problems. Facilities and equipment had to be

¹²¹ (1) Army Service Forces Manual M 107, Military Training Program for ASTP Trainees and ASTRP Students, 2 June 1944. Change No. 1, dated 17 July 1944. (2) See footnote 117, p. 86.

provided, instructors had to be selected and trained, and educational techniques had to be geared to an accelerated program.

Facilities and Equipment

The expansion and acceleration of officer training programs created a corresponding need for an expansion of training facilities. At Carlisle Barracks, extensive construction was required to prepare the Medical Field Service School for its role in training commissioned and noncommissioned officers. During the first half of 1940, barracks were built to house 125 men, and the school received an appropriation of \$375,000 for the construction of a new permanent school building.¹²² The training area was expanded to include 220 tent platforms, 14 lavatories, a 400-man messhall, and buildings for storage and administration. The following year, construction began on 18 barracks (63-man), two temporary classroom buildings, and a variety of overhead buildings. Most of these were intended for use by officer candidates, but were eventually used for student officers as well.¹²³ At the Army Medical Center, construction was limited to two new officers' barracks.¹²⁴

While helpful, this construction in no way prepared the service schools for the expansion that lay ahead. By mid-1941, the Medical Field Service School had been required to increase its capacity from approximately 100 officers to 6,000, and that of the Army Medical Center increased from approximately 100 to 1,200.¹²⁵ Construction did not expand space. To increase the output of schools, courses were shortened, classes were staggered at intervals of as little as 2 weeks, and year-round use was made of existing facilities. During 1941, for example, classes at the Medical Field Service School were conducted in the gymnasium while the new school was under construction.¹²⁶ Both schools found it difficult to house their expanded enrollment, and students were encouraged or required to live off-post.¹²⁷

Construction undertaken in 1940 and 1941 solved many of these problems, but others persisted throughout the war. By mid-1942, the Medical Field Service School was able to report that existing facilities were adequate for its program,¹²⁸ but continued, even after 1942, to resort to expedients. The new classroom building, for example, was designed to hold only 200 students at a time, and it was necessary to continue using the gymnasium as a classroom and auditorium.¹²⁹ Both the Army Medical Center and the Medical Field Service School had to terminate programs to allow the expansion of others.¹³⁰ In some instances, it was necessary to establish new special service schools, which usually encountered difficulties similar to those experienced by the parent schools.

¹²² See footnote 1, p. 36.

¹²³ See footnotes 6, p. 37; and 21, p. 44.

¹²⁴ Annual Report, Headquarters, Army Medical Center, Washington, D.C., calendar year 1940.

¹²⁵ See footnote 5 (2), p. 36.

¹²⁶ See footnote 21, p. 44.

¹²⁷ (1) See footnote 10, p. 39. (2) Annual Report, Commanding General, Headquarters, Army Medical Center, Washington, D.C., 1942.

¹²⁸ See footnote 22 (2), p. 45.

¹²⁹ See footnote 50 (2), p. 58.

¹³⁰ (1) See footnote 77 (1), p. 65. (2) Annual Report of The Surgeon General of the Army for the Commanding General, Army Service Forces, fiscal year 1943.

Instructional Staff¹³¹

Instructors in the Medical Department officer training program can be divided into two categories: those concerned with the military aspects of medicine, and those concerned with the technical phases of medicine, dentistry, veterinary medicine, and related sciences. Instructors in the first category were necessarily graduates of the courses they taught, while those in the second were usually men who had become specialists through extensive study at civilian institutions. Each was selected by different procedures.

Instructors in military subjects.—With minor variations, the pattern of selecting and training instructors for military subjects at the Medical Field Service School was typical of all military programs. Until a supply of officers returning from overseas became available, instructors were selected from among candidates who had demonstrated leadership ability during their own training. Responsibility for recognizing potential instructors among trainees at the school rested upon individual department heads, who interviewed promising candidates and selected those who would remain at the school for further training. As overseas returnees became available, fewer students were retained for teaching assignments, and officers with combat experience were selected for faculty assignments.

Until 1944, the training of new instructors was almost exclusively a departmental responsibility. Candidates were oriented through conferences with veteran members of their department, by studying materials used by the department, and by observing other instructors in the classroom and in the field. New teachers were required to present lectures in front of experienced instructors before being allowed in the classroom. When it was considered necessary to give them experience in handling troops, they were temporarily attached to the demonstration battalion at Carlisle Barracks.

In 1944, departmental indoctrination of new teachers was supplemented by an instructor guidance course conducted by the Training Department. This course, established at all ASF training centers, was designed to familiarize new or potential instructors with approved teaching techniques, and with procedures for selecting materials and making lesson plans. At the Medical Field Service School, the establishment of an instructor guidance program did little more than elevate existing procedures to the status of formal requirements.

At the Medical Field Service School, as at other military training facilities, the major staff problem was not selection and training, but retention. Between June 1942 and June 1944, for example, the annual rate of replacement at the school exceeded 40 percent. This lack of stability in instructor assignments created a need for constant selection and training of new personnel.¹³²

Instructors in technical subjects.—Vacancies in technical teaching positions could not be filled through on-the-job training, or intensive short courses. The specialized skills required for these positions could be acquired only through extensive study or experience. Neurosurgery, for example, could be taught only by

¹³¹ See footnote 10, p. 39.

¹³² See footnotes 22 (2) and (8), p. 45.

a qualified neurosurgeon, and the parasitology of tropical diseases could be taught only by an expert in the field. Instructors in technical subjects had to be selected in much the same manner as instructors at civilian colleges. Instructors were selected by the Military Personnel Division of the Office of The Surgeon General according to the specific requirements for each position. In some instances, the commandants of schools were able to request specific individuals who had gained reputations in a field as civilians, and preference was given to men who had been college instructors before being commissioned. Once hired or assigned to a position, instructors were indoctrinated through conferences with veteran members of the staff at each school.

Each technical course or school had different requirements, and filled its staff from different sources. At the Medical Supply Services School, for example, key instructors in the Officers' Supply Division were staff officers at the St. Louis Medical Supply Depot. Instructors in the Maintenance and Repair Division were civilians who had been sent to the depot by large manufacturing firms and were later commissioned and formally assigned to the staff. Instructors in the Optical Division were opticians. Most of the instructors at the Army Medical Center were staff officers who were assigned additional duties as teachers. As a result, the Army Medical Center also experienced difficulties in staff retention.¹³³

Educational Techniques

In training officers to perform the varied duties of the Medical Department, a wide variety of techniques were employed. Courses designed to provide trainees with military skills usually employed standard military techniques. Those designed to impart technical skills varied as widely as the skills themselves.

Class organization.—Class organization varied according to the number of trainees enrolled, and the degree to which drill, road marches, and field problems were part of the curriculum. In a course such as the Officers' Basic Course at the Medical Field Service School, drill and field problems played a large role, and classes were organized into battalions, companies, and platoons. Faculty members selected for their military ability were assigned as platoon leaders, class directors, and battalion commanders. These officers usually supplemented the technical instruction given by the school's academic departments with training in military subjects and were responsible for details such as messing, housing, and supplying units under their command.¹³⁴

In courses involving purely technical subjects, class organization differed little from that of typical civilian colleges. At the Army Medical Center, for example, selected students were appointed as "monitors" and made responsible for details such as keeping attendance records. Because of the relatively small numbers attending such courses, formal organization into companies and battalions was not considered practical.¹³⁵

¹³³ (1) Annual Report, Technical Activities, Medical Department Professional Service Schools, Army Medical Center, Washington, D.C., fiscal year 1941. (2) See footnotes 21, p. 44, and 22 (2), p. 45.

¹³⁴ See footnote 21, p. 44.

¹³⁵ See footnote 10, p. 39.

Teaching methods.—Service schools conducting courses for Medical Department officers followed approved military teaching techniques as closely as possible. In general, these consisted of the lecture, the conference, the demonstration, and the practical exercise. The frequency with which any one method of presentation was utilized varied with the content of the course.

Courses such as the Officers' Basic Course, the Special Cadre Course, and the National Guard and Reserve Officers' Course used much the same techniques as those employed by the MAC Officer Candidate School, and a report by one of these schools best illustrates their application. Courses emphasizing principles of command, organization, and administration relied heavily upon conferences, demonstrations, and practical exercises. Conferences and lectures were used solely to introduce and develop subject matter, but practical exercises which emphasized learning by doing rather than by listening were the preferred technique. Whenever possible, demonstrations and practical exercises were used exclusively. The Medical Field Service School, for example, had utilized demonstration troops since 1921.¹³⁶ The 1st Medical Regiment was assigned to Carlisle Barracks as a demonstration unit until 1940, when it was replaced by the 32d Medical Battalion. The battalion was used to demonstrate the operation of medical field installations and the employment of specialized equipment used in emergency medical treatment and field sanitation.¹³⁷

In highly technical courses, lectures and conferences were used in conjunction with practical exercises; such as, working in laboratories, participating in hospital rounds, and assisting in operations. In neurosurgery, for example, academic reviews of the anatomy of the nervous system were followed by neurological examination of patients. In thoracic surgery, lectures and demonstrations on the fundamentals of surgery were balanced by experience in assisting at operations and anatomical dissections of the thorax. In surgery of the extremities, cadaver surgery was practiced, with special emphasis on the surgical approaches to the treatment of fractures. The course in anesthesiology consisted almost entirely of applied work.¹³⁸

The courses at the Medical Supply Services School, although different in content, were conducted along similar lines. In the Officers' Supply Division, lectures and conferences on Medical Department supply functions were followed by practical exercises on the methods of handling supplies. Instruction in the Maintenance and Repair Division of the school consisted largely of on-the-job experience with X-ray equipment, sterilizers, gas anesthesia apparatus, oxygen therapy appliances, and other technical equipment. In the Optical Division, courses were essentially designed to provide experience in the operation of optical repair equipment.¹³⁹

In sum, courses for Medical Department officers were designed to provide them with skills that had immediate application in the operation of field medical

¹³⁶ See footnote 22 (7), p. 45.

¹³⁷ Hume, E. E.: Training of Medical Officers for War Duty. *War Med.* 1: 642-643, September 1941.

¹³⁸ Memorandum, Lt. Col. Sanford V. Larkey, MC, Chief, School Branch, Training Division, Office of The Surgeon General, U.S. Army, to Col. Frank B. Wakeman, MC, Director, Training Division, Office of The Surgeon General, U.S. Army, 12 Mar. 1943, subject: Report of Inspection of Training Courses for Medical Department Officers at Civilian Institutions.

¹³⁹ See footnote 26 (2), p. 48.

installations. Courses stressed application, rather than theory, and were designed to provide a maximum of practical work.¹⁴⁰

Training aids.—Training aids played a major role in converting theory into applicable knowledge. Items classified as training aids ranged from pictures, films, and demonstration units to areas set aside for demonstrating field sanitary equipment, and infiltration courses. Drill fields, obstacle courses, and bivouac areas fell into this category, as well as rubber moulages of wounds, scale model compasses, and other devices used to provide visual assistance.¹⁴¹

In military courses, audiovisual aids were used extensively. These included War Department filmstrips, film bulletins, and training films. Most service schools operated auxiliary film libraries, to make them continuously available.¹⁴² Charts, diagrams, and posters were prepared for use in lectures and conferences. Some, such as graphic portfolios on first aid and map reading, were prepared at higher echelons for distribution to all schools. Others were prepared at the schools for use in specific lessons. The Medical Field Service School maintained an art department, and the operations officer was made responsible for scheduling the use of aids, for having aids on display, and for training and supplying projectionists.¹⁴³ Field manuals, training manuals, and other War Department publications were used almost exclusively as texts in military subjects.

Since technical courses covered a broad range of subjects, the training aids and equipment used in each course were different. Just as sanitary areas and obstacle courses were considered training aids in military courses, the laboratories, operating rooms, and medical and surgical wards used to enhance training were considered training aids for technical courses. The same definition was frequently applied to cadavers used in surgical courses, and patients treated in medical courses. In the Maintenance and Repair Course at the Medical Supply Services School, the equipment used and items repaired fell into the same category. Visual aids used in technical courses included anatomical charts and diagrams and pictures projected on photographic screens.¹⁴⁴

Standard medical textbooks were assigned in most technical courses, but in a few, a combination of War Department publications and special texts was used. The Maintenance and Repair Division and the Optical Division of the Medical Supply Services School used special texts prepared by the instructors in these divisions to supplement material in War Department publications. The special textbook issued for the Maintenance and Repair Course was issued in three volumes totaling 2,200 pages, and the textbook for the Optical Course was a volume of approximately 300 pages.¹⁴⁵ These special textbooks were used for enlisted men, as well as for officers, and were similar to those prepared in schools for enlisted technicians.

Tests and critiques.—Written examinations were used as measures of student achievement, as instructional devices, and as a means of checking the effec-

¹⁴⁰ See footnote 138, p. 92.

¹⁴¹ See footnote 22 (8), p. 45.

¹⁴² See footnote 26 (2), p. 48.

¹⁴³ See footnote 10, p. 39.

¹⁴⁴ See footnote 138, p. 92.

¹⁴⁵ See footnote 26 (2), p. 48.

tiveness of instruction. At most schools, the construction of tests was a departmental responsibility. At the Medical Field Service School, test questions, prepared by the instructors who presented the material in a given class, were submitted to department directors for approval or modification before being incorporated into an examination. Schools relied almost exclusively on objective examinations, consisting of true-false, multiple choice, and completion questions. The same tests were often used for succeeding classes and, therefore, were not returned to the student for study and analysis. Instead, tests were reviewed in class, and doubtful points were clarified. Students who failed were scheduled for conferences on their individual problems. When an unusually high number of students failed, the test was reevaluated.

Supervision and inspection of instruction.—To insure a continuing quality of instruction, department heads or officers corresponding to department heads were charged with responsibility for supervising the performance of instructors on their staff.¹⁴⁶ The most widely used technique of supervision and evaluation was a personal visit to the classroom. There was no set schedule for observing instructors, and periodic reports were not required on instructors doing satisfactory work. New instructors were frequently visited, and reports on those whose performance was inadequate were forwarded to the assistant commandant of the school. When necessary, instructors were relieved. From time to time, officers senior to the department head visited classes to check on his evaluations.

Representatives of higher echelons periodically inspected special service schools and civilian schools employed by the Medical Department. Inspection reports included comments on the school's facilities, teaching staff, methods of instruction, training aids, and trainees, and enabled higher echelons to compare schools and maintain an Army-wide standard of training.¹⁴⁷

Trainee Quality

Schools conducting courses for medical, dental, and veterinary officers had the good fortune of receiving trainees of consistently high quality. While marked differences in background and ability existed between trainees, all were graduates of approved professional colleges. Schools for such officers had to cope with few of the problems confronting training centers established for other categories of personnel.

Among medical, dental, and veterinary officers, attrition rates were low. Samples taken during the first 2 years of the war revealed a gross attrition rate of 5.6 percent in professional courses and 4.9 percent in military courses. Studies of these rates are incomplete, but available data indicate that at least half of the trainees who failed in technical courses, and approximately 25 percent of those who failed military courses, failed because they were recalled to their units before they could complete enough work to be credited with passing the course.

¹⁴⁶ See footnote 10, p. 39.

¹⁴⁷ Army Service Forces Manual M 4, Military Training, 20 Sept. 1944.

In most other instances, age and inadequate background seem to account for failure. A study conducted in the Tropical Medicine Course revealed that students over 40 years of age, who represented only 14 percent of the trainees enrolled, accounted for 64 percent of the failures in the course. Older students, long removed from intensive study, seemed to have found it more difficult to assimilate the material presented in accelerated programs. A second study of this program uncovered a high incidence of failures among graduates of less prestigious medical schools.¹⁴⁸ Graduates of these schools frequently lacked skill in laboratory techniques and the background to absorb highly technical subjects. Studies of failures in military courses are less complete and do not isolate groups with a high incidence of failure.

Although the principles of medicine and surgery are the same in military and civilian life, the conditions under which they are practiced are radically different. The military physician and surgeon must be able to deal with mass casualties, often under combat conditions. To perform on the field of battle, the surgeon requires an understanding of evacuation procedures, the medical equipment and treatment available at each stage in the chain of evacuation, and the limitations of field medicine and surgery. He must also understand the relationship of field medical service to the combat arm it serves, the tactical employment of medical units, and the principles of medical supply. Administrative and tactical courses conducted at the Medical Field Service School, and other service schools, were designed to provide the Army physician with the basic knowledge required for field service. Other more technical courses were designed to provide him with the skills needed to engage in restorative treatment of battle casualties in rear echelons, or to combat the diseases which have traditionally ravaged armies in garrison and in the field.

Three facts testify to the caliber of service provided by the Medical Department in World War II: The recovery of 97 percent of all hospitalized battle casualties, the control of a number of diseases which had caused high rates of noneffectiveness in past wars, and the absence of major epidemics.¹⁴⁹

An important factor in the improvement of surgical care was the development of new facilities and procedures for evacuation of casualties, and a knowledge of how to use them. Similarly, improved approaches to the treatment of neuropsychiatric breakdowns and increased attention to reconditioning casualties returned many men to duty who would have been lost to the Army in earlier wars. Improved immunizing agents, and techniques for controlling disease-bearing insects, were applied with marked effect against such diseases as dengue fever, typhus, typhoid fever, and malaria. These successes cannot be attributed solely to training; advances in medical science and education played a major role. But it was training in military procedures that allowed members of the Medical, Dental, Veterinary, and Sanitary Corps to apply their knowledge to military problems.

¹⁴⁸ See footnote 10, p. 39.

¹⁴⁹ Medical Department, United States Army. *Surgery in World War II. Thoracic Surgery. Volume I.* Washington: U.S. Government Printing Office, 1963.

CHAPTER III

The Medical Administrative Corps¹

In December 1941, 1,470 MAC (Medical Administrative Corps) officers were serving in the Medical Department. Of these, 77 were graduates of the MAC Officer Candidate School. By August 1945, 17,072 officers had graduated from the MAC Officer Candidate School, and the Corps had expanded to 19,867. During the same period, the ratio of the Medical Administrative Corps to the strength of the Army grew from 0.87 to 2.48 per thousand.² Such growth was more than a simple response to wartime expansion; it reflected the Medical Department's continuous efforts to relieve physicians from the burdens of nonprofessional responsibility. Almost without exception, officers assuming these responsibilities were graduates of MAC officer candidate schools.

OFFICER CANDIDATE SCHOOLS

Prewar plans called for the establishment of officer candidate schools shortly after the beginning of mobilization. Because the supply of Reserve officers was adequate for the demands of the limited mobilization that began in September 1940, however, programs for officer candidates were held in abeyance for nearly a year. In April 1941, The Surgeon General joined the chiefs of other arms and services in requesting the establishment of an officer candidate school.³ Through such a school, The Surgeon General hoped to train approximately 100 officers who were needed as instructors at medical replacement training centers. Since these proposals had been anticipated by the Chief of Staff, a directive establishing officer candidate schools for a 3-month period was issued by The Adjutant General on 26 April 1941.⁴ Three months later, on 28 July 1941, the schools were authorized to continue indefinitely.⁵

The first class of 100 officer candidates began a 12-week program of training at Carlisle Barracks, Carlisle, Pa., on 1 July 1941. Until the war accelerated training, new classes enrolled every 3 months. The second class had an enrollment of 200 candidates, and enrollment for the third was expanded to 250.⁶

¹ Except as otherwise indicated, this chapter is based on two manuscripts: (1) Goodman, Samuel M.: *History of Medical Department Training, United States Army World War II. Volume II. A Report of the History of the Medical Administrative Corps Officer Candidate Schools, 1 July 1939 to 30 June 1944, and Supplement for Period 1 July 1944 to 30 June 1945.* [Official record.] (2) Armstrong, George E., and Ey, John A.: *Training in the Medical Department During World War II. Chapter IX. Medical Administrative Corps Officer Candidate Schools.* [Official record.]

² Medical Department, United States Army. *Personnel in World War II.* Washington: U.S. Government Printing Office, 1963.

³ Letter, The Surgeon General to The Adjutant General, 3 Apr. 1941, subject: Officer Candidate Schools.

⁴ Letter, The Adjutant General to Commanding Generals, All Armies, Departments, and Corps Areas, 26 Apr. 1941, subject: Officer Candidate Schools.

⁵ Memorandum, Brig. Gen. Harry L. Twaddle, Assistant Chief of Staff, G-3, for the Chiefs of Arms and Services, 28 July 1941, subject: Officer Candidate Schools.

⁶ Technical Report of Activities, Medical Field Service School, Carlisle Barracks, Pa., fiscal year 1942.

The United States entry into World War II produced a rapid expansion of the officer candidate program. Following the publication of the War Department General Staff, G-3, troop basis in January 1942, it became apparent that the Medical Department could not fill its requirements for administrative officers without increasing the capacity of its officer candidate school. On 16 January 1942, The Surgeon General was directed to formulate plans for expanding the MAC Officer Candidate School at Carlisle Barracks to accommodate 750 trainees.⁷

The capacity of the school at Carlisle Barracks was expanded by shifting from consecutive to staggered scheduling. Beginning with the fourth class, on 9 March 1942, a new class of 250 candidates was enrolled each month. Since the program for a given class covered 3 months, the new schedule resulted in the presence of three classes with a total of 750 candidates.⁸

By the spring of 1942, it was evident that facilities at Carlisle Barracks would be inadequate to meet the demand created by the rapid activation of numbered medical units and installations and by the increasing use of MAC officers to replace MC (Medical Corps) officers in nonprofessional assignments. Without further expansion, the Medical Department was capable of training only 1,600 of the 2,450 MAC officers required by 1 January 1943. On 11 April 1942, The Surgeon General requested authority from the Commanding General, ASF (Army Service Forces), to establish a second school for officer candidates at Camp Barkeley, Tex.⁹ Permission was granted on 15 April,¹⁰ and on 9 May 1942, the first class was enrolled.¹¹ Since capacity was set at 750 candidates, and classes of 250 were enrolled monthly, the school was scheduled to reach a capacity with the enrollment of its third class.¹² The officer candidate school at Camp Barkeley had been in operation less than a month, however, when the Medical Department began to consider expanding its capacity. On 5 June 1942, the Commandant, Medical Replacement Training Center, Camp Barkeley, suggested increasing enrollment to 1,000.¹³ The Surgeon General, in turn, recommended that facilities be made available at Camp Barkeley for training 1,500 candidates.¹⁴ On 25 June 1942, Army Service Forces approved his request.¹⁵ By September, the demand for MAC officers had grown to the point that the school had to be expanded for a third time. Beginning on 28 September 1942, a new class of 500

⁷ Memorandum, Brig. Gen. Harry L. Twaddle, Assistant Chief of Staff, G-3, for The Surgeon General, 16 Jan. 1942, subject: Increase in the Medical Administrative Corps Officer Candidate School.

⁸ See footnote 6, p. 97.

⁹ Letter, The Surgeon General to Commanding General, Services of Supply, 11 Apr. 1942, subject: Officer Candidate School.

¹⁰ Memorandum, Brig. Gen. Harold R. Bull, Assistant Chief of Staff, Operations and Training Division, G-3, for Commanding General, Services of Supply, 15 Apr. 1942, subject: Additional Medical Corps Officer Candidate School. 1st indorsement thereto, 23 Apr. 1942.

¹¹ Letter, The Adjutant General to Each Commander listed in paragraph 1 b, 17 Apr. 1942, subject: Quotas for Medical Administrative Corps Officer Candidate School, Camp Barkeley, Tex., Class 1.

¹² Memorandum, The Surgeon General to Commanding General, Services of Supply, 11 Apr. 1942, subject: Officer Candidate School.

¹³ Letter, Brig. Gen. Roy C. Heflebower, Commanding, Medical Replacement Training Center, Camp Barkeley, Tex., to The Surgeon General, 5 June 1942, subject: Increase in Capacity of MAC Officer Candidate School. 1st indorsement thereto, 10 June 1942.

¹⁴ Letter, Col. John A. Rogers, MC, Executive Officer, Office of The Surgeon General, Director of Training, Services of Supply, 18 June 1942, subject: Increase in Officer Candidate School Facilities.

¹⁵ Memorandum, Col. Walter L. Weible, GSC, Deputy Director of Training, Services of Supply, for The Surgeon General, 25 June 1942, subject: Increase in Officer Candidate Facilities.

was enrolled every 2 weeks, instead of every 4, bringing the capacity of the school to 3,000.¹⁶ Peak enrollment was reached in July 1943, when 3,011 candidates were in training.¹⁷

On 27 February 1943, the officer candidate school at Carlisle Barracks, already dwarfed by the officer candidate school at Camp Barkeley, was discontinued to make room for an expansion of Medical Corps programs at the Medical Field Service School.¹⁸ The school at Camp Barkeley continued to operate at capacity for another 5 months before enrollment began to taper off. On 1 July 1943, the training cycle was lengthened from 12 to 17 weeks, with a proportionate decrease in annual capacity. Even with this reduction, representatives of the Military Training Division, ASF, estimated that a continuation of training at existing levels would produce a surplus of nearly 3,000 MAC officers by the end of the year. Late in July, the school at Camp Barkeley was directed to reduce its capacity to 1,000 candidates each cycle, beginning on 1 October 1943.¹⁹

From then on, retrenchment was rapid. In August, the Assistant Commandant of the Officer Candidate School, Camp Barkeley, was notified to anticipate a reduction in the capacity of the school to 250 candidates by 1 January 1944.²⁰ In October, The Surgeon General was requested by the Director of Military Personnel, ASF, to concur in a recommendation for discontinuing the school. In reply, The Surgeon General pointed out that the Medical Department was conducting a study on the practicality of using MAC officers to replace junior MC officers as battalion surgeon's assistants and might need the school to train additional officers. In addition, he believed that discontinuation of the school would pose a threat to the morale of Medical Department enlisted men, and he asked that the school be continued, if only for 50 men every 17 weeks. This proposal for a token school was approved by the Army Service Forces on 27 October 1943.²¹ A class of 106 candidates, the smallest in the history of the school, enrolled on 21 January 1944. Between January and May, no further classes were scheduled.

In the spring of 1944, retrenchment gave way to a new period of expansion. As a result of the Kenner Board's²² investigations into the utilization of Medical

¹⁶ Memorandum, Brig. Gen. Clarence R. Huebner, GSC, Director of Training, Services of Supply, for The Surgeon General, 3 Sept. 1942, subject: Increase in Officer Candidate School Facilities.

¹⁷ Annual Report, Army Service Forces Training Center, Camp Barkeley, Tex., fiscal year 1944, with parts 1 and 2, thereto.

¹⁸ (1) Memorandum, Col. Russell B. Reynolds, GSC, Director of Military Personnel, Services of Supply, for The Surgeon General, 9 Nov. 1942, subject: Capacity of Medical Administrative Officer Candidate School for 1943. (2) Memorandum, Col. John A. Rogers, MC, Executive Officer, Office of The Surgeon General, for Director of Military Personnel, Services of Supply, 20 Nov. 1942, subject: Capacity of Medical Administrative Officer Candidate School for 1943.

¹⁹ (1) Memorandum, Col. S. V. Hasbrouck, GSC, Chief, Management and Separation Branch, Services of Supply, for Col. F. B. Wakeman, MC, Director, Training Division, Office of The Surgeon General, 26 July 1943, subject: Officer Candidate School Capacity. (2) Memorandum, Col. F. B. Wakeman, MC, Director, Training Division, Office of The Surgeon General, for the Commandant, Medical Administrative Corps Officer Candidate School, Medical Replacement Training Center, Camp Barkeley, Tex., 31 July 1943, subject: Officer Candidate School Capacity.

²⁰ Letter, Capt. Thomas C. M. Robinson, MAC, Administrative Assistant, Training Division, Office of The Surgeon General, to Lt. Col. August H. Groeschel, MC, Medical Administrative Corps Officer Candidate School, Medical Replacement Training Center, Camp Barkeley, Tex., 16 Aug. 1943.

²¹ Memorandum, Maj. Gen. George F. Lull, Deputy Surgeon General, to Director of Military Personnel, Army Service Forces, 15 Oct. 1943, subject: Discontinuance of Medical Administrative Corps Officer Candidate School. 1st indorsement thereto, 27 Oct. 1943.

²² On 16 Sept. 1943, The Surgeon General appointed a committee of five officers under Brig. Gen. (later Maj. Gen.) Albert W. Kenner to study the utilization of Medical Department personnel.

TABLE 5.—Numbers of enrollees and graduates, MAC officer candidate schools, by month, July 1941–October 1945

Date	Carlisle Barracks		Camp Barkeley		Total	
	Enrolled	Graduated	Enrolled	Graduated	Enrolled	Graduated
<i>1941</i>						
July	100				100	
August						
September		77				77
October	196				196	
November						
December		169				169
<i>1942</i>						
January	249				249	
February						
March	275	224			275	224
April	255				255	
May	263	241	272		535	241
June	282	236	261		543	236
July	516	240	266	238	782	478
August		238	539	226	539	464
September	306	242	1,110	232	1,416	474
October	560	221	1,168	480	1,728	701
November		244	1,091	487	1,091	731
December	261	248	545	928	806	1,176
<i>1943</i>						
January		209	1,628	865	1,628	1,074
February		220	1,095	772	1,095	992
March			1,093	758	1,093	758
April			1,656	633	1,656	633
May			1,144	593	1,144	593
June			1,080	646	1,080	646
July			1,108	629	1,108	629
August			542	681	542	681
September			746	641	746	641
October						
November			201	632	201	632
December				616		616
<i>1944</i>						
January			106	106	106	106
February						
March				88		88
April						
May			255	52	255	52
June	248				248	
July	252		918		1,170	
August	253		1,075		1,328	
September			304	178	304	178
October		208	248		248	208
November		192	547	540	547	732
December	485	165		688	485	853

TABLE 5.—Numbers of enrollees and graduates, MAC officer candidate schools, by month, July 1941–October 1945—Continued

Date	Carlisle Barracks		Camp Barkeley		Total	
	Enrolled	Graduated	Enrolled	Graduated	Enrolled	Graduated
<i>1945</i>						
January.....	226			188	226	188
February.....	480			318	480	318
March.....	368	150		191	368	341
April.....	322	182			322	182
May.....		298				298
June.....	34	186			34	186
July.....		256				256
August.....		220				220
September.....						
October.....		22				22
Total.....	5,931	4,688	18,998	12,406	24,929	17,094

Department personnel, table-of-organization revisions published on 9 March 1944 authorized officers in the Medical Administrative Corps to fill many positions previously reserved for the Medical Corps, including battalion surgeon's assistant, medical inspector, hospital executive officer, and hospital registrar.²³ Since the number of unassigned MAC officers was inadequate to fill these positions, the officer candidate schools at both Camp Barkeley and Carlisle Barracks were revived. On 26 May, a class of 250 candidates was enrolled at Camp Barkeley, and a month later, the school at Carlisle Barracks was reactivated.²⁴

After June 1944, the program at Camp Barkeley expanded rapidly. Four classes were enrolled between July and September, each with an authorized capacity of 500 candidates. In the following month, three classes with an authorized strength of 250 were enrolled. The 40th and final class of the war was enrolled on 17 November. From then on, enrollment at the school gradually declined. The school was closed on 15 March 1945, when the final class graduated.²⁵ Between June 1944 and March 1945, 3,337 candidates were admitted to the program, of whom 2,105 were commissioned.²⁶

Training at Carlisle Barracks continued until October 1945. Between June 1944 and April 1945, 12 classes enrolled, each with an authorized capacity for 250 trainees. By August, all of these classes had graduated. The 13th class, containing

²³ (1) See footnote 2, p. 97. (2) War Department Circular No. 99, 9 Mar. 1944.

²⁴ (1) See footnote 17, p. 99. (2) Special Report of Training Activities, Officer Candidate School, fiscal year 1944. In Annual Report, Army Service Forces Medical Field Service School, Carlisle Barracks, Pa., fiscal year 1944.

²⁵ (1) Memorandum, Col. Floyd L. Wergeland, MC, Acting Chief, Operations Service, Office of The Surgeon General, for the Commanding General, Army Service Forces, 23 Feb. 1945, subject: Closing of Medical Administrative Corps Officers Candidate School, Camp Barkeley, Tex. 1st memorandum indorsement thereto, 3 Mar. 1945. (2) Army Service Forces Circular No. 93, 15 Mar. 1945.

²⁶ See footnote 17, p. 99.

34 candidates, continued after the war ended.²⁷ On 17 October 1945, the training program for MAC officer candidates came to a close. A statistical summary of enrollment and graduation at the officer candidate schools is presented in table 5.

Organization and Administration

The MAC Officer Candidate School at Carlisle Barracks was established as a function of the Medical Field Service School. The chain of command ran from the Commandant of the Medical Field Service School, through the Assistant Commandant, to the Officer Candidate School battalion commander, who was responsible for the conduct of the course. The battalion commander, in turn, was assisted by class directors who were responsible for the administration, housing, messing, and training of officer candidates. For administrative purposes, candidates were organized into companies and platoons. Courses in training, sanitation, military art, and administration were taught by Officer Candidate School instructors, under the supervision of the corresponding academic departments at the Medical Field Service School. Classes in logistics, field medicine and surgery, chemical warfare, infantry and armored force tactics, and dental and veterinary medicine were taught by regular Medical Field Service School instructors.

The MAC Officer Candidate School at Camp Barkeley was established as part of the Medical Replacement Training Center, and the Commandant of the Medical Replacement Training Center was also the Commandant of the Officer Candidate School. Responsibility for the operation of the school was vested in an assistant commandant, who reported directly to the Commandant, Medical Replacement Training Center. Trainees were organized on a battalion pattern, the number varying in proportion to the total enrollment. A battalion commander, assisted by class directors, supervised the housing, messing, and administration of each battalion. In contrast with Carlisle Barracks, the academic and administrative departments were organized as an integral part of the school (charts 1 and 2).

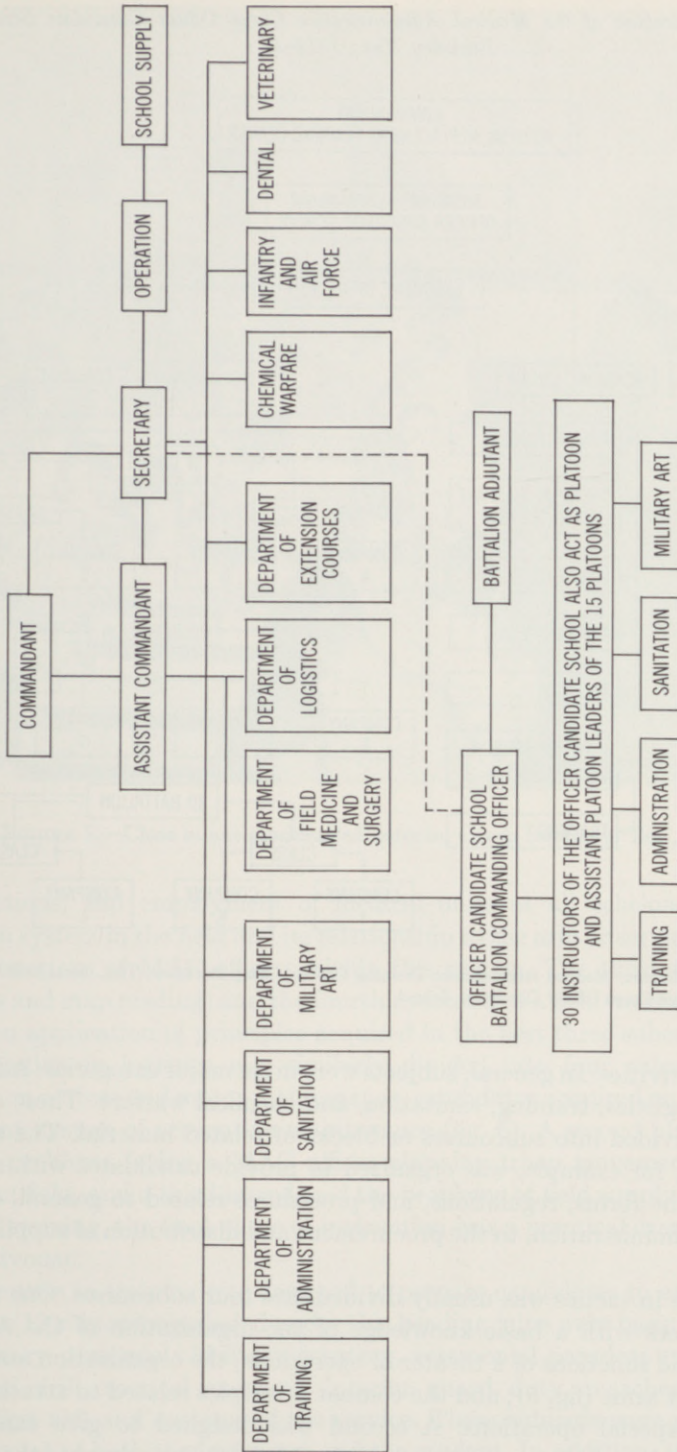
Program of Instruction

The MAC Officer Candidate School was designed to produce officers trained for a wide variety of duties in tactical units, hospitals, and other medical installations. By the end of 1944, the responsibilities of MAC officers had grown to the point that they were expected to fill more than 60 nonprofessional positions. Members of the Corps served in positions ranging from adjutant, supply officer, and transportation officer, to hospital administrator, and battalion surgeon's assistant. Programs had to be broadly based and designed to include as many subjects as possible. Specialized training was postponed until after commissioning.

The curriculum of the officer candidate school included a variety of subjects, some required by the War Department, and others related specifically to Medical

²⁷ Special Report of Training Activities, Officer Candidate School, fiscal year 1945. In Annual Report, Medical Field Service School, Carlisle Barracks, Pa., fiscal year 1945.

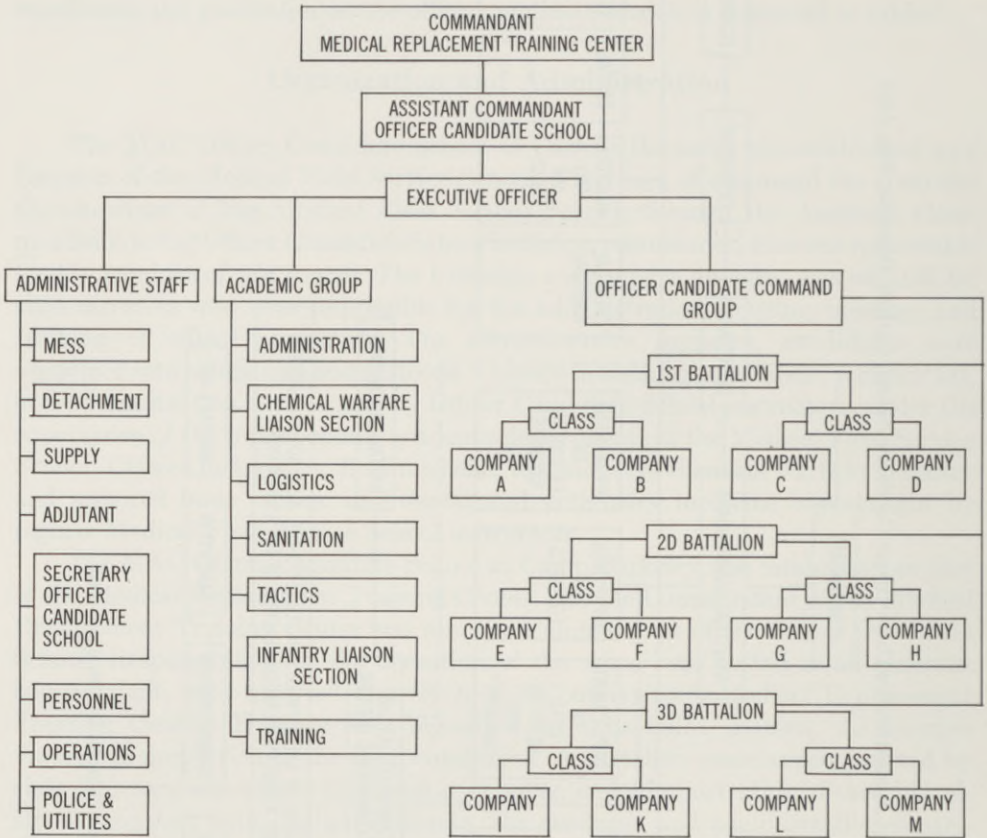
CHART 1.—Organization of the Medical Administrative Corps Officer Candidate School, Carlisle Barracks, Pa., 1942



KEY:
 — COMMAND CHANNEL
 - - - ADMINISTRATIVE CHANNEL

Source: Annual Report, Medical Field Service School, Carlisle Barracks, Pa., fiscal year 1942.

CHART 2.—Organization of the Medical Administrative Corps Officer Candidate School, Camp Berkeley, Tex., 1942-43



Source: Annual Report, Medical Replacement Training Center, Camp Berkeley, Tex., fiscal year 1943. Part 2. Medical Administrative Corps Officer Candidate School.

Department activities. In general, subjects were in six major categories: Administration, tactics, logistics, training, sanitation, and chemical warfare. These categories were usually divided into subcourses or blocks of related material. The subject of administration, for example, was organized to provide candidates with a detailed knowledge of the forms, regulations, and procedures related to general, company, and hospital administration, to the procurement and distribution of supplies, and to military law.

The course in tactics was usually divided into four subcourses. One subcourse provided trainees with a basic knowledge of the organization of the Army; the organization and functions of a theater of operations; the organization and employment of combat arms (fig. 5); and the combat principles related to attack, defense, security, and special operations. A second was designed to give candidates a working knowledge of the organization of the Medical Department; the organiza-



FIGURE 5.—Class in antimechanized defense, Camp Barkeley, Tex., 1943.

tion, functions, and employment of medical units at all echelons; the medical evacuation system in the field and its relationship to the arm or service it supported; and the functions of MAC officers within this system. The third subcourse dealt with maps and map reading; and the fourth consisted of a field exercise and bivouac, focusing on application of principles acquired in the first three subcourses.

Instruction in logistics was similarly divided into four subcourses. In the subcourse on motors and motor maintenance, candidates acquired an understanding of the Army system of preventive maintenance (fig. 6). A second block of material presented problems facing a MAC officer planning troop movements for medical units in the field, and a third introduced the problems of field supply. As in the case of tactical training, the final phase of instruction was a practical exercise integrated into the bivouac.

The course in training was designed to prepare candidates to serve as instructors. Of the 12 subtopics included under this heading, nine were basic to the training of all military personnel: Military courtesy, ceremonial parades, unit inspections, dismounted drill, tactical exercises, interior guard duty, marches and physical training, first aid, and customs of the service. These subjects were presented from the standpoint of both the instructor and the student. In addition, the program for



FIGURE 6.—Officer candidates participate in application and inspection of preventive maintenance, Camp Berkeley, Tex., 1943.

officer candidates was supplemented by three subcourses designed to prepare them to become instructors. The first of these was a subcourse in the techniques of instruction, based on War Department Technical Manual 21-250, "Army Instruction," dated 19 April 1943, which included practice teaching, lesson presentation, selection of training aids, and use of testing devices. In the second, trainees were given a working knowledge of the construction of master and weekly training schedules, and were familiarized with the documents governing Medical Department training. The final subcourse, combat orientation, included a study of combat psychology, U.S. war aims, and methods of orientation instruction.

The block of material related to sanitation was designed to orient candidates to military sanitation under field conditions. One phase of the course was designed to familiarize trainees with the control of respiratory, intestinal, venereal, and insectborne diseases. A second phase dealt with the selection of campsites and with sanitary surveys, reports, and orders. Field exercises in the use of sanitary expedients and the supervision of sanitation were conducted during the trainee's bivouac.

The purpose of the course in chemical warfare was to qualify candidates to serve as unit gas officers. Course topics included the characteristics, uses, and factors determining the use of chemical agents; individual, collective, and tactical protection; first aid for gas casualties; decontamination methods and materials; chemical weapons and munitions; and chemical warfare tactics. In all phases, special emphasis was placed on the methods of orienting enlisted men to chemical warfare (fig. 7).



FIGURE 7.—Class in the identification of chemical warfare agents, Camp Barkeley, Tex., 1943.

The program for MAC officers was seldom static. War Department directives continuously translated the lessons of combat into new training requirements, and schools frequently adjusted the structure and substance of their own programs to reflect the experience of medical units and the growing responsibilities of the Corps.

The 12-week course for MAC officer candidates established at Carlisle Barracks in 1941 was an outgrowth of the prewar noncommissioned officer and Reserve officer refresher courses conducted at the Medical Field Service School. Anticipating the inauguration of a school for officer candidates, the Commandant of the Medical Field Service School directed school department heads to begin planning an officer candidate program on 10 April 1941. On 5 May 1941, the school was formally authorized to prepare a program, and on 28 June, the program received War Department approval.²⁸

The initial program at Carlisle Barracks scheduled 561 hours of instruction. The largest block of time, 218 hours, was allotted to the activities controlled by the Department of Training. A total of 150 hours was assigned to the Department of Administration, making its single area of responsibility the most heavily weighted subject in the program. The remaining hours were divided among the Departments of Military Art, Sanitation, and Logistics.

During the first few months after the school began operation, the program underwent a series of changes. By 1942, however, a version had been developed that would remain stabilized until the school closed in February 1943. In its final form,

²⁸ (1) Letter, Maj. F. B. Wakeman, MC, Assistant Chief, Training Subdivision, Planning and Training Division, Office of The Surgeon General, to the Commandant, Medical Field Service School, Carlisle Barracks, Pa., 5 May 1941, subject: Officer Candidate Schools. (2) Letter, Maj. E. D. Liston, MC, Acting Executive Officer, Office of The Surgeon General, to the Assistant Commandant, Medical Field Service School, Carlisle Barracks, Pa., 12 June 1941, subject: Officer Candidate Schools. 3d indorsement thereto, 28 June 1941.

the program consisted of 576 hours of instruction. A growing emphasis on tactics and organization was accompanied by an increase in the time allotted to the Department of Military Art from 81 hours to 110. By the same token, the time devoted to logistics was increased from 34 to 48 hours. A relative decline in the emphasis placed on basic military training and sanitation was apparent in the reduction of the hours assigned to the Department of Training from 218 to 162, and a reduction of the program of the Department of Sanitation from 72 hours to 55. The program in administration was only slightly altered, declining from 150 hours to 139. Three blocks of time were reserved for the professional departments: 7 hours for the Department of Field Medicine and Surgery, 4 hours for the Department of Dental Field Service, and 4 hours for the Department of Veterinary Field Service. Other innovations included 15 hours of instruction by a Chemical Warfare Service liaison officer and 3 hours of training by a British liaison officer.²⁹

The program established by the Officer Candidate School at Camp Barkeley in mid-1942 was essentially the same as the program already in effect at Carlisle Barracks. When the school began, its administrative staff and training cadre were recruited entirely from the instructional staff at Carlisle Barracks. Programs of instruction, lesson plans, and instructional aids were transplanted from the parent school with only slight modification. Minor variations developed as time passed, but until mid-1943, the programs at Carlisle Barracks and Camp Barkeley were nearly identical.

On 1 July 1943, the programs at all officer candidate schools were extended from 12 to 17 weeks. Since the school at Carlisle had been suspended in February, the new program was put into effect only at Camp Barkeley. The addition of 190 hours of training made few basic alterations in the program. A majority of the time, approximately 100 hours, was allotted to activities controlled by the Department of Training. Twenty hours were added to the bivouac, and 50 were divided among the academic departments. The remaining 20 hours were reserved for company activities.³⁰

When the school at Carlisle Barracks was reactivated in May 1944, its program was patterned upon the one already in effect at Camp Barkeley. With minor alterations, both programs remained in effect until the end of the war. During the final year of the war, no major modifications were reported.

The allocation of hours to courses and subjects provides only a crude index of the trends and changes in the MAC officer candidate program. Substantive changes were frequently masked behind the similarity of course titles and objectives. Manuals were revised, lectures rewritten, and approaches changed, all with no apparent alteration in the program. In January 1942, for example, a group of officers from the Medical Field Service School visited the headquarters of the

²⁹ Program of Instruction, 12-Week Officer Candidate Course, 1942. Medical Field Service School, Carlisle Barracks, Pa.

³⁰ (1) Letter, Capt. Thomas C. M. Robinson, MAC, Administrative Assistant, Training Division, Office of The Surgeon General, to Lt. Col. George E. Armstrong, MC, Assistant Commandant, MAC Officer Candidate School, Medical Replacement Training Center, Camp Barkeley, Tex., 21 May 1943. (2) Letter, Col. George E. Armstrong, MC, Assistant Commandant, MAC Officer Candidate School, Medical Replacement Training Center, Camp Barkeley, Tex., to Capt. Thomas C. M. Robinson, MAC, Training Division, Office of The Surgeon General, Army Service Forces, U.S. Army, 9 June 1943.

Armored Force at Fort Knox, Ky., to determine what could be done at Carlisle Barracks to improve medical service supporting armored units. Until this time, lessons at the school had focused on the square division and cavalry auxiliary troops, with 2 or 3 hours allotted to discussion of the Armored Force. After school officials toured Fort Knox, the curriculum was reorganized to feature the triangular division and the Armored Force. A request by the commandant for two tank hulls that could be used as training aids illustrates the responsiveness of school authorities to reports from the field.³¹

* * * Since our conversation with the authorities at Fort Knox and our observations there, particularly our observation of a demonstration by trained medical soldiers of the evacuation of the wounded from tanks, other confirmatory evidence of the need for these tanks here has come to my attention. An officer of high rank of the Royal Army Medical Service has told me of an instance in Libya where the body of a dead soldier had to be dismembered before being removed from a tank. He inferred that this horrible procedure could have been avoided. An officer of our Army recently in command of a tank regiment has told me that he had personal knowledge of an incident where a soldier of his regiment was killed in a tank and that it required four hours to get the body out.

It is obvious if such undesirable incidents as those described can be avoided by proper training in the field and proper teaching here that all the necessary aids should be provided.

Later in the war, the subcourse in supply conducted by the Department of Administration at Camp Barkeley was similarly adjusted when problems were reported in transferring supplies from the Zone of Interior to the theaters of operations.³² Neither of these adjustments resulted in a reallocation of training time, nor in a change in course title.

Educational Procedures

Techniques of instruction.—At both Camp Barkeley and Carlisle Barracks, classes were conducted either by members of the school's academic departments or by platoon leaders and their assistants. Usually, sessions attended by an entire class were conducted by instructors from the academic staff, and platoon leaders took over when the class was divided into sections for practical exercises or review sessions. At both schools, platoon leaders conducted a majority of the classes in subjects such as map reading, first aid, drill and command, and physical conditioning (fig. 8). Platoon leaders always taught under the supervision of the academic staff, which was responsible for preparing the lesson outlines for practical exercises as well as for selecting forms and other instructional aids. Outlines were so detailed that they frequently included even diagrams to be drawn on the blackboard.

Classes at the schools were conducted according to approved Army training doctrine. Demonstrations, conferences, and practical exercises were the favored techniques. Lectures were deliberately held to a minimum. A study of the relative

³¹ Letter, Brig. Gen. Addison D. Davis, Commandant, Medical Field Service School, Carlisle Barracks, Pa., to The Surgeon General, 30 Mar. 1942, subject: Request for Instruction Aids (Tanks).

³² Memorandum, Maj. Gen. James C. Magee, The Surgeon General, for Commanding General, Medical Replacement Training Center, Camp Barkeley, Tex., 23 Apr. 1943, subject: Training in Medical Supplies.

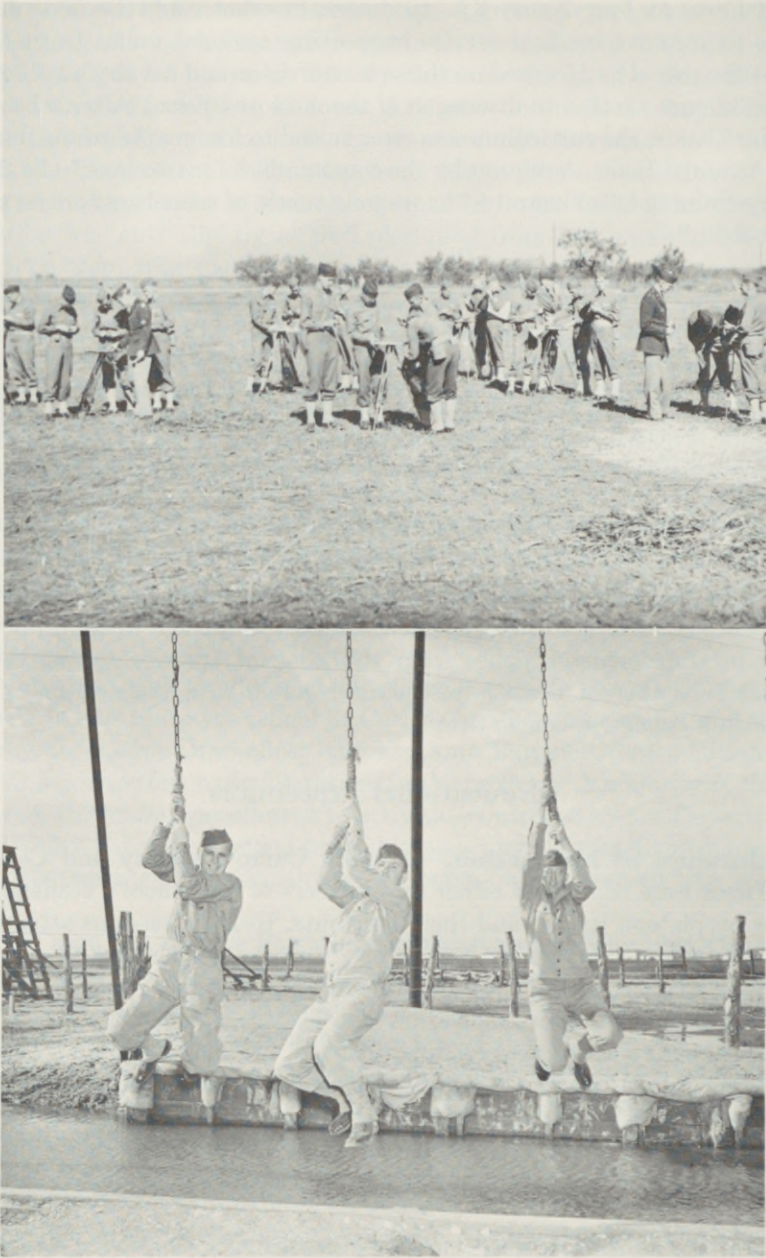


FIGURE 8.—Activities at officer candidate school, Camp Barkeley, Tex., 1944. (Top) Field application of map reading techniques. (Bottom) Candidates negotiating water jump on obstacle course.

use of training methods in 502 scheduled hours of instruction at Camp Barkeley revealed that 179 hours were spent in conferences, and 172 in practical exercises. Demonstrations accounted for another 67 hours, and only 11 hours were used for lectures. Lectures were scheduled even less frequently than examinations, which were allotted 24 hours.

Programs at the schools stressed observation and participation. A medical battalion had traditionally been assigned to the Medical Field Service School to provide demonstrations. When the officer candidate school was activated at Carlisle Barracks, the battalion had assumed responsibility for conducting demonstrations for officer candidates in much the same manner as the academic departments assumed the responsibility for their instruction. During its first year of operation, the demonstrations for the officer candidate school at Camp Barkeley were provided by men from the training battalions at the Medical Replacement Training Center. The quality of demonstrations was difficult to maintain, however, because of frequent changes in the personnel of the units. The problem was resolved by the establishment of a special demonstration platoon. By mid-1943, when the school had reached a capacity of 3,000, the platoon had an authorized strength of 60 men. These units allowed the schools to provide demonstrations ranging from dismantled drill to the deployment of medical units in the field.

Academic departments at both schools used practical exercises to supplement classroom instruction. As part of the program in administration, candidates were required to complete forms and records used by company headquarters, field installations, messes, hospitals, military courts, and boards of officers. Field exercises in the selection of sites for medical installations and the use of maps were an integral part of the training provided by the Department of Tactics. To prepare candidates for the possibility of gas attacks, the Department of Chemical Warfare conducted gas mask drills and exercises in the use of chlorine and tear gas chambers. Under the program of the Department of Training, students practiced teaching and first aid, constructed course schedules, and participated in road marches and dismantled drill.

Emphasis on practical exercises was particularly intense during the class bivouac, a highly organized 6-day exercise that had its origins in a half-day demonstration presented for officer candidates by units of the Medical Replacement Training Center at Camp Barkeley. By stages, the exercise was extended to include an overnight bivouac, a 3½-day bivouac, and finally, a 6-day exercise. During bivouac, candidates participated in field and map problems and practiced the skills required for the operation of medical units in the field. Practical application of classroom training in sanitation was provided, for example, by making a selected group of trainees responsible for sanitation in the bivouac area. Every phase of the exercise was designed to translate some aspect of theory into working knowledge.

Training aids.—In addition to practical exercises, schools frequently used audio, visual, and physical training aids to reinforce lessons and provide experience not readily available in the classroom. Both schools made maximum use of training films, filmstrips, and slides provided by the War Department. At Camp Barkeley, an officer assigned from the school reviewed all new films received by the



FIGURE 9.—Portable public address system, one of the training aids used by the MAC Officer Candidate School, Camp Barkeley, Tex., 1943.

Visual Aids Library of the Medical Replacement Training Center, and evaluated their potential for use in the officer candidate program. War Department training aids were supplemented by large-scale charts, maps, and diagrams designed for specific lessons by the art departments at the Medical Field Service School and the Medical Replacement Training Center, Camp Barkeley.

Schools made use of almost any device that would aid in presenting material. At Camp Barkeley, a truck-mounted public address system was used to present classes and demonstrations in the field (fig. 9). Both schools used installations such as gas chambers, obstacle courses, and infiltration courses to supplement classroom instruction, and at Camp Barkeley, the motor pool and maintenance shops were used as training aids for the course in logistics.

To illustrate the echelons of medical support and to depict the chain of evacuation from the frontlines to the Zone of Interior, the Department of Tactics at Camp Barkeley constructed a miniature battlefield that was approximately 60 feet wide and 350 feet long (fig. 10). The first 212 feet of the demonstration area portrayed the tactical deployment of an infantry division and its medical support. Roads, buildings, medical installations, bridges, tanks, and ambulances were constructed to scale. The remaining portion of the area contained miniature models of all medical

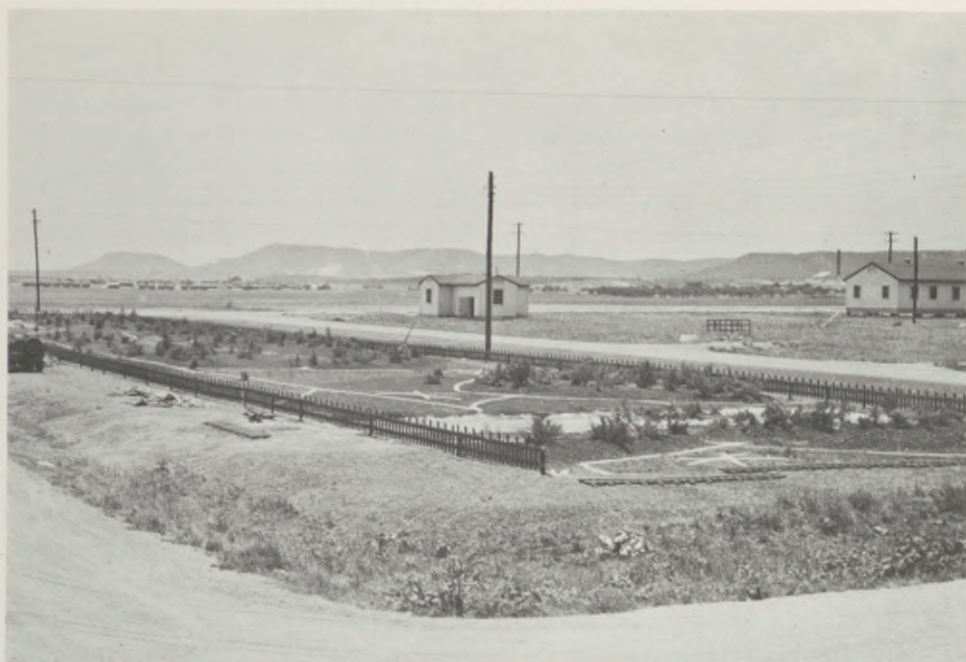


FIGURE 10.—Miniature battlefield depicts chain of evacuation from frontlines to Zone of Interior, Camp Barkeley, Tex., 1943.

installations in the corps and army areas, the communications zone, and the Zone of Interior, not necessarily constructed to scale. An artificial pond represented an ocean separating the theater of operations from the Zone of Interior. A second demonstration area at Camp Barkeley housed a sanitary exhibit containing equipment used in the disposal of animal, human, and kitchen wastes; the sanitary control of field messes; delousing; and mosquito control (fig. 11). Still another area contained examples of hasty entrenchments.

Two- and three-dimensional training aids had important roles in the programs of MAC officer candidate schools. At times, they became so extensive that the distinction between observation and participation lost meaning.

Tests and critiques.—Tests and critiques were an important part of the curriculum at all officer candidate schools. At both Medical Department schools, tests were designed to serve three purposes: to evaluate student achievement, to measure the effectiveness of the training program, and to reinforce training received in the classroom.

The construction and administration of tests at MAC officer candidate schools were a departmental responsibility. Instructors for each course or subject were required to submit questions to the heads of their departments covering material they had presented in class. Department heads, in turn, passed these questions to a review board that determined the validity of questions and approved the test in its final form. Such boards usually consisted of the department head and at least one



FIGURE 11.—Sanitary demonstration area, MAC Officer Candidate School, Camp Barkeley, Tex., 1943.

representative of the Department of Training who was familiar with the theory of testing. Schools relied almost exclusively on objective examinations consisting of multiple-choice, completion, and true or false questions. On occasion, candidates were required to complete forms used in Medical Department administration and to solve problems requiring the use of mathematics, maps, and symbols.

To qualify for commissions, candidates were required to achieve a grade of 75 in all subjects. When a candidate failed tests in two subjects, his records were automatically brought before a board of officers, commonly referred to as the Benzine Board, that reviewed his status as a candidate. Failure in the subjects of map reading or administration could also bring a candidate before the board. Candidates considered unlikely to succeed were dismissed.

Since tests were also designed as a training device, examinations were always followed by a period of review and discussion. Usually, the next class session following the test was set aside for a discussion session. Trainees were provided with the correct answers to questions they had missed and were allowed to discuss problems they found difficult. Critiques were also scheduled at the conclusion of bivouacs and field problems.³³

³³ See footnote 17, p. 99.

Standards for Commissioning

The rate of attrition among candidates for commissions in the Medical Administrative Corps was the second highest in ASF officer candidate schools.³⁴ Between July 1941 and October 1945, MAC officer candidate schools enrolled 24,929 candidates and graduated 17,094 with commissions. Thirty-one percent of all candidates, or a total of 7,835, failed to complete the course. Twenty-one percent of the candidates enrolled at Carlisle Barracks were relieved before graduation, and nearly 35 percent of the trainees at Camp Barkeley were either "washed out" or allowed to resign.³⁵ A year before the end of the war, the contrast between the two schools was even more marked: 13.9 percent of the candidates at Carlisle Barracks failed to graduate, while at Camp Barkeley, the rate was 34.1 percent.³⁶ In September 1944, the high rate of attrition at Camp Barkeley focused the attention of the Medical Department and the Army Service Forces on the standards of selection and retention for MAC officer candidates.

By November 1942, War Department procedures for selecting officer candidates had been standardized in a single regulation emphasizing leadership, ability, and experience.³⁷ Local commanders were directed to encourage enlisted men with an AGCT (Army General Classification Test) score above 110, who had completed basic training and demonstrated a capacity for leadership, to apply for officer candidate school. Applicants for MAC Officer Candidate School were required to have a year of college training or a year of experience in administrative or managerial positions. After preliminary testing and screening, applicants were selected by reviewing boards appointed by commanders responsible for filling quotas. Since many of the qualities required in an officer candidate were intangible, standards were subject to varying interpretations, some more stringent than others.

After a visit to Camp Barkeley in September 1944, the Director of the School Division, ASF, notified The Surgeon General that he was dissatisfied with the quality of trainees in the officer candidate school. Candidates were being selected on the basis of applications submitted months earlier, when the school was operating at a reduced capacity. Many had since become technicians or noncommissioned officers and had no desire to become officers. Candidates reporting from service command installations, he observed, "had absolutely no military background for the course." The Surgeon General was asked to determine the sources from which improperly qualified personnel were being received.

In response, the Medical Department conducted a study of five classes at Camp Barkeley and three at Carlisle Barracks. The gross rates of attrition at the two schools, including several classes still in session, were 22 percent and 8 percent, respectively (tables 6 and 7). The highest rate of failure was among candidates from

³⁴ Memorandum, Capt. John M. Gracie II, MAC, Executive Officer, Training Division, Office of The Surgeon General, for Director of Training, Services of Supply, 9 Sept. 1944, subject: Attrition of Officer Candidates.

³⁵ (1) See footnotes 17, p. 99, and 27, p. 102. (2) Special Report of Training Activities of the Officer Candidate School, fiscal year 1946. *In* Annual Report, Field Service School, Army Medical Department Schools, Army Service Forces, Brooke Army Medical Center, Fort Sam Houston, Tex., fiscal year 1946.

³⁶ See footnote 34.

³⁷ (1) Army Regulations No. 625-5, 26 Nov. 1942. (2) Army Regulations No. 625-5, 12 Sept. 1944.

TABLE 6.—Attrition rates of trainees for Officer Candidate Schools, Camp Barkeley, Tex., 1944

Source	Total enrollment	Total dropped	Rate of failure
			<i>Percent</i>
Army Air Forces	231	92	39
Service commands	685	228	31
Foreign service	192	46	23
Army Ground Forces and Defense Commands	423	53	12
Army Service Forces Training Centers (Med)	567	60	10
Ports of embarkation	20	2	10
Army Service Forces	55	5	9
Total	2,173	486	22

Source: Memorandum, Col. A. W. Chilton, GSC, Director, School Division, Army Service Forces, for The Surgeon General, 19 Sept. 1944, subject: Selection of Officer Candidates for the Medical Administrative Corps, 1st indorsement (Tab A), 9 Oct. 1944, thereto.

the Army Air Forces, and the lowest was experienced by those from ASF training centers.

Class 33 at Camp Barkeley, which had an attrition rate of 48 percent at the end of the 12th week of training, was thought to provide "a much truer picture than the summary of all classes." In this class, 63 percent of the failures were attributed to lack of leadership, and candidates from the service commands accounted for 64

TABLE 7.—Attrition rates of trainees for Officer Candidate Schools, Carlisle Barracks, Pa., 1944

Source	Total enrollment	Total dropped	Rate of failure
			<i>Percent</i>
Army Air Forces	6	3	50
Service commands	246	25	10
Foreign service	12	3	25
Army Ground Forces and Defense Commands	42	5	12
Army Service Forces Training Centers (Med)	434	24	6
Army Service Forces Training Centers (other than Med)	6	1	17
Ports of embarkation	3	0	-----
Miscellaneous	2	0	-----
Total	751	61	8

Source: Memorandum, Col. A. W. Chilton, GSC, Director, School Division, Army Service Forces, for The Surgeon General, 19 Sept. 1944, subject: Selection of Officer Candidates for the Medical Administrative Corps, 1st indorsement (Tab B), 9 Oct. 1944, thereto.

percent of those dropped from the course. Candidates from the Army Air Forces, accounting for 25 percent of the enrollment, had already lost 58 percent of their number.

The attrition rate at Carlisle Barracks was appreciably lower, but candidates from the service commands still accounted for the bulk of the losses. Of the 751 students enrolled, only 61 had been dropped from the program. This relatively low rate of attrition was attributed to a basic difference in the interpretation of the training mission at Carlisle Barracks:

* * * Resignation accounts for 18 percent of the total dropped from the three classes. All other students were dismissed; last time 20 percent of the total attrition was dropped for lack of leadership and approximately 50 percent failed in academic studies. The policy of "suggested resignations" has not been pursued at the school at Carlisle, with the result that figures on these classes are not comparable to the Officer Candidate School at Camp Barkeley. Academic failure versus lack of leadership may be considered an indication of a difference of emphasis between the two installations.³⁸

Since the use of outdated applications had been eliminated by a revised version of the regulation governing officer candidates issued on 12 September 1944, the Medical Department believed that there would be fewer disinterested candidates. The major problem was the lack of leadership and military background prevalent among candidates sent by the service commands, and the marked success of candidates from ASF training centers, who had either served as cadre or attended officer candidate preparatory schools, seemed to lead to a solution. The rate of attrition among candidates from the service commands could be significantly reduced if men who had served for long periods in technical or administrative positions were given preschool training in drill and command at service command installations.

After reviewing the study submitted by the Medical Department, the Director of Military Training, ASF, concluded that the contrast between the attrition rates at Camp Barkeley and Carlisle Barracks was difficult to reconcile since both schools operated under the same program of instruction and War Department doctrine and received many students from the same sources. He directed the Officer Candidate School, Camp Barkeley, and the Eighth Service Command to inspect the school "to determine the reasons for the very high rate of attrition" and submit a "report of action taken to relieve the high attrition rate."

In its reply, the Eighth Service Command focused on the standard of superior performance set by platoon leaders at Camp Barkeley and concluded that "based upon the high standards and superior performance of duties required of candidates for graduation from the MAC Officer Candidate School, Camp Barkeley, that the present rate of attrition is not high." The school was determined to maintain these standards and had little control over injudiciously and carelessly selected candidates with inadequate backgrounds who used the privilege of resignation to escape the rigors of training. Living conditions at Camp Barkeley were also cited as

³⁸ Memorandum, Col. A. W. Chilton, GSC, Director, School Division, Army Service Forces, for The Surgeon General, 19 Sept. 1944, subject: Selection of Officer Candidates for the Medical Administrative Corps. 1st indorsement, 9 Oct. 1944, with inclosures thereto; and 2d and 3d memorandum indorsements, 21 Oct. 1944 and 14 Nov. 1944.

contributing to trainee discontent. Recommendations for reducing the attrition rate at Camp Barkeley included screening candidates more carefully, eliminating the privilege of resignation, and establishing flexible quotas that would allow boards to select only qualified applicants. On 22 November 1944, the Director of Military Training, ASF, asked the Surgeon General's Office to review the Eighth Service Command's report.

The Director, Training Division, Surgeon General's Office, refused to endorse the Eighth Service Command's analysis. He agreed that candidates were occasionally selected by hasty or haphazard methods but denied that selection procedures had to be spelled out in greater detail. The standards defined in existing regulations were adequate, and commanders who failed to meet their responsibilities could be dealt with through command channels. Since The Adjutant General allocated quotas on the basis of reports of availability submitted by local commanders, he believed that the flexible quotas suggested by the Eighth Service Command would add little to the existing system. In any case, both schools received candidates from the same sources, a fact which led the Director, Training Division, SGO, to believe that Camp Barkeley and Carlisle Barracks had different philosophies of training.³⁹

* * * It is evident that a gross discrepancy exists between the two MAC OCS which cannot be lightly explained away by citing "exacting demands of platoon leaders and officer instructors for superior performance." There is no evidence that graduates of the Medical Administrative Corps Officer Candidate School, Camp Barkeley, are superior to graduates of the school conducted at Carlisle Barracks, and it is therefore considered presumptuous to state that the standards established at one institution are in any way superior to those of another. * * * It can be reasonably presumed that no less "exacting standards" are in force at the Medical Administrative Corps Officer Candidate School at Carlisle Barracks. The factor of the basic philosophy involved at both institutions contributes materially to the rate of attrition. The high rate of attrition leads to the belief that the philosophy employed at one installation is to "see how many candidates can be kept from becoming officers" and, at the other, "to help as many get through as possible." Normal standards of performance of duties, commensurate with the demands of military service, for officer candidates are desirable. Unattainable standards or standards set at such level as to render their attainment by a major group selected for the training involved are considered wasteful of time, funds, and human energies.

While quarters and living conditions at Camp Barkeley did not equal those at Carlisle Barracks, they were as good as those at many other officer candidate schools, and the Director, Training Division, Surgeon General's Office, did not think they were responsible for the rate of voluntary withdrawal at Camp Barkeley. He believed that candidates withdrew because a policy of suggested resignations had been adopted by the school, and that candidates were under continuous pressure to resign. In sum, he charged that the privilege of resignation had been abused by the school, and not by the candidates.

Two weeks before the Director, Training Division, SGO, submitted his review, the officer candidate school at Camp Barkeley was notified that it was to be phased

³⁹ Transmittal Sheet, Office of the Director of Military Training, Army Service Forces, to The Surgeon General; Director, Military Personnel Division, Army Service Forces, *in turn*, 22 Nov. 1944, subject: Selection of Officer Candidates for the Medical Administrative Corps. 1st indorsement, 11 Dec. 1944, with inclosures thereto.

out of the program.⁴⁰ His review marked the end of official debate over the problem of attrition at MAC officer candidate schools. In addition to providing insight into the training program at Camp Barkeley, the debate demonstrated the degree to which differing interpretations could alter the standards governing the selection, training, and commissioning of officer candidates.

Negroes

Negro students were enrolled at both MAC officer candidate schools. Between 1942 and 1945, a total of 260 Negroes, or an average of seven per class, were enrolled at Camp Barkeley (table 8). In the same period, 127 Negroes, or an average of five per class, were enrolled at Carlisle Barracks.⁴¹ Since enrollment was small, segregation was impractical, and Negro candidates were integrated not only into classes but also in barracks and messes as well.

Statistics compiled at Camp Barkeley indicated few differences in the performance of Negro and white officer candidates. As a group, Negro candidates were slightly less successful than white trainees: 60.8 percent of the Negro trainees graduated from the course, compared with 65.4 percent of white candidates. By the same token, however, Negro candidates were more often successful than were candidates sent by the Army Air Forces, service commands, ports of embarkation, and theaters of operations. Negro trainees were relieved for academic and physical reasons more frequently than white trainees, and less frequently for lack of leadership. The rate of resignation was slightly below that of other candidates.

ADVANCED TRAINING

The MAC officer candidate program was designed to produce junior officers capable of relieving doctors, dentists, and veterinarians from a wide variety of nonprofessional responsibilities. In many cases, members of the Medical Administrative Corps were assigned to positions requiring preparation beyond that provided at officer candidate schools. As the war continued, MAC officers assumed an increasing number of duties previously assigned to officers of the professional corps, and opportunities for advanced training increased proportionally.

Many advanced training programs for the Medical Administrative Corps were outgrowths of programs initially designed for medical, dental, and veterinary officers. Frequently, training opportunities were provided for MAC officers by integrating them into courses established for the officers they were replacing. MAC officers who were assigned to medical replacement training centers, for example, were trained in pools originally established for officers of the professional corps. Those assigned to administrative positions at large hospitals were allowed to

⁴⁰ Letter, Lt. Col. Wayne A. Starkey, MC, Chief, School Branch, Training Division, Office of The Surgeon General, to Lt. Col. John A. Nave, Assistant Commandant, MAC Officer Candidate School, Camp Barkeley, Tex., 28 Nov. 1944.

⁴¹ (1) See footnotes 6, p. 97; 27, p. 102; and 35 (2), p. 115. (2) Special Report of Training Activities, Officer Candidate School, fiscal year 1943. *In* Annual Report, Medical Field Service School, Carlisle Barracks, Pa., fiscal year 1943.

TABLE 8.—Number and percentage of candidates who enrolled and graduated or who failed to complete the MAC Officer Candidate Course, Camp Bartkeley, Tex., classes 1-40, inclusive, by Army component, age, race, source, and education

Category	Total enrolled		Graduated and commissioned			Candidates relieved						Transferred to later class or Carlisle Barracks		Miscellaneous			
	Number	Percent	Number	Group percent	Class percent	Relieved by board action			Resigned on own request		Number	Percent	Number	Percent	Number	Percent	
						Deficient academically	Lack of leadership	Physically disqualified	Number	Percent							Number
<i>Army components</i>																	
Regular Army	3,783	19.9	2,300	60.8	18.5	166	4.4	266	7.0	28	0.7	869	23.0	132	3.5	22	0.6
National Guard	1,152	6.1	754	65.4	6.1	60	5.2	71	6.2	6	0.5	212	18.4	45	4.0	4	0.3
Special Services	13,960	73.5	9,306	66.6	75.0	545	4.0	1,243	9.0	120	0.9	2,256	16.1	434	3.0	56	0.4
Reserve Officers' Training Corps	103	0.5	48	46.6	0.4	4	3.9	13	12.6	5	4.9	22	21.4	11	10.6		
<i>Age</i>																	
Under 21	404	2.1	302	74.7	2.4	14	3.5	51	12.6	1	0.2	28	7.0	8	2.0		
21-30	14,751	77.6	10,196	69.0	82.2	542	3.7	1,146	7.8	112	0.8	2,279	15.4	436	3.0	40	0.3
31-40	3,594	19.0	1,813	50.4	14.6	204	5.7	381	10.6	42	1.2	970	27.0	163	4.5	21	0.6
41 years and older	249	1.3	97	39.0	0.8	15	6.0	15	6.0	4	1.6	82	33.0	15	6.0	21	8.4
<i>Race</i>																	
White	18,725	98.5	12,240	65.4	98.6	736	4.0	1,580	8.4	155	0.8	3,318	17.7	615	3.3	81	0.4
Colored	260	1.4	158	60.8	1.3	38	14.6	11	4.2	4	1.5	41	15.8	7	2.7	1	0.4
Miscellaneous	13	0.1	10	77.0	0.1	1	7.7	2	15.3								
<i>Source</i>																	
Defense Command and Army Ground Forces	4,479	23.6	2,969	66.3	24.0	203	4.5	337	7.5	26	0.6	798	17.8	124	2.8	22	0.5
Service Commands	3,406	18.0	1,925	56.4	15.5	145	4.3	319	9.4	50	1.5	811	23.8	134	4.0	22	0.6
Army Air Forces	2,870	15.1	1,501	52.4	12.1	166	5.4	271	9.4	29	1.0	798	27.8	101	3.5	14	0.5
Army Service Forces Training Center	5,681	30.0	4,576	80.4	36.8	148	2.6	368	6.5	28	0.5	436	7.7	108	2.0	17	0.3
(Camp Bartkeley)	(1,891)	(10.0)	(1,660)	(87.8)	(13.4)	(32)	(1.7)	(57)	(3.0)	(7)	(0.4)	(100)	(5.3)	(27)	(1.4)	(8)	(0.4)
(Camp Grant)	(721)	(3.8)	(601)	(83.3)	(4.8)	(12)	(1.7)	(54)	(7.5)	(1)	(0.1)	(43)	(6.1)	(8)	(1.1)	(2)	(0.2)
(Camp Ellis)	(661)	(3.5)	(610)	(92.3)	(4.9)	(3)	(0.5)	(23)	(3.4)	(2)	(0.3)	(10)	(1.5)	(12)	(1.8)	(1)	(0.1)
(Fort Lewis)	(1,631)	(8.6)	(1,249)	(76.6)	(10.0)	(59)	(3.6)	(134)	(8.2)	(9)	(0.6)	(149)	(9.1)	(29)	(1.8)	(2)	(0.1)
Ports of embarkation	171	0.8	89	52.0	0.7	7	4.1	12	7.0	2	1.2	53	31.0	7	4.1	1	0.6
Foreign Service	2,172	11.4	1,212	55.8	9.8	113	5.2	258	11.9	20	0.9	432	20.0	131	6.0	6	0.2
Army Specialized Training Programs	117	0.6	94	80.4	0.8			15	12.8			4	3.4	4	3.4		

Miscellaneous.....	102	0.5	42	41.2	0.3	3	3.0	13	12.7	4	4.0	27	26.4	13	12.7	6	0.7
<i>Education</i>																	
Grammar.....	895	4.7	410	45.8	3.3	81	9.0	41	4.6	3	0.3	328	36.6	26	3.0	6	0.7
High school.....	5,478	28.8	3,499	63.9	28.2	295	5.4	368	6.7	35	0.6	1,095	20.0	175	3.2	11	0.2
College.....	6,333	33.4	4,209	66.5	34.0	247	4.0	516	8.1	75	1.2	1,033	16.3	217	3.4	36	0.5
College graduate.....	6,292	33.1	4,290	68.2	34.5	152	2.4	668	10.6	46	0.7	903	14.4	204	3.2	29	0.5
Pharmacists.....	1,033	5.4	600	58.1	4.8	36	3.5	147	14.2	7	0.7	204	19.7	35	3.4	4	0.4
Warrant officers.....	130	0.7	77	59.2	0.6	3	2.3	5	3.8	3	2.3	35	27.0	7	5.4		
Verbal orders.....	214	1.1	171	80.0	1.4	3	1.4	14	6.5			21	9.8	5	2.3		
Total.....	18,998	100.0	12,408	65.3	100.0	775	4.1	1,593	8.4	159	0.8	3,359	17.7	622	3.3	82	0.4

Source: Annual Report, Army Service Forces Training Center, Camp Barkeley, Tex., 1 July 1944 to 1 April 1945. Part 2. Medical Administrative Corps Officer Candidate School.

participate in the job-understudy programs available through hospital training pools. By the end of the war, members of the Medical Administrative Corps were attending almost every nonprofessional course offered by the Medical Department, including the Medical Field and Sanitary Inspector Course, and the courses in supply and maintenance at the St. Louis Medical Depot, St. Louis, Mo. A number of officers also attended courses and schools outside the Medical Department, including the Adjutant General's School, Fort Washington, Md., and the Ordnance Automotive Maintenance Course.

The first programs exclusively for members of the Medical Administrative Corps were the courses in mess and motor management at the Medical Replacement Training Center, Camp Barkeley. These courses, established at the suggestion of the Commandant, Medical Replacement Training Center, were designed to fill the need of fixed installations and field units for administrative officers trained in these fields.⁴² The Mess Management Course, conducted at the Camp Barkeley Cooks and Bakers School, emphasized the management of hospital messes, mess sanitation, purchasing methods, and the completion of forms used by mess officers. The Motor Transport Officers' Course was conducted at the center's Motor Transport School and provided training in the operation and maintenance of all types of vehicles used by the Medical Department, the administration of motor convoys, and the problems of day and night driving under tactical conditions. Each month, a group of officers graduating from the Officer Candidate School at Camp Barkeley was selected to attend these courses and retained at the center for an additional 4 weeks of training. Between June 1942 and April 1945, 278 and 289 officers graduated from the Motor and Mess Management Courses, respectively.⁴³

In mid-1943, the Medical Department began developing a series of special training programs for the Medical Administrative Corps. On 11 June 1943, Army Service Forces notified the chiefs of the administrative and technical services that they were required to provide continuous training for all surplus officers held in replacement pools.⁴⁴ Since the Medical Department anticipated a surplus of MAC officers by 1 January 1944, plans for training them in special pools were submitted to the Army Service Forces on 7 July 1943.⁴⁵ On 14 August, the service commands and the Military District of Washington were provided with the names of station and general hospitals that had been selected to conduct pool training.⁴⁶

The pools established for the Medical Administrative Corps, in the summer of 1943, were designed to supplement facilities already available at Medical Depart-

⁴² Letter, Brig. Gen. Roy C. Hefebower, Commanding General, Medical Replacement Training Center, Camp Barkeley, Tex., to The Surgeon General, 5 June 1942, subject: Courses in Mess Management and Motor Transport for MAC Officers.

⁴³ See footnote 17, p. 99.

⁴⁴ Army Service Forces Circular No. 39, 11 June 1943.

⁴⁵ Memorandum, Col. R. W. Bliss, MC, Chief, Operations Service, Office of The Surgeon General, for Director of Military Training, Army Service Forces, 7 July 1943, subject: Replacement Pools for MAC Officers.

⁴⁶ (1) Memorandum, Lt. Col. Charles H. Moseley, MC, Chief, Training Doctrine Branch, Training Division, Operations Service, Office of The Surgeon General, and Capt. T. C. M. Robinson, MAC, Administrative Assistant, Training Division, Operations Service, Office of The Surgeon General, for Director, Training Division, Office of The Surgeon General, 19 July 1943, subject: Conference on Officer Pool Training, 19 July 1943. (2) Memorandum, Maj. Gen. Norman T. Kirk, The Surgeon General, U. S. Army, for Commanding Generals, First through Ninth Service Commands and Military District of Washington, 14 Aug. 1943, subject: Replacement Pools for Medical Administrative Corps Officers.

ment replacement pools. While awaiting assignment as fillers or replacements, officers in the pools were provided with an opportunity to understudy members of the staff in positions ranging from adjutant and registrar to medical detachment commanders. Training was conducted under the pool program in hospital administration originally designed for officers in the Medical and Dental Corps. Since all MAC officers were graduates of officer candidate schools, the program was modified to eliminate basic training.⁴⁷

School for Battalion Surgeon's Assistants

In the fall of 1943, The Surgeon General decided to replace one of the two surgeons assigned to battalion aid stations with a specially trained MAC officer who would be known as the battalion surgeon's assistant. Despite fears that such officers might assume unwarranted diagnostic powers, The Surgeon General was confident that with special training they could replace one physician and relieve the second from many of the distractions of detachment administration and tactical employment.

Fortunately, approximately 1,500 MAC officers were in replacement pools in the Zone of Interior at the time The Surgeon General made his decision, and beginning in January 1944, successive groups of these officers were ordered to report to a newly established School for Battalion Surgeon's Assistants at Camp Barkeley.⁴⁸ Between January 1944 and January 1945, approximately 2,000 officers graduated from the course. The second class, which began late in February 1944, contained more than half of the officers enrolled during the year that the school was in operation. By March, replacement pools were empty, and the school began enrolling recently commissioned officers. Each of the five classes enrolled between March 1944 and January 1945, when training was suspended, contained between 99 and 178 trainees.⁴⁹

The 6-week course for battalion surgeon's assistants focused on subjects that would qualify a nonprofessional lieutenant in the Medical Administrative Corps to assume responsibility for a battalion aid station and assist the battalion surgeon in the treatment of casualties. A total of 140 hours of training time, or almost half of the scheduled 300 hours of instruction, were devoted to subjects related to field medicine and surgery, including emergency medical treatment, treatment of chemical casualties, transfusions, chemotherapy, and use of penicillin. Fifty hours were devoted to the tactical use of battalion aid stations in the attack and retrograde movements, and 42 hours were devoted to field sanitation. The balance of the time was allotted to administration and military training. Two weeks of the course were spent in field exercises.⁵⁰

Although designated as a separate school, the School for Battalion Surgeon's Assistants was managed in conjunction with the MAC Officer Candidate School at

⁴⁷ See footnote 46 (2), p. 122.

⁴⁸ See footnote 2, p. 97.

⁴⁹ See footnote 17, p. 99.

⁵⁰ Training Program for Assistant Battalion Surgeons (Medical Administrative Corps Officers), 7 Dec. 1943.

Camp Barkeley. The assistant commandant of the MAC Officer Candidate School acted as the assistant commandant of the School for Battalion Surgeon's Assistants, and most of the officers teaching at the school were instructors at the Officer Candidate School. Classes in field medicine and surgery were conducted by members of the Medical Corps who were assigned to the school by the War Department.⁵¹

In May 1945, the Surgeon General's Office decided to train 500 additional battalion surgeon's assistants for employment in the Pacific theater. Since training at Camp Barkeley had already been discontinued, the course was shifted to the Medical Field Service School, and the program was revised to reflect conditions in active theaters.⁵² On 7 July 1945, a class of 102 officers was enrolled, of which 100 graduated on 4 August. A second class of 100, enrolled on 11 August, was disbanded after the military collapse of Japan.⁵³

Physical and Educational Reconditioning Officers

Plans for an Armywide program for reconditioning convalescent soldiers were developed by the Surgeon General's Office early in 1943, and by April, the program was theoretically underway. Until early 1944, however, only a few hospitals established successful programs. Uncertainty continued until March 1944, when the Army Service Forces issued tables of organization for reconditioning programs in general hospitals and made the Army Reconditioning Program a service command responsibility.⁵⁴

At the request of the Office of The Surgeon General, courses for educational and physical reconditioning officers were established at the School for Personnel Services, in April and May 1944. Both courses were placed under the control of a newly created Department of Reconditioning headed by a Medical Department officer. Outlines for the courses were developed at the Office of The Surgeon General by members of the Reconditioning and Training Divisions.⁵⁵

The Physical Reconditioning Officers' Course was a 1-month program focusing on physical and neuropsychiatric disorders, kinesiology and physiology, remedial exercises, developmental and adaptive exercises, and the administration of the Army Reconditioning Program. In the 4-week course for educational reconditioning officers, material on exercises was replaced by instruction in the philosophy and methodology of education, guidance, and prevocational counseling. Educational reconditioning officers were also oriented to recreational activities that included dramatics, radio programs, and music.

⁵¹ See footnote 17, p. 99.

⁵² Letter, Brig. Gen. R. W. Bliss, Chief, Operations Service, Office of The Surgeon General, to Commanding General, Army Service Forces, Director of Military Training, 31 May 1945, subject: Training of Medical Administrative Corps Officer Candidate School Officers as Battalion Surgeon Assistants.

⁵³ Goodman, Samuel M.: History of Medical Department Training. United States Army World War II. Volume IX: Medical Department Training Activities, 1 July 1945-2 September 1945. A Supplement to Historical Monographs and Supplements Covering the Period 1 July 1939-30 June 1945. [Official record.]

⁵⁴ Medical Department, United States Army. Organization and Administration in World War II. Washington: U.S. Government Printing Office, 1963.

⁵⁵ Loughlin, Richard L.: The Medical History of the United States Army in World War II. Reconditioning. [Official record, 1946.]

The table of organization for reconditioning programs included many officers in addition to members of the Medical Administrative Corps. The program at each hospital of 500 beds or larger was directed by a Medical Department officer, and his assistant for physical reconditioning could be either a MAC officer or an officer with the requisite background from any other corps in the Army. The position of Educational Reconditioning Officer could be filled by an officer from any branch of the Army who had experience in morale services.⁵⁶ Between June 1944 and October 1945, a total of 679 officers graduated from the course for physical reconditioning officers. In the period from May 1944 to October 1945, 635 graduated from the Educational Reconditioning Course.⁵⁷

⁵⁶ Army Service Forces Circular No. 73, 11 Mar. 1944.

⁵⁷ See footnote 55, p. 124.

PREWAR PROGRAMS

As a part of their activities there were few opportunities for either basic or advanced training during the interwar years. Training opportunities in the Army Medical Corps were limited to a few at a time, and were provided only as informal education in the Army at large, not during. A few Army hospitals provided the

⁵⁸ The Medical Department, *Medical Department, Army, 1919-1945*, p. 124. The Medical Department, *Medical Department, Army, 1919-1945*, p. 124.

⁵⁹ The Medical Department, *Medical Department, Army, 1919-1945*, p. 124. The Medical Department, *Medical Department, Army, 1919-1945*, p. 124.

⁶⁰ The Medical Department, *Medical Department, Army, 1919-1945*, p. 124.

CHAPTER IV

The Army Nurse Corps¹

Before World War II, training programs for Army nurses were few and were designed only to prepare nurses for clinical or functional assignments and not to provide military training. Indeed, between 1920, when they were granted relative rank as officers, and July 1944, when they received full commissions, nurses enjoyed only quasi-military status.² Even membership in the Army's Reserve components, authorized for all other Medical Department corps, was denied them.³ Reasons offered for this peculiar arrangement in 1935 help to explain not only the absence of a Reserve corps for nurses, but also the quasi-military status of nurses and their lack of military training:

The creation of a formal Nurse Reserve Corps analogous to the Officers Reserve Corps would be difficult to defend * * *. The duties of a nurse in a military hospital do not differ in any important particular from the duties * * * in civil hospitals. Preliminary military training is not essential therefore and active duty training periods * * *, similar to those held for reserve officers, are not required. Marriage would terminate eligibility in too many instances and inject an almost prohibitive obstacle to the maintenance of such a corps. The War Department in lieu of a Nurse Reserve Corps relies almost entirely upon the American National Red Cross Nursing Service for the supply of qualified nurses during an emergency. This is eminently proper as the Red Cross recognizes this responsibility as one of its charter obligations and has the national set-up for such a mission.⁴

Even more to the point was a remark made by The Surgeon General, Maj. Gen. James C. Magee, to members of the National Medical Association in March 1941, in attempting to quiet their fears that military recruiting would strip the Nation of public health nurses: "After all there are 500,000 nurses in America and we are only asking for 1 to 1½ percent." Before the war, planners considered nurses so plentiful that military requirements could be met without special programs or incentives.

PREWAR PROGRAMS

As a result of these attitudes, there were few opportunities for either basic or advanced training during the interwar years. Peacetime appointments to the Army Nurse Corps were made a few at a time, and nurses received only an informal orientation to the Army at their first station. A few Army hospitals provided lim-

¹ Unless otherwise indicated, this chapter is based on a study entitled "History of the Army Nurse Corps," by Lt. Col. Hortense E. McKay, USA (Ret.). [Official record.]

² (1) 41 Stat. 767. (2) 58 Stat. 324.

³ Medical Department, United States Army. *Personnel in World War II*. Washington: U.S. Government Printing Office, 1963.

⁴ Rogers, J. A.: *Reserve Nurses*. Army M. Bull. No. 32, July 1935.

ited programs in anesthesia and other clinical skills. Most of this training was tutorial, on-the-job training comparable to that provided for enlisted specialists, and designed to meet the requirements of a specific hospital. Early in 1933, The Surgeon General required six general hospitals to conduct a course in "Medical Department Administration" for nurses with less than 3 years' service, and by the end of June, 236, about a third of the corps, had completed the program of 18 lectures.⁵ This appears to have been a "one-time-only" program for there is no evidence that the series was ever repeated. Finally, funds available under the 2-percent clause of the National Defense Act, as amended in 1920, were used to train Army nurses at civilian institutions. Until 1933, these funds were used primarily to train instructors for the Army School of Nursing. After the school was suspended, the funds were used to train nurse-anesthetists.⁶

Interwar programs left the Medical Department with fewer training precedents than it had for enlisted men, or even MAC (Medical Administrative Corps) officers. As the Army Nurse Corps grew from 672 on 30 June 1939 to 55,590 at the end of August 1945, the need for training became increasingly obvious, and wartime training methods evolved gradually through trial and error.⁷

BASIC MILITARY TRAINING

Traditional Orientation

In contrast to the 9 months of postgraduate training provided for Medical Corps officers before the war, Army nurses received little training to prepare them for wartime nursing. The peacetime orientation of an Army nurse began with assignment to a station in the continental United States "to afford her an opportunity to become acquainted with military customs." Much of this initial orientation was spent in personal processing: obtaining uniforms, initiating records, and becoming acquainted with the military post, Army hospitals, and nurses' quarters. Instructing new nurses in regulations governing the Army Nurse Corps in "duties peculiar to Army work" was the responsibility of the chief nurse.⁸

Before World War II, the traditional techniques of orientation were reasonably effective. Their most serious defect was the complete absence of training for operation under field and combat conditions. Under the stress of expansion between 1939 and 1941, with newly recruited nurses arriving at stations almost daily, informal and tutorial methods became increasingly unsatisfactory. Chief nurses were heavily taxed by the responsibility for supervising nurses in varying stages of orientation. Individual nurses could not be assured of balanced and progressive basic training to prepare them for unit training.

⁵ (1) Annual Report of The Surgeon General, U.S. Army. Washington: U.S. Government Printing Office, 1933. (2) Adult Education in the Army Nurse Corps. *Am. J. Nursing* 34: 725, July 1934.

⁶ (1) Annual Report of The Surgeon General, U.S. Army. Washington: U.S. Government Printing Office, 1940. (2) Annual Report of The Surgeon General, U.S. Army, Washington: U.S. Government Printing Office, 1939. (3) Annual Report of The Surgeon General, U.S. Army. Washington: U.S. Government Printing Office, 1937. (4) Annual Report of The Surgeon General, U.S. Army. Washington: U.S. Government Printing Office, 1936.

⁷ See footnote 3, p. 127.

⁸ Army Regulations No. 40-20, 31 Dec. 1934.

After entry of the United States into the war, the system suffered a complete breakdown. The Medical Department had planned to use affiliated units to support combat units. After Pearl Harbor, the Medical Department found itself unable to mobilize and equip them in time to accompany combat forces being shipped overseas. The problem was further complicated by the need of task forces for station hospitals, an organization which had no counterpart among affiliated units. As a result, established hospital training units had to be shipped to the theater, and with them, many of the Army's most experienced nurses.

During 1942, numbered hospitals were usually activated at military posts where there was a large station hospital or general hospital at which the unit's officers and men could engage in parallel training. Under this system, members of the unit participated in a mixture of formal training and job-understudy designed to prepare them for their positions when the unit went into operation.⁹ If present during this phase, the unit's nurses were usually assigned to serve in the post hospital, and they received military training only at the hospital commander's discretion.

As an increasing number of nurses entered the Army, there was even less opportunity to fit them into an organization. Hospitals were too pressed to provide leisurely orientations, and many experienced nurses were being promoted and transferred. Many chief nurses had been recruited only recently from comparable civilian positions and had little more experience in military procedures than did their trainees. In short, the prewar pattern of on-the-job training proved as unwieldy for mobilizing the Army Nurse Corps as it had for other components of the Medical Department.

Program Guides

Despite these problems, a formal guide for training Army nurses was not issued by the Office of The Surgeon General until late 1942. Numbered hospitals training in the United States had guidelines for officers and enlisted men but none for nurses. In September 1942, the Training and Nursing Divisions of the Office of The Surgeon General recognized that hospitals destined for theater assignment required guidance in training nurses. A program was published in October that provided 4 weeks of instruction, including 16 hours of duty assignment in a 44-hour week for nurses in theater-of-operations units. Required instruction included military courtesy and customs; uniform regulations; dismounted drill; physical training defense against chemical, mechanized, and air attacks; Army and Medical Department organization; military administration; first aid, field sanitation, and communicable disease control; ward management; and routine hospital procedures.¹⁰

The limitations of this program soon became apparent. Nurses were frequently on duty in active hospitals while the rest of their unit was in training, unable to join them in time to participate in unit training, or to be trained according to the

⁹ Smith, Clarence McKittrick: *The Medical Department: Hospitalization and Evacuation, Zone of Interior. United States Army in World War II. The Technical Services.* Washington: U.S. Government Printing Office, 1956.

¹⁰ Mobilization Training Program No. 8-10, 29 July 1942.

program. The number of those who actually received military training before their unit was shipped to the theater was further reduced when nurses assigned to a unit were withdrawn because of physical disqualification for overseas service or other reasons.

To reduce these problems, the Nursing Division recommended in January 1943 that Army nurses under 50 years of age be trained while assigned to Zone of Interior hospitals.¹¹ This recommendation was approved by ASF (Army Service Forces) on 30 May 1943, and commanding officers of all hospitals of 250-bed or greater capacity in the Zone of Interior were directed to provide training under MTP (Mobilization Training Program) No. 8-10 to all members of the Army Nurse Corps under 50 years of age.¹² The guide published for this program late in June reduced the age for such training to 45 and prescribed a list of topics that were nearly identical to those required under the earlier program.¹³ Two months later, this ASF directive was superseded by a War Department directive which extended the program to all hospitals, regardless of capacity, and added the "basic" to the title.¹⁴

Even with these changes, the program proved inadequate. Despite determined efforts, patient care continued to take precedence over training. Nurses reported to hospitals almost daily, making it difficult to fit them into the program. Training at hospitals with a capacity of less than 250 beds was still permissive, difficult to administer, and frequently intermittent. Finally, it became obvious that a new approach to basic training was required if nurses were to function effectively within the Medical Department. In the last half of 1943, the Training Division, Office of The Surgeon General, recognized the advantages of providing basic training for Army nurses before they were assigned to units with a responsibility for patient care. After a proposal submitted to Army Service Forces in August for the establishment of a single basic training center for nurses was disapproved, the Medical Department tried another tack that ultimately proved fruitful.¹⁵

Basic Training Centers

Following the rejection of its request to establish a centralized basic training center, the Office of The Surgeon General countered with a proposal to establish centers within the service commands under a standardized program of instruction. In late July, Maj. Gen. Brehon B. Somervell, Commanding General, Army Service Forces, authorized the establishment of a basic training center in each service command, and on 16 October, a formal syllabus was published. The earlier, local train-

¹¹ Memorandum, Col. Florence A. Blanchfield, ANC, for Col. F. B. Wakeman, MC, Chief of Training Division, Surgeon General's Office, 14 Jan. 1943, subject: Army Nurse Corps.

¹² Memorandum, Col. R. T. Beurket, GSC, Executive Officer, Training Division, Army Service Forces, for The Surgeon General, 30 May 1943, subject: Basic Military Training for Army Nurse Corps.

¹³ Army Service Forces Memorandum No. S350-32-43, 23 June 1943, subject: Training of Army Nurses.

¹⁴ War Department Memorandum No. W350-233-43, 23 Aug. 1943, subject: Basic Training of Army Nurses.

¹⁵ (1) Memorandum, Col. R. W. Bliss, MC, Chief, Operations Service, Office of The Surgeon General, for Commanding General, Army Service Forces, 2 Aug. 1943, subject: Course of Basic Military Training for Nurses. (2) Memorandum, Col. R. T. Beurket, GSC, Executive Officer, Military Training Division, Army Service Forces, for The Surgeon General, 8 Oct. 1943, subject: Course of Basic Military Training for Nurses.

TABLE 9.—Basic training centers for Army nurses

Service command	Installation and location	First class enrolled	Last class completed	Total graduates
First.....	Fort Devens, Mass.....	19 July 1943.....	22 Sept. 1945.....	3,663
Second.....	Halloran General Hospital, N.Y.....	19 July 1943.....	15 Jan. 1944.....	545
	England General Hospital, N.J.....	5 Dec. 1943.....	30 Jan. 1945.....	1,440
Third.....	Tilton General Hospital, N.J.....	1 Feb. 1945.....	11 Aug. 1945.....	2,011
	Fort George G. Meade, Md.....	6 Sept. 1943.....	14 Apr. 1945.....	2,317
Fourth.....	Camp Lee, Va.....	1 Mar. 1945.....	4 Sept. 1945.....	1,252
	Camp Rucker, Ala.....	10 Oct. 1943.....	13 Aug. 1945.....	2,080
Fifth.....	Billings General Hospital, Ind.....	1 Sept. 1943.....	1 July 1945.....	1,494
	Fort Knox, Ky.....	8 Feb. 1945.....	28 Aug. 1945.....	829
Sixth.....	Camp McCoy, Wis.....	19 July 1943.....	25 Aug. 1945.....	4,120
Seventh.....	Camp Carson, Colo.....	22 Nov. 1943.....	25 Aug. 1945.....	2,538
Eighth.....	Brooke General Hospital, Fort Sam Houston, Tex.....	19 July 1943.....	23 May 1945.....	1,391
	Camp Swift, Tex.....	15 Mar. 1945.....	4 Aug. 1945.....	861
	Madigan General Hospital, Fort Lewis, Wash.....	29 Nov. 1943.....	31 Aug. 1945.....	2,739
Ninth.....	Fort Huachuca, Ariz. (Negro personnel).....	10 July 1944.....	23 Sept. 1944.....	50
	Total.....			27,330

Source: Completed AG ASF Forms R-5218, dated 8 Nov. 1945. In Report—Flow of Trainees Thru Nurses Basic Training Centers.

ing program was retained for nurses with more than 60 days' service who had not completed training under previous programs, but all newly inducted nurses were required to participate in basic training.¹⁶

Most service commands responded enthusiastically to the establishment of basic training centers for Army nurses. Indeed, several service commands had already taken the initiative in establishing such centers as shown in table 9. Early basic training centers were established at hospitals, where the chief nurse had a dual assignment as school commandant and hospital chief nurse. They had the advantage of a close working relationship with the hospital but the disadvantage of placing dual, and sometimes conflicting, responsibilities on those charged with the program. Conditions at these pioneer centers were far from ideal. Later centers were established as separate organizations to increase the efficiency of the program in processing, outfitting, and training newly recruited nurses.

Army nurses assigned to small AAF (Army Air Forces) hospitals directly from civilian life were provided training when 11 AAF nurse training detachments were organized in November 1943. This type of training continued until 1944 when nurses

¹⁶ (1) Memorandum, Lt. Col. Florence A. Blanchfield, Acting Superintendent, Army Nurse Corps, for Col. Francis C. Tyng, MC, Chief, Finance and Supply Division, Office of The Surgeon General, 26 May 1943, subject: Army Nurse Corps. (2) Letter, Maj. Gen. Norman T. Kirk, The Surgeon General, to Commanding General, Each Service Command, 30 July 1943, subject: Training Centers, Army Nurse Corps. (3) See footnote 15 (1), p. 130. (4) Letter, The Adjutant General to Commanding Generals, First to Ninth Service Commands, 16 Oct. 1943, subject: Course of Basic Military Training for Nurses.

were no longer recruited directly by the Army Air Forces.¹⁷ A basic training program for Negro nurses was established at Fort Huachuca, Ariz., but was in operation less than 3 months. After training for women at Fort Huachuca was suspended, most Negro nurses were sent to Camp McCoy, Wis., for training.¹⁸

Program of Instruction

The initial program of instruction prescribed for Army nurses encompassed a period of 144 training hours, including basic military training, administration, organization, military sanitation, and ward and clinic nursing. The largest single block of hours was devoted to such basic military subjects as military courtesy, care of clothing and equipment, dismounted drill, and physical training (fig. 12). A week was allowed for processing incoming students. With the passage of time, course content was adjusted to provide nurses with a broader and more balanced program. Hours devoted to Army and Medical Department organization and to the duties of the Army nurse were expanded. In response to reports from the field, increased emphasis was placed on field training, map reading, tent pitching, efficiency reports, and obstacle and infiltration courses (fig. 13). In April 1945, instruction in malaria control and tropical diseases was added to prepare nurses for duty in the Pacific theater. Hours devoted to hospital ward duty were gradually decreased to provide for the inclusion of these subjects. Other changes in the conduct of training included an increase in the time devoted to outdoor training from 19 percent to approximately 35 percent by June 1944 and an increased use of "applicatory" training and training aids to provide more realism.¹⁹ Training aids were usually locally fabricated and assembled, and their quantity, quality, and use by instructors improved as time passed.

Facilities and Techniques

After October 1943, when training centers were established on an Armywide basis, the basic training program for nurses was better organized. Overhead personnel were authorized for administration and instruction, and tables of allowances were established for supplies and equipment. At first, classrooms at some centers consisted of converted hospital wards with space for 15 to 35 trainees. The program grew to larger proportions late in 1944, when as many as 750 trainees were present at one time, and plans were in process to train as many as 2,000 each month at

¹⁷ (1) Annual Report of Personnel Division, Air Surgeon's Office, fiscal year 1944. (2) Medical History of Second Air Force, 1944. [Official record. U.S. Air Force, Research Studies Institute, Maxwell Air Force Base, Ala.] (3) Link, Mae Mills, and Coleman, Hubert A.: Medical Support of the Army Air Forces in World War II. Washington: U.S. Government Printing Office, 1955.

¹⁸ (1) Telegram, Lt. Gen. Brehon B. Somervell to Commanding Generals, First to Ninth Service Commands and Military District of Washington, 6 Sept. 1944. (2) Memorandum, Lt. Col. Charles H. Moseley, MC, Deputy Director, Training Division, Office of The Surgeon General, for Maj. Edna B. Groppe, ANC, 25 Sept. 1944.

¹⁹ (1) Letter, The Adjutant General to Commanding Generals, First to Ninth Service Commands, 16 Oct. 1943, subject: Course of Basic Military Training for Nurses. (2) Annual Report of Medical Department Activities, Headquarters, First Service Command, 1945. (3) Diary, Brig. Gen. Floyd L. Wergeland, 20 Sept. 1944 to 31 Dec. 1945, entry for 15 May 1945.



FIGURE 12.—Army nurses in training, Camp McCoy, Wis. (Top) Army nurses engage in calisthenics. (Bottom) Army nurses crawl through an obstruction on the obstacle course.



FIGURE 13.—Army nurses in training, Camp McCoy, Wis. (Top) Army nurses negotiate a rope ladder during basic training. (Bottom) Army nurse negotiates the simulated jungle river crossing.

some centers. To cope with the increased training load, methods used in Army Service Forces schools were adopted. Weekly schedules of instruction were published, lesson plans prepared, and instructor guidance programs instituted. Unfortunately, instructor guidance programs did not always include hospital ward nurses responsible for ward teaching, most of whom were more concerned with nursing service than with training. Inspections were instituted to point out strengths and weaknesses in instructional methods and to allow comparison of training between centers.

The facilities provided at basic training centers in 1943 proved inadequate for the training requirements of later years. Not only did the number of nurses in basic training grow, but also in 1944, the training load was further increased by the assignment of dietitians and physical therapists to centers originally intended for nurses. In all, 27,330 nurses received basic training between July 1943 and September 1945. To accommodate these trainees, some commands moved training centers within or between installations or provided an additional center during periods of heavy enrollment. When the number to be trained by one command exceeded its capacity, nurses were sent to other commands. The number of nurses recruited and assigned to training centers varied so much from month to month that a high degree of flexibility was necessary. Only four nurse training centers did not have to be relocated at some time during the war. Relocation was most often necessary because early centers, established at general hospitals, did not have the capacity to adjust to the 1945 training load. Plans were made in June 1945 to decrease the number of training centers, and by September, all centers were closed.²⁰

From time to time, other problems plagued the program. One was the degree of realism and "ruggedness" to be injected into training. For a time, trainees were sent through infiltration courses, but this was later discontinued in the belief that general physical conditioning was more valuable.²¹ Other problems that were eventually solved included an initial shortage of qualified instructors, shortages of clothing, and inadequate training aids. At training centers, these problems were more readily identified and resolved than they could have been at scattered hospitals.

The Contribution of Basic Training

Directives and letters issued early in the war, outlining basic training plans for Army nurses, failed to realize their objectives. Initial directives required nurses assigned to field medical units to possess a satisfactory knowledge of basic military subjects broader than that required for duty in fixed hospitals. Because of inadequate prewar programs, instructors were rarely available. Directives permitting local program modifications, such as allowing nurses to spend half their basic training time in hospital wards, frequently weakened the program. This happened most often when nurses were assigned to fixed hospitals, which did not require a knowl-

²⁰ (1) Army Service Forces Circular No. 300, 7 Aug. 1945. (2) Army Service Forces Circular No. 323, 25 Aug. 1945.

²¹ (1) Army Service Forces Circular No. 90, 27 Sept. 1943. (2) Office Memorandum, Lt. David M. Campbell, MAC, Training Division, Office of The Surgeon General, 2 Nov. 1943.

edge of field techniques to function effectively, and which frequently had patient loads requiring 24-hour nursing service 7 days a week. Establishment of basic training centers with fixed programs guaranteed uniform and continuous training.

Perhaps the most obvious advantage was the high morale developed during basic training. Nurses graduating from such programs could be sure that they had learned their duties and responsibilities as officers, that their personnel records and immunizations were complete, and that they were correctly outfitted. Army nurses were all volunteers, trained in their technical specialties. Yet, it was possible to gain the maximum benefit from these skills only after nurses had become familiar with the Army and the Medical Department and could be confident that they had been trained to come to grips with the special problems of Army nursing.

CHIEF NURSES

Prewar Training

In the interim between World Wars I and II, vacancies and promotions to chief nurse were rare. Examinations were required for promotion to chief nurse, and beginning in 1935, a few chief nurses were assigned for a short period to the Nursing Division, Office of The Surgeon General, to supplement knowledge gained in preparing for the examination with experience. Subjects included hospital administration, records administration, efficiency reports, personnel assignment, disciplinary action, nurses' rights and privileges, management of overseas nurse rosters, and the function of The Surgeon General, The Adjutant General, and the Inspector General. Such training was slow and limited to chief nurses who were changing stations. As the Army Nurse Corps expanded during 1940 and 1941, the authorization for chief nurses increased from 72 to 494. During 1941, 180 candidates selected for leadership and executive ability passed the qualifying examination.²²

Informal, on-the-job techniques satisfied the requirements of the Medical Department until 1942, when the mobilization of theater units thinned the ranks of experienced nurses at fixed hospitals. At this point, the system broke down because too many candidates were studying under inexperienced chief nurses. But until late in 1942, on-the-job training remained the only technique available.

Wartime Training

Under pressure, stopgap methods were used to accelerate the training of chief nurses. Early in 1942, the Superintendent of Nurses, Col. Julia O. Flikke, ANC, revised instructions for training chief nurses to incorporate essential information on personnel procedures and administration. Training procedures were relaxed in April, when written examinations for promotion to chief nurse were abandoned. Commanders empowered to promote officers were authorized to promote nurses to

²² (1) See footnote 6 (4), p. 127. (2) Annual Report of The Surgeon General, U.S. Army. Washington: U.S. Government Printing Office, 1941.

the position of chief nurse to fill vacancies in units under their command and were required only to report the promotion to The Surgeon General. After a few months, even the requirement for a report was suspended.²³ Late in 1942, an effort was made to give chief nurses short courses at four general hospitals, but because of patient loads, only one program was successful.²⁴

Aside from this course, and one developed late in the war by the Army Air Forces, a formal training program for chief nurses did not evolve during World War II. Throughout the war, nurses at service command headquarters provided informal guidance through letters and visits, and some devised more detailed training. At the hospital level, chief nurses attempted to provide on-the-job training for potential candidates, but the mounting pressure of patient loads limited training to Army procedures at the expense of administrative principles and theory. Such training was ostensibly for duty in the theaters, but the duties of chief nurses in Zone of Interior hospitals were also emphasized. Nurses were selected on the basis of civilian administrative experience and physical ability to serve overseas. Those who had already been in the theaters and were qualified to return were also selected. Army Air Forces established a 4-week training course at Bowman Field, Ky., in the autumn of 1944, and later transferred it to the School of Aviation Medicine, Randolph Field, Tex.²⁵

NURSE ANESTHETISTS

In contrast with basic military training, which could not be conducted efficiently in hospitals, the training of nurse anesthetists could be carried out only in a hospital with an active surgical load. The on-the-job training program for nurse anesthetists that evolved during World War II demonstrated that prewar techniques could be adapted to wartime training conditions in technical fields requiring a high degree of supervised practice.

The Prewar Program

The Army began training and utilizing nurses as anesthetists during World War I. Satisfied with the results, the Medical Department continued to use nurses in this capacity throughout the interwar years. No quotas were set, and peacetime training was limited to providing replacements, but in response to "occasion and necessity," a few Army nurses were sent to civilian hospitals or the Army Medical Center, Washington, D.C.²⁶

²³ (1) War Department Circular No. 118, 23 Apr. 1942. (2) War Department Circular No. 202, 23 June 1942. (3) Army Regulations No. 40-20, 15 Aug. 1942.

²⁴ Blanchfield, Florence A., and Standlee, Mary W.: *Organized Nursing and the Army in Three Wars*, vol. 1, p. 362. [Official record.]

²⁵ (1) Memorandum, Nursing Division, Office of The Surgeon General, for Col. Arden Freer, MC, Chief, Professional Administrative Service, Office of The Surgeon General, 15 Jan. 1945. (2) *The Army Nurse* 1:10, October 1944.

²⁶ (1) Huntington, P. W.: *Medical Department Professional Service Schools, Army Medical Center, Washington, D.C. School Year 1934-35*. Army M. Bull. No. 33, October 1935. (2) Stimson, Julia C.: *The Army Nurse Corps. In The Medical Department of the United States Army in the World War*. Washington: U.S. Government Printing Office, 1927, vol. XIII, pt. 2. (3) See footnotes 6 (1), (2), (3), p. 128.

Between 1939 and 1941, Army expansion increased requirements for trained anesthetists. During this period, 15 nurses were sent to civilian hospitals, and 16 others were trained at general hospitals and the station hospital at Fort Sam Houston, Tex.²⁷ Despite these efforts, training failed to keep pace with expansion.

Wartime Programs

The outbreak of war increased and sustained the demand for anesthetists. The first response of the Medical Department was to issue program guides that did little more than continue local programs on an expanded scale. Courses were authorized at Walter Reed General Hospital, Washington, D.C.; Army and Navy General Hospital, Hot Springs, Ark.; Fitzsimons General Hospital, Denver, Colo.; and Lawson General Hospital, Atlanta, Ga.; and at several station hospitals.²⁸ More courses were added as new hospitals opened. In the absence of a standardized program, significant variations in course length and content developed.

The first clear outline of the duties and training of nurse anesthetists was provided by The Surgeon General in a directive issued to the service commands on 11 November 1943. Under this directive, course length was standardized at 6 months, and Zone of Interior training was limited to general hospitals. Administrators were required to submit the names of students to The Surgeon General when they entered training.²⁹ Later, this stipulation was changed to require the names of nurses completing the course, accompanied by a statement of proficiency and the supervision they would require in their duties. The names of students failing the course and the reasons for their failure were also required.³⁰ Nurses were to be trained to administer inhaled anesthetics and to care for patients under all other types. They were not expected to give intraspinal, intravenous, local, or endotracheal anesthetics, but were expected to be able to care for the instruments with which they were administered. By mid-1944, about 100 nurses had completed the program.³¹

Until July 1944, nurse anesthetists were not listed in hospital tables of organization, and the Medical Department could make only rough estimates of its requirements. Their incorporation into tables of organization clarified requirements, which in turn pointed out the need for a formal program of instruction. Such a program was prepared by the Training Division, Office of The Surgeon General, and approved by Army Service Forces on 17 August 1944 as "a general guide for the balanced training of members of the Army Nurse Corps in general anesthesia."³² Included in the subjects required were the principles of anesthesia, pharmacology in relation to anesthesia, the signs and stages of general anesthesia, and the effect of anesthesia on the body. Both pre- and post-operative patient care was covered

²⁷ See footnotes 6 (1), p. 128; and 22 (2), p. 136.

²⁸ Letter, Col. Julia O. Flikke, ANC, Assistant Superintendent, to the Surgeon, Headquarters, Sixth Corps Area, 23 Mar. 1942, subject: Army Nurse Corps.

²⁹ Letter, Maj. Gen. Norman T. Kirk, The Surgeon General, U.S. Army, to Commanding General, Each Service Command, 11 Nov. 1943, subject: Course in Anesthesia.

³⁰ Army Service Forces Circular No. 140, 13 May 1944.

³¹ (1) Annual Report of the Surgeon General of the Army, for the Commanding General, Army Service Forces, fiscal year 1944. (2) Memorandum, Maj. Gen. Norman T. Kirk, The Surgeon General, U.S. Army, to Commanding General, Each Service Command, 15 Aug. 1944, subject: Nurse Anesthetists. (3) See footnote 29.

³² Army Service Forces Program of Instruction for Applicatory Training of Nurse Anesthetists, 17 Aug. 1944.

in detail, as well as procedures in anesthetic emergencies and oxygen therapy. Instruction was also required in methods of obtaining medical supplies. The scope of instruction, methods of presentation, and details of subject and sequence were prescribed, and only minor modifications could be made without the approval of The Surgeon General. The staff and its methods were subject to inspection by Medical Department consultants in surgery and anesthesiology. Reports of course capacity, numbers enrolled, and course completion were closely supervised, and the practice of holding students for service after they had completed their training was prohibited. By these techniques, the Medical Department was able to standardize and control on-the-job training at a large number of widely scattered hospitals.

Instructional Methods

Before the standardization of programs, courses prepared locally exhibited marked differences in content and the time allotted to supervised practice. The course developed by The Surgeon General in 1944 was intended primarily to develop competence in the administration of inhaled anesthetics. Ninety percent of the course consisted of supervised practice. Students received highly individualized instruction, usually in formal conferences, and observed instructors administering anesthetics. Later, the student was allowed to practice partial, and then complete application. Students were required to administer a minimum of 100 anesthetics under supervision before completing the course, and some Army hospitals required a minimum of 300 practice cases. Despite the urgent need for trained nurse anesthetists, the availability of patients suitable for student practice limited course enrollments to between two and six students.

Another factor limiting the number of students was the practice of retaining qualified anesthetists in student status to provide service at the hospital. After this practice came to the attention of The Surgeon General, it was discouraged by allowing inspecting officers discovering cases of excessive retention to recommend the transfer of one of the offending hospital's experienced anesthetists. When students were unable to gain enough clinical experience at a hospital, The Surgeon General was notified.

After January 1944, when the course was confined to general hospitals, an MC officer was designated course director and was assisted by selected nurse anesthetists. The selection of instructional personnel was closely supervised by the Surgeon General's Office, and practicing anesthetists were encouraged to become course directors.

Nurse anesthetists were also trained in theaters of operation, but programs outside the Zone of Interior failed to achieve the standardization of those in the continental United States. Nurses in the Mediterranean theater, for example, were trained on a continuing basis at four general hospitals. The program theoretically required 3 months in residence, but in practice varied from 1 to 3 months, depending on the time a nurse could be spared from a unit.³³

³³ Medical Department, United States Army. *Surgery in World War II. Volume II. General Surgery.* Washington: U.S. Government Printing Office, 1955.

Selection of Students

Before World War II, the Superintendent of the Army Nurse Corps selected student anesthetists from nurses who demonstrated aptitude and interest. After the establishment of the Army Service Forces, responsibility for selection rested largely on hospital commanders. Inequalities of supply and demand were resolved by liaison at service command level. Selection procedures became more formal in August 1944, when courses were standardized. Students were required to be volunteers from the Army Nurse Corps who had completed the basic training course. Consultants to service command surgeons were encouraged to expand their activities to include selection. Consultants were encouraged also to check on the progress of students they selected so as to overcome the conflict of interest created by assigning students to facilities that were responsible also for patient care.³⁴

Strength and Utilization

Early in World War II, hospitals were not required to report nurses with specialized training, and the training of nurse anesthetists was well underway before training requirements could be estimated. To determine the number of nurse anesthetists actually serving in the Army, two surveys were conducted by The Surgeon General in April 1943. The first requested service commands to list the hospitals doing major surgical work and the names of anesthetists at each station with their grade and an evaluation of their work.³⁵ As the need for anesthetists became increasingly acute, a second survey was made by personal letters requesting the names of nurses who had completed the anesthetists course and a statement of their proficiency. In September 1943, the Medical Department estimated that 2,495 nurse anesthetists would be needed for numbered units and Zone of Interior installations. With only 273 reported on duty, 2,222 would have to be recruited or trained.³⁶

Recruiting experience revealed that 3.7 percent of the nurses entering the Army had postgraduate courses in the combined areas of neuropsychiatry, operating room procedures, and anesthesia, but there was no report of the number who were qualified anesthetists. The Medical Department hoped to train 260 annually and to recruit the remainder by assuring them of proper assignments on entry into the Army. This goal was not even approached in 1944. Prospects were brighter in 1945 because of the pace set during the first 6 months. It was estimated that 2,000 qualified nurse anesthetists were in the Army in July 1945. Approximately 220 completed training in Zone of Interior hospitals between December 1941 and December 1945.³⁷

³⁴ Letter, Brig. Gen. Fred W. Rankin, Chief Consultant in Surgery, Office of The Surgeon General, to Lt. Col. Bradley L. Coley, MC, Headquarters, Eighth Service Command, 24 July 1944.

³⁵ Letter, Maj. Gen. James C. Magee, The Surgeon General, U.S. Army, to the Commanding General, Each Service Command, 27 Apr. 1943, subject: Assignment of Anesthetists.

³⁶ Memorandum, Lt. Col. Sanford V. Larkey, MC, Chief, School Branch, Training Division, for the Director of Training, Surgeon General's Office, 23 Sept. 1943, subject: Training of Nurse Anesthetists.

³⁷ Completed AG ASF Forms R-5218, dated 8 Nov. 1945. In Report—Flow of Trainees thru Nurses Basic Training Centers.

As a result of the decentralization of training, withdrawals from the course can only be estimated. For the short period in which records are available, the number was not excessive. In common with other programs, they rose sharply after the surrender of Japan, even though courses were not suspended. Hospitals were notified in September 1945 that courses in session would be completed but that future courses would be canceled, and nurses were allowed to withdraw from the course to separate from the service.³⁸

NEUROPSYCHIATRIC NURSING³⁹

Before World War II, there was little need for trained psychiatric nurses in the Army. Psychiatric cases were kept in Army hospitals only until arrangements were made for them to be sent to either St. Elizabeths Hospital, Washington, D.C., or other institutions providing long term custodial care and treatment. At the outbreak of the war, there were no special training programs for Army nurses in neuropsychiatry and no plans for developing such programs. During the war, courses were established at various Army hospitals, but the development of a full-blown program was frustrated by the War Department's refusal to authorize an Armywide school. The problem persisted despite efforts by both the Nursing Division and the Neuropsychiatry Consultants Division to convince other divisions of the Surgeon General's Office and the War Department that a formal program was essential. In common with most developments in psychiatry during World War II, each step forward was a limited victory for those attempting to educate higher authorities.

In the wake of the passage of the Selective Service Act, new hospitals were built. Typical hospitals had closed neuropsychiatric wards designed to give maximum security. The nurses' office was separated from the patient area by a locked iron grillwork, and patients were housed in wards behind this partition. Space and facilities for anything other than custodial care were severely limited. Attempts were made to screen incoming nurses for previous experience, but many chief nurses questioned the need for nurses to care for patients who were neither physically ill nor confined to a bed. The nurse, nominally assigned to psychiatric wards, often spent much of her time in surgical wards or performing administrative tasks. Little time was spent in locked-ward sections. This lack of recognition of the role of psychiatric nursing resulted in patients being under the care of nurses with a variety of backgrounds; some nurses qualified neither by training, experience, nor desire for their duties. Others, with desirable backgrounds, were malassigned.

Attempts to Establish Formal Courses

During the first year of the war, the Medical Department attempted to satisfy its requirements by drawing on nurses who had received psychiatric training at

³⁸ Memorandum, Col. Florence A. Blanchfield, Superintendent, Army Nurse Corps, to Col. Floyd L. Wergeland, MC, Director, Training Division, Office of The Surgeon General, 10 Sept. 1945.

³⁹ Unless otherwise indicated, this section is based on: Medical Department, United States Army. Neuropsychiatry in World War II. Volume I. Zone of Interior. Washington: U.S. Government Printing Office, 1966.

civilian hospitals before entering the Army.⁴⁰ When this proved inadequate, members of the Nursing and Psychiatric Consultants Division directed their efforts toward establishing an Armywide training course. Planning for the course began early in 1943, shortly after the establishment of the School of Military Neuropsychiatry at Lawson General Hospital, Atlanta, Ga.⁴¹ In the summer of 1943, the officer in charge of preparing program guides for the course reported: "All plans are made and we have nurses ready to send, but Army Service Forces had not approved it so we can't go ahead until they do."⁴² At least part of the difficulty in gaining approval for the program arose from the inability to justify training on the basis of tables of organization: even a 1,000-bed general hospital for neuropsychiatric patients overseas was authorized only one neuropsychiatric nurse, the same strength authorization approved for a nonspecialized general hospital.⁴³ For some reason, the Training Division of the Surgeon General's Office also refused to approve the program.⁴⁴

In October 1943, the School of Military Neuropsychiatry was moved to Mason General Hospital, Brentwood, N.Y., and plans were again made to conduct a postgraduate course for nurses. Finally, in February 1944, a 12-week program in neuropsychiatry was established under the authority of the Second Service Command, without Army Service Forces approval as an Armywide school. An overstrength of 10 nurses was authorized for the hospital, and the hospital commander was directed to give them "such didactic instruction as may be feasible with their duty assignment."⁴⁵

Local Programs

In the absence of an Armywide school, hospitals began to establish local programs. Early in April 1944, Lt. Col. Ruth I. Taylor, ANC, Headquarters, First Service Command, was informed that a course in neuropsychiatric nursing had been started at the Station Hospital, Camp Edwards, Boston, Mass. On 3 June

⁴⁰ (1) Letter, Maj. Julia O. Flikke, Superintendent, Army Nurse Corps, to Capt. Ida W. Danielson, ANC, Assistant Superintendent, Headquarters, Sixth Corps Area, 28 Nov. 1941. (2) Letter, Capt. Ida W. Danielson, ANC, Assistant Superintendent, to Maj. Julia O. Flikke, Superintendent, Army Nurse Corps, Office of The Surgeon General, 13 Dec. 1941. (3) War Department Circular No. 34, 1 Feb. 1943.

⁴¹ (1) Memorandum, Col. Florence A. Blanchfield, Superintendent, Army Nurse Corps, to Brig. Gen. Charles C. Hillman, Chief, Professional Service, Office of The Surgeon General, 18 Jan. 1944. (2) Annual Report, Mason General Hospital, Long Island, N.Y., 1943.

⁴² Letter, Capt. Kathleen N. Atto, Assistant Superintendent, ANC, to Lt. Col. Pearl C. Fisher, ANC, Headquarters, Sixth Service Command, 7 Aug. 1943.

⁴³ (1) War Department Table of Organization and Equipment No. 8-5508, 26 Oct. 1943. (2) War Department Table of Organization and Equipment No. 8-550, 3 July 1944.

⁴⁴ In TM (Technical Manual) 12-406, "Officer Classification, Commissioned and Warrant," 30 Oct. 1943, psychiatric nursing was recognized as a specialized field of nursing and coded as MOS (Military Occupational Specialty) 3437. In describing the requirements for awarding this MOS, TM 12-406 stated that nursing experience in a neuropsychiatric ward was essential. It strongly recommended postgraduate training in psychiatric nursing but did not make such training mandatory.

⁴⁵ (1) Memorandum, Maj. Gen. Norman T. Kirk, The Surgeon General, U.S. Army, for Commanding Officer, Mason General Hospital, 8 Feb. 1944, subject: Training in Neuropsychiatric Nursing. (2) Memorandum, Maj. Gen. Norman T. Kirk, The Surgeon General, U.S. Army, for Commanding Officer, Mason General Hospital, 13 Jan. 1944, subject: Training in Neuropsychiatric Nursing. (3) Transmittal Sheet, Lt. Col. Charles H. Moseley, MC, Deputy Director, Training Division, Office of The Surgeon General, to Col. Florence A. Blanchfield, ANC, Nursing Division, Surgeon General's Office, 8 Feb. 1944, subject: Training in Neuropsychiatric Nursing.

1944, Colonel Taylor informed The Surgeon General that 15 nurses would complete the first course on 30 June 1944 and that, because of the reduced number of patients at Camp Edwards, the school would be transferred to Cushing General Hospital, Framingham, Mass., on 1 July. Colonel Taylor recommended that three full-time nursing instructors be assigned to Cushing General Hospital and that the school be approved by The Surgeon General so that an authorized certificate could be presented upon satisfactory completion of the course.

On 16 June 1944, Maj. Gen. Norman T. Kirk concurred with the establishment of a course in the First Service Command, but added that he did "not deem it advisable to authorize or approve a neuropsychiatric nursing school."⁴⁶ While The Surgeon General did not object to the issuance of a certificate of completion, he advised that a local certificate be used because the "Certificate of Proficiency, Various Courses, Special Schools, U.S. Army" (MD Form 60e) was not to be used for local courses.

In December 1943, authority was given to provide a 3-month affiliation in neuropsychiatric nursing at Fitzsimons General Hospital, for student nurses from St. Joseph's Hospital School of Nursing, Denver, Colo. In May 1944, Army and cadet nurses were also accepted in the course.⁴⁷ In June, The Surgeon General authorized official recognition for the course by issuing a certificate to Army Nurse Corps officer graduates.

Because of continued failure to obtain approval for an Armywide postgraduate course, commands were encouraged to establish their own schools in the fall of 1944. By the summer of 1945, each service command had established at least one course for nurses. A total of 585 nurses and 296 cadet nurses completed these courses in service command hospitals.⁴⁸

OPERATING ROOM NURSES

The training of operating room nurses was seldom mentioned in hospital and service command reports. All nurses received operating room training and experience in their basic program, but the number with advanced skills and experience was below wartime requirements. On-the-job training was required to sharpen unused skills and to develop competence in specialized fields of war surgery.

A formal course in operating room techniques was established at Cushing General Hospital in August 1944 to prepare nurses for duty with surgical teams and for overseas assignment. The course was initially 3 months, and concentrated on training nurses for general surgery, neurosurgery, and plastic surgery. Included were 75 hours of lectures, demonstrations, films, and discussions. The basic principles of operating room technique were reviewed, and, under careful supervision, nurses

⁴⁶ Letter, Lt. Col. Ruth I. Taylor, ANC, Chief, Nursing Service, Headquarters, First Service Command, to Commanding General, Army Service Forces, 3 June 1944, subject: Report of Neuropsychiatric Nursing School 3114 SCU, FSC, Camp Edwards, Mass.

⁴⁷ These were senior students from civilian schools of nursing who elected and were accepted to serve their final 6 months before graduation in Army hospitals. For a discussion of the Cadet Corps Program authorized by Public Law 74, 78th Congress, see *The United States Cadet Nurse Corps 1943-48*. PHS Publication No. 38. Washington: U.S. Government Printing Office, 1950.

⁴⁸ See footnote 39, p. 141.

became experienced in the administration of blood and plasma and in scrubbing and circulating duties. Training was also received in orthopedic, urological, and vascular surgical procedures.⁴⁹ The course was increased to 4 months in May 1945 to provide instruction in operating room administration. Thirty-six nurses completed the course.⁵⁰

The amount of operating room training conducted on-the-job at Zone of Interior hospitals and hospitals overseas is unknown. No reporting procedure was established, and courses were never standardized. Course length varied from 75 to 85 hours of classroom work and from 295 to 420 hours of clinical experience. In July 1945, the Office of The Surgeon General began preparation of an outline of a 4- to 6-month course in operating room technique that included some 50 hours of classroom instruction. The length of the clinical phase depended upon the facilities available at the hospital conducting the course.⁵¹ Work on the preparation of the course stopped at the end of the war.

FEVER THERAPY NURSES

Fever therapy was one of the few specialties in which the Army Nurse Corps was able to meet its training. In part, this was due to the priority given this treatment for sulfonamide-resistant gonorrhea early in the war, and in part, because the advent of penicillin reduced the requirement for fever therapy. Until the effectiveness of penicillin in treating gonorrhea was demonstrated in 1943, fever therapy training was an important part of the postgraduate program for nurses.

At the beginning of World War II, there was a wide disparity between the recommendations of experts and the average care given patients with gonorrhea. Beginning in June 1940, cooperative efforts by the Surgeons General of the Army and the Navy, and the Subcommittee on Venereal Diseases, Division of Medical Sciences, National Research Council, produced a series of directives standardizing treatment. Among the developments resulting from their efforts was the establishment of fever therapy centers at designated general hospitals in 1942 and an expansion of the program to other types of hospitals in 1943.⁵²

The first known training program for nurses followed the establishment of a Department of Fever Therapy at Walter Reed General Hospital in 1941. Eight nurses were reported trained that year.⁵³ As fever therapy centers were established, nurses either were trained on the job or were sent to other hospitals for an unspecified period for training. After September 1942, The Surgeon General took an active part in arranging for the training of doctors and nurses in this specialty. When hospitals did not have trained personnel to operate fever therapy cabinets (hyper-

⁴⁹ Poole, R.: Army Courses in Operating Room Technic. *Am. J. Nursing* 45: 270-271, April 1945.

⁵⁰ (1) Annual Report, Cushing General Hospital, Framingham, Mass., 1944. (2) Annual Report, Cushing General Hospital, Framingham, Mass., 1945.

⁵¹ Memorandum, Col. Florence A. Blanchfield, Superintendent, Army Nurse Corps, for Chief, Training Division, Office of The Surgeon General, 17 July 1945, subject: Outline for Course in Operating Room Technic.

⁵² Medical Department, United States Army. *Internal Medicine in World War II. Volume II. Infectious Diseases.* Washington: U.S. Government Printing Office, 1963.

⁵³ Annual Report, Walter Reed General Hospital, Army Medical Center, 1941.

therms), they were required to submit the names of two nurses selected for training to The Surgeon General.⁵⁴ Once a program of fever therapy had been established at a hospital, replacements were trained as needed.

The purpose of fever therapy training was to teach nurses to produce an artificial fever by the use of therapy cabinets. Skilled nursing was required during all phases of therapy from preparation, through the induction of a fever ranging from 106° to 107° F., until post-fever recovery. Nurses had to be trained to detect the signs of irreversible physiological reaction. Treatment time usually exceeded 8 hours, and one patient was treated daily. Medical officers were on call for emergencies. No reports were required, and no attempt was made to keep statistical records.

The absence of a standardized training program produced a wide variety of courses. Some medical officers held the opinion that a minimum of 3 months in a busy clinic was required, while others defended the observation and treatment of a minimum of 25 cases. With special selection and careful supervision, course length could be reduced to 1 week. Courses established at Army hospitals varied from 1 week to 3 months.

FLIGHT NURSES⁵⁵

Before World War II, proposals for the training of flight nurses received an unsympathetic response from both the Air Corps and the American Red Cross. At the beginning of the war, air evacuation was not an accepted practice, and it was not until terrain problems in Alaska, Burma, and New Guinea made it expedient to transport patients by air that attention was focused on developing an evacuation system.

On 18 June 1942, the Army Air Forces was assigned responsibility for developing an air evacuation system, and primary planning responsibility was delegated to the Air Surgeon. As a result of initial efforts, the 349th Air Evacuation Group, Headquarters and Headquarters Squadron, was activated on 6 October to control and train flight surgeons, flight nurses, and enlisted personnel for air evacuation. The table of organization, issued in November, set up the squadron as a unit composed entirely of medical personnel, having no planes assigned. The 349th consisted of three squadrons, each with a headquarters section and four evacuation flights. The headquarters section included the Commanding Officer, a Chief Nurse, and a MAC officer. Each flight, headed by a flight surgeon, consisted of six flight nurses and six medical technicians, one nurse and one technician to a team. On 30 November, an urgent appeal was made for graduate nurses with experience in aviation to volunteer for the Army Nurse Corps and subsequent assignment to the AAF Evacuation Service. On 18 February 1943, a formal graduation ceremony was held for the first 39 nurses to complete 4 weeks of flight training.

The original 4-week course consisted of military indoctrination, air evacuation and tactics, survival, physiology, mental hygiene, and loading procedures. In

⁵⁴ Circular Letter No. 86, Office of The Surgeon General, U.S. Army, 18 Aug. 1942, subject: Fever Therapy in the Treatment of Gonorrhoea.

⁵⁵ See footnote 17 (3), p. 132.

February 1943, after the graduation of the first class, the training period was expanded to 6 weeks, and in November, it was lengthened to 8 weeks. The additional time allowed the inclusion of instruction on ward management, operating room technique, sanitation, and patient care, and 2 weeks of specialized training at hospitals in Louisville, Ky. The amount of in-flight training depended upon the availability of evacuation planes.

Flight nurse training remained under the control of the 349th Air Evacuation Group until June 1943, when the AAF School of Air Evacuation was activated at Bowman Field, Louisville, Ky. At that point, it was placed under the administrative control of the Commanding General, AAF, and the Air Surgeon was charged with the responsibility for supervising curriculum and research. In October 1944, the School of Air Evacuation was absorbed into the School of Aviation Medicine, Randolph Field, Tex.

At the time of its transfer to the School of Aviation Medicine, the course was extended to 9 weeks and divided into three equal phases. The first two phases consolidated material from the previous curriculum, and the last 3 weeks were devoted to participating in evacuation under the guidance of an experienced instructor. Course content gradually expanded to include familiarization with the types of airplanes used in evacuation, methods of loading and unloading, and the use of supplies and equipment provided for in-flight care. Special instruction in aeromedical physiology provided a foundation for further training in the use of oxygen equipment in high-altitude flights. Because doctors did not usually accompany patients in flight, nurses were prepared to treat shock, hemorrhage, and other emergencies without the assistance of a flight surgeon. Problems in the transportation of neuropsychiatric patients also received consideration. Course length did not change again until 20 August 1945, when each of the phases was shortened to 2 weeks to increase the number of flight nurses available for deployment to the Pacific theater.

Because nurses accepted for flight training were volunteers who met rigid standards, the rate of attrition was remarkably low. Under standards published in December 1942, applicants were required to be members of the Army Nurse Corps, between 21 and 36 years of age, between 105 and 135 pounds in weight, and between 62 and 72 inches in height. Applicants had to certify their willingness to participate in regular and frequent flights and to indicate any previous flying experience. Previous supervisors were required to certify the applicant's professional qualifications, personality, and judgment. Later, 6 months of experience in the Army Nurse Corps was also made a prerequisite. Between December 1942 and October 1944, 1,079 flight nurses graduated from the School of Air Evacuation at Bowman Field. An additional 435 students graduated from the School of Aviation Medicine between November 1944 and June 1946. Only 15 students failed to graduate.

THE SENIOR CADET NURSE CORPS

The concept of a Senior Cadet Nurse Corps first emerged during World War I, when the Medical Department planned to train senior students from civilian nursing schools to utilize their services and simultaneously prepare them for military

service after graduation. The end of the war terminated the program before it could be put into effect.⁵⁶ After the Army School of Nursing closed in 1933, the Army had neither the facilities nor the personnel to train student nurses. Reestablishment of the school was never seriously considered during World War II because experienced Army nurses were reluctant to take on the added burden of training students when it had been demonstrated that civilian nurses could be utilized after a brief orientation to military life. As a consequence, the Cadet Nurse Corps of World War II was developed primarily to meet the needs of civilian hospitals. As the Corps history states: "Perhaps the strongest case for the Cadet Nurse Corps was the plea of hospital authorities that nursing care in civilian hospitals was in a desperate state. Since the military forces took only graduate nurses, it was not expected that the Cadet Nurse Corps would directly or immediately aid the Army and Navy, except in the use of advanced students * * * they would help to replace graduate nurses enlisting for military service."⁵⁷ For its part, the Medical Department hoped that an increased supply of civilian nurses would aid Army recruiting and that, in any event, senior cadets in Army hospitals would temporarily ease the shortage of nurses.⁵⁸

Authority for the formation of the U.S. Cadet Nurse Corps was provided on 15 June 1943 by the Bolton Act which made the U.S. Public Health Service responsible for its administration.⁵⁹ The purpose of the program was to allow schools of nursing to expand their primary training capacity by sending senior students to Federal hospitals for their last 6 months of training. At the same time, participating schools were required to accelerate their programs and provide student nurses with their primary training within a period ranging from 24 to 30 months.

Anticipating the passage of the Bolton Act, the U.S. Public Health Service called representatives of the Federal nursing services together in early 1943 to coordinate planning. On 5 April 1943, Lt. (later Lt. Col.) Mary C. Walker, ANC, was assigned by the Surgeon General's Office to organize and supervise the program in Army hospitals and coordinate plans with other agencies.⁶⁰ Broad policies were formulated at a series of conferences and disseminated through U.S. Public Health Service regulations, guides, and bulletins. The Surgeon General sent the first specific instructions to Army hospitals in November 1943.⁶¹

Under the program worked out through these conferences, schools and State boards retained their traditional prerogatives, while Federal hospitals recruited cadets and provided facilities. The U.S. Civil Service Commission acted as the clearing house for Cadet Nurse Corps applicants. Students appointed to the U.S. Cadet Nurse Corps were pledged to remain in essential military or civilian nursing during the war, although the pledge was not binding.

⁵⁶ See footnote 26 (2), p. 137.

⁵⁷ See footnote 47, p. 143.

⁵⁸ See footnote 3, p. 127.

⁵⁹ 57 Stat. 153.

⁶⁰ Diary, Nursing Division, Office of The Surgeon General, U.S. Army, 1942-45, entry for 5 Apr. 1943.

⁶¹ Letter, Maj. Gen. George F. Lull, Deputy Surgeon General, U.S. Army, to Commanding Officer, Station Hospital, Camp Edwards, Mass., 19 Nov. 1943, subject: United States Cadet Nurse Corps—Senior Cadet Period, Army Hospital.



FIGURE 14.—Senior cadet nurses in training. (Top) Three senior cadet nurses, right, receive training in operating room procedures at the Station Hospital, Camp McCoy, Wis., Army Nurse Corps officer, left, administers anesthesia. (Bottom) Senior cadet nurse, center, receives supervised on-the-job training in the dressing room on a neurosurgical ward at England General Hospital, Atlantic City, N.J., August 1944.

The Program in Army Hospitals

The program began with a survey to determine the quality and quantity of facilities available to cadets. State boards of nurse examiners then used these surveys to evaluate the hospital nursing staff, clinical, educational, and recreational facilities, and living conditions. Representatives of the State boards also visited Army hospitals on invitation. State boards had the power to withhold approval until the Army corrected conditions that did not meet their standards. Usually, hospitals were cooperative, since it was estimated that each student would provide services equal to 80 percent of those expected from a graduate nurse.

The first senior cadets were assigned to Army hospitals on 15 June 1944. By 1 October 1945, the U.S. Civil Service Commission had submitted 9,891 applications to The Surgeon General, and 5,688 applicants had been accepted and assigned to Army hospitals. Of these, 1,674 were still in training on 1 October 1945, and all but 61 of the balance had completed the course.⁶² A total of 44 Army hospitals had participated in the program before the Medical Department withdrew in February 1946.⁶³

Techniques of Instruction

The assignment of cadet nurses within a hospital depended upon the needs of the hospital. At first, efforts were made to plan clinical instruction for individual cadets (fig. 14), but this was discontinued. In the 6-month cadet period, about 120 hours of instruction were provided, including 2 hours of ward teaching each week and a total of 70 hours of Army basic training. The time spent in basic training was later reduced to 50 hours. Periods of instruction were included in a 48-hour work-week, but physical training was done during off-duty time. Records were sent to the home school when cadets completed their training, including a summary of the cadet's instruction and clinical experience, a record of illnesses, and an efficiency report.⁶⁴

Results of the Program

Despite the quotas established for Army hospitals, the number of cadets assigned to them varied. Early estimates indicated that 50 percent of the senior cadet nurses could be trained in Federal hospitals, but in practice, only 15 percent enrolled, and only 6.4 percent of these were assigned to military hospitals. The Army trained 85 percent of those assigned to military hospitals, even though it participated for only 20 of the 64 months the program was in operation.⁶⁵

For most purposes, the senior cadet program came too late to be of use during World War II. Even after the Bolton Act was passed, cadets could not be assigned

⁶² See footnote 3, p. 127.

⁶³ History of Nursing Branch, Military Personnel Division, Office of The Surgeon General, 1 June-30 Sept. 1945.

⁶⁴ (1) Army Service Forces Circular No. 168, 3 June 1944. (2) Army Service Forces Circular No. 292, 6 Sept. 1944 (3) Army Service Forces Circular No. 75, 28 Feb. 1945.

⁶⁵ See footnote 49, p. 144.

to Federal hospitals until Congress amended the Act to provide a stipend. At the beginning of the program, the Army optimistically agreed to train 1,500 senior cadets every 6 months and agreed to limit acceptance to 50 percent of each class. Such precautions proved unnecessary because of the strong influence of nursing schools on their students. Student interest increased only after the President proposed drafting nurses in January 1945.⁶⁶ Available evidence does not permit measurement of the program's impact on civilian nursing, or on recruitment rates. Even the number of students graduated is not a measure of impact, because the senior cadet's promise to remain in nursing throughout the war was not legally binding.

Direct recruiting was not a primary objective of the program, but the Medical Department did make efforts to interest cadets in Army nursing. Despite efforts to make them "feel a part of it," very few cadets were ultimately persuaded to remain in the service. There is no record of the number of cadets who accepted appointment, but only 93 had been commissioned by 1 January 1945.⁶⁷

⁶⁶ Congressional Record, vol. 91, pt. 1, p. 67. 79th Congress, 1st Session.

⁶⁷ See footnote 3, p. 127.

CHAPTER V

Dietitians, Physical Therapists, and Occupational Therapists

Dietitians, physical therapists, and occupational therapists became part of the Army's medical program during World War I. As civilian employees, they served not only in the United States, but also with the American Expeditionary Forces in France and with the army of occupation in Germany.¹ Because they were not expected to enter hostile fire zones, they continued to perform their duties as civilians in the years between World Wars I and II. As such, they were entitled neither to military pay and privileges nor to military training. Military status was not authorized until the first year of World War II had demonstrated that civilian employees of the Army serving overseas were subject to the same risks as military personnel, with virtually no protection under international law. In December 1942, Congress approved military status with relative rank for physical therapists and dietitians but excluded occupational therapists. It was not until June 1944 that dietitians and physical therapists achieved full commissioned status. Occupational therapists continued to serve as civilians throughout the war.

Wartime training programs in dietetics, physical therapy, and occupational therapy were designed to accomplish two major objectives: to provide military orientation of civilian-trained, and to increase the number of, qualified graduates available for Army service. Physical and occupational therapists also conducted training programs for enlisted technicians. Although they engaged in training programs at different times and in various ways, their solutions to the problems of training were similar.

BASIC MILITARY ORIENTATION FOR NEWLY APPOINTED PERSONNEL

Dietitians

In the early years of World War II, dietitians were expected to perform their duties after a brief period of on-the-job military orientation. From October 1940 until late 1941, all dietitians were sent to Walter Reed General Hospital, Washington, D.C., for military orientation. Upon completion of approximately 6 months' duty at the hospital, they were transferred to other Army hospitals to organize dietetic departments. Special training in administrative procedures peculiar to

¹ Unless otherwise indicated, this chapter is based on Army Medical Specialist Corps. Washington: U.S. Government Printing Office, 1968.

military service was approved by the Surgeon General's Office on 15 February 1941. This training was initiated at fixed Army hospitals from 2 to 4 weeks before dietitians were to be transferred to newly constructed installations.²

In April 1942, The Surgeon General authorized establishment of training pools for civilian dietitians with no experience in the Medical Department who were designated for duty outside the continental United States.³ In addition, overseas volunteers from the American National Red Cross, upon request, were assigned to these pools for training. Instruction included lectures on organization of Army hospitals, Army regulations, organization of the mess department, relationship of dietitians with other personnel in the mess department and departments of the hospitals, personnel records, hospital fund reports, and procurement of food. Dietitians were given on-the-job experience in each section of the hospital mess so they would be familiar with all phases of management: procuring, preparing, and serving food, and planning special diets. Assignment to these pools was discontinued in December 1942 when military status was authorized.

Dietitians assigned to affiliated units scheduled for overseas service went on active duty with their units at specified Army posts. They worked with the post hospital dietitian to become familiar with procedures and methods and participated in maneuvers to learn to work and live under field conditions. These maneuvers made the dietitians conscious of ways to improve or improvise equipment and to substitute various foods to relieve ration shortages. A special 60-hour course, "Cooking of Dehydrated Foods," was made available to dietitians selected for overseas service. The production of dehydrated foods, packaging and storing, reconstituting, menu planning, and actual preparation of meals were studied. Special training was given in the preparation of dehydrated food under field conditions as well as in maintenance and operation of cooking equipment and sanitation in field messes. These dietitians lived on dehydrated foods or combination of dehydrated foods and fresh rations for part of the course.

In October 1943, the Army Nurse Corps established basic training centers throughout the country for new nurses going overseas. It was not until 1944, however, that dietitians entering the Army or those assigned to overseas hospital units were sent to the training course for nurses. To accommodate dietitians, the nurses' training course eliminated 23 hours of nursing subjects and substituted 23 hours of dietetic subjects.⁴ In 1945, 53 hours of instruction were deleted from the nurses' training course and other material was substituted for the basic training of dietitians.⁵ This program provided 17 hours of lectures and demonstrations conducted by dietitians and 36 hours of on-the-job understudy in a hospital mess.

Physical Therapists

The training programs for physical therapists developed in a pattern similar to those for dietitians. Many physical therapists joining affiliated units at the beginning

² Unless otherwise indicated, sections on Army dietitians are based on Manchester, Katharine E.: *History of the Army Dietitian*. [Official record.]

³ Circular Letter No. 34, Office of The Surgeon General, U.S. Army, 16 Apr. 1942.

⁴ Army Service Forces Circular No. 163, 27 Dec. 1943.

⁵ War Department Mobilization Training Program No. 8-7, 16 June 1945.

of the war had no previous Army experience. Training plans called for a period of observation and orientation that included on-the-job training, instruction in customs of the service, organization of the Medical Department, procurement of supplies, and the organization and administration of physical therapy clinics in Army hospitals. Orientation courses were to be established in 1942 at several hospitals,⁶ but available evidence indicates that only Walter Reed General Hospital activated a program. Without supervision from the Surgeon General's Office, command responsibility was confused and the program was poorly executed.

In 1943, after military status was achieved, newly appointed physical therapists, who had not been trained in one of the Army physical therapy courses, were included in courses for newly appointed nurses and dietitians. Hours scheduled for the professional orientation of nurses and dietitians were replaced by special instruction for physical therapists. Special topics included the organization and administration of Army physical therapy clinics, their relationship to other hospital activities, and the treatment of patients not normally seen in civilian hospitals. Particular attention was given to the treatment of amputees and patients with injuries of the central and peripheral nervous systems; muscle, sensory, and electrodiagnostic tests; measurements of joint range of motion; bandaging adaptations of exercise apparatus; and the utilization of floor space. Following V-J Day, all of these basic military training courses were terminated.

Occupational Therapists

Because occupational therapists did not have military status during World War II, they could not be integrated into the basic military training programs established for nurses, dietitians, and physical therapists.

In October 1943, 2-week indoctrination courses were established for newly appointed occupational therapists at Lovell General Hospital, Ayer, Mass., Lawson General Hospital, Atlanta, Ga., and Letterman General Hospital, San Francisco, Calif.⁷ Of the 96 hours of instruction, 36 were devoted to on-the-job experience with orthopedic and psychiatric patients, in convalescent shops, and on wards under the direct supervision of experienced occupational therapists. The remaining hours were devoted to lectures, conferences, demonstrations, and tours. The schedule avoided solid blocks of time on any given subject. Students had access to the medical library and sat in on roundtable discussions with members of the occupational therapy staff. Orientation courses were discontinued in July 1944.⁸ By this time, a majority of chief occupational therapists had attended the course and could indoctrinate the new personnel on their staffs.

PROFESSIONAL TRAINING PROGRAMS

In contrast to the relatively simple matter of arranging short military orientation courses, a far greater problem confronted the Medical Department: that of

⁶ See footnote 3, p. 152.

⁷ Letter, The Adjutant General to Commanding Generals, First to Ninth Service Commands, 7 Oct. 1943, subject: Orientation Course for Occupational Therapists, inclosure thereto.

⁸ Army Service Forces Circular No. 229, 22 July 1944.

providing the additional numbers of qualified occupational therapists, physical therapists, and dietitians needed to staff Army hospitals. Neither the outbreak of war in Europe nor the expansion resulting from the Selective Service Act brought these specialists into military service in adequate numbers because most of them were women and were not subject to compulsory military service. In any event, the total number of qualified dietitians, physical therapists, and occupational therapists in the United States was not sufficient to meet both civilian and military requirements if the Army was to fulfill its patient care responsibilities. Emergency training programs for all three specialist groups were required.

ACCELERATION AND EMERGENCY TRAINING PLANS

Dietitians

The need for training student dietitians in Army hospitals was recognized shortly after World War I. In 1922, a course was established at Walter Reed General Hospital for such a purpose. Throughout the interwar period, enough qualified dietitians graduated from the course to supply all Army hospitals authorized to employ them. The training program at Walter Reed General Hospital provided theoretical instruction as well as on-the-job experience, and graduates were qualified for duty in Army hospitals. In addition, students were given an opportunity for staff experience by service in positions of responsibility. By August 1942, 211 dietitians had graduated from the course at Walter Reed General Hospital. A single course satisfied the needs of the peacetime Army but, to meet wartime requirement, the program had to be accelerated and expanded to include other hospitals. In civilian hospitals, the number of training courses increased from 38 to 60. Even this was not enough, and other plans had to be developed to meet the increased demand for dietitians.

On 17 July 1942, a meeting was held between representatives of the Surgeon General's Office, the American Dietetic Association, and the Civil Service Commission. Two plans were recommended. Plan A provided that the program conducted in Army hospitals would be divided into two sections, the student dietitian course and the apprentice dietitian course. Plan B provided for the establishment of a 6-month student dietitian program in approved civilian hospitals from which the students would be transferred to an Army hospital for the 6-month Army hospital apprentice course. A combination of these plans was finally adopted. Minimum educational qualifications were the same as those previously established for the student dietitian program. The first class, 16 students appointed under Plan A, reported to Walter Reed General Hospital on 24 August 1942.

Six-month Army hospital student course.—The 6-month curriculum established for student dietitians at Walter Reed General Hospital was used as a guide for setting up three additional Army hospital student dietitian training courses, all approved by the American Dietetic Association. In May 1943, Fitzsimons General Hospital, Denver, Colo., started a course under the direction of Capt. Mildred G. Allbritton, AMSC. The course at Brooke General Hospital,

Fort Sam Houston, Tex., started in July 1943, under the direction of Capt. Nell Wickliffe, AMSC. The last student dietitian course was established at Lawson General Hospital, in September 1943, under the direction of Capt. Hilda M. Lovett, AMSC.

The abbreviated, 6-month course was designed to furnish thorough training in the diet in health and disease and in the organization and administration of a dietetic department in an Army hospital. Over 200 hours of lectures were given in diet therapy and administration. Dietetics for medical and surgical patients was taught by Medical Corps officers and heads of dietary departments. On-the-job training in therapeutics totaled 11 weeks and included writing special diets, diet instruction to ward and clinic patients, supervision of ward kitchens, and participation in ward rounds. A minimum of 2 weeks each was spent in the surgical cardiac, urological, and pediatric wards, gastrointestinal and diabetic sections, and in the infant formula room. Fourteen weeks were spent in administrative on-the-job training. A comprehensive program afforded experience in all areas of administration: menu planning; purchasing; ordering, preparing, and serving food; inventory and portion control; cost accounting; and personnel management.

Six-month civilian hospital student course.—In September 1942, Miss Nelda Ross, President of the American Dietetic Association, sent a letter to the director of each of the 60 approved civilian training courses for dietitians in an attempt to determine which civilian hospitals had facilities to cooperate with the Army. In her letter, Miss Ross made it clear that students who successfully completed this program would meet the 1-year requirement for membership in the American Dietetic Association. Response to her inquiry indicated that the plan was generally acceptable to hospitals in which at least 10 students were enrolled. At a few hospitals, problems with staff and facilities made it impossible to participate. Some chief dietitians were afraid that the release of students after 6 months would further disorganize dietary departments, already plagued with excessive wartime turnover of employees. Other chief dietitians, who had already rearranged their training plan to provide for enrollment of student dietitians twice a year, believed that it would be difficult to add still another program to their training schedule.

Under the program finally adopted, training in civilian hospitals included 6 weeks in special diet kitchen and ward service; 2 weeks of private patient service; 4 weeks of pediatrics, including formula preparation; 4 to 6 weeks in outpatient clinics; 6 to 8 weeks of administration, including purchasing, ordering, accounting, and menu planning; as well as some work with personnel and preferably experience in a cafeteria or dining room. Lectures in diet therapy and infant feeding and experience in teaching dietetics to student nurses were required.

Six-month Army hospital apprentice course.—Because of differences in the civilian and military basic courses, the 6-month apprentice course in Army hospitals had to be tailored to provide apprentices with the experience required to qualify them for membership in the American Dietetic Association. Every effort was made to establish appropriate programs at the 32 hospitals to which students could be assigned for apprentice training (fig. 15).



FIGURE 15.—Student dietitian discussing recipe with head cook.

Throughout 1943, the apprentice training course followed a program of instruction outlined by The Surgeon General. A subsequent program, published by The Surgeon General on 1 May 1944, provided a more detailed guide for instructors. These courses were adapted locally to meet the individual needs of apprentice dietitians at each hospital.

The 26-week apprentice program emphasized practical experience by including 16 weeks in administration of food service sections, 8 weeks in therapeutic phases of food service activities, and 2 weeks of lectures. To meet American Dietetic Association requirements for staff experience during dietetic internship, assignment in a supervisory capacity was scheduled during the last month of apprentice training.

Qualified experience apprentice entrance plan.—A final dimension was added to the program when courses were adjusted to permit home economists with bachelor of science degrees in foods and nutrition, or majors in institutional man-

agement that contained specified courses, to substitute work experience for the first 6 months of hospital training. Early in 1943, an increasing interest in the Army's training program was expressed by home economists who possessed every qualification for certification except internship or hospital work experience. When it was determined that the number of home economists with food service experience interested in becoming dietitians was large enough to make a special program practical, The Surgeon General won approval of the American Dietetic Association for a plan to substitute such experience for the Army or civilian hospital student course, and admit experienced home economists directly into the 6-month apprentice program. Between September 1943 and September 1945, 128 home economists received direct appointments to apprenticeship.

Several enlisted members of the Women's Army Corps with backgrounds in home economics also expressed an interest in the dietitian course. On 6 March 1945, the Surgeon General's Office authorized the establishment of the first training course for enlisted members of the Women's Army Corps at McCloskey General Hospital, Temple, Tex.⁹ Ten apprentices were authorized in each class, but only five applied. Upon completion of the course, they were commissioned as Medical Department dietitians. The course, which began on 15 June 1945 and was discontinued on 1 January 1946, was the only dietitian course for enlisted women given during World War II.

After V-J Day, a study was made to determine postwar requirements. Authority was subsequently granted to proceed with the training of students on duty as of 1 October 1945, and to commission them upon completion of the course. Appointments for individuals who had not yet begun training were canceled. By October 1946, all training courses for dietitians were terminated, except the one at Brooke General Hospital.

Physical Therapists

In 1941, a Central Physical Therapy Board was established in the Surgeon General's Office¹⁰ to work with the Subcommittee on Physical Therapy, National Research Council, and the Federal Security Agency on problems associated with the expansion of the physical therapy program in Army hospitals. Among the problems presented to this board was the subsidization of civilian physical therapy training courses. A survey made by the American Medical Association's Council on Medical Education and Hospitals, early in 1942, revealed that civilian physical therapy training courses requiring tuition were experiencing difficulty in maintaining full enrollment. The Subcommittee on Physical Therapy recommended that the War Department subsidize these courses. Because of the planned expansion of the Army physical therapy training program, it was The Surgeon General's opinion that the subsidy of civilian training courses could not be justified.¹¹ The Subcommittee on

⁹ War Department Circular No. 71, 6 Mar. 1945.

¹⁰ Office Order No. 348, Office of The Surgeon General, U.S. Army, 21 Nov. 1941.

¹¹ Memorandum, Col. John A. Rogers, MC, Office of The Surgeon General, for Chief of Staff, G-3, attention: Colonel West, 10 June 1942.

Physical Therapy was similarly unable to persuade the Selective Service to defer male physical therapists until completion of their training.

Expansion of the Army physical therapy training program was accomplished by the establishment of courses directed to three groups: Civilian students who would take all of their training in Army hospitals; enlisted members of the Women's Army Corps who would take all of their training in Army hospitals or take the apprenticeship phase of their training in Army hospitals after completing courses in selected civilian institutions; civilian students who would take the apprenticeship phase of their training in Army hospitals following the completion of courses in a civilian institution.

Civilian students.—Early in 1941, The Surgeon General proposed the establishment of an emergency training course. This course, consisting of 6 months of formal instruction followed by 6 months of applicatory training, was to replace the regular 9-month course conducted at Walter Reed General Hospital. The proposal was approved by the Council on Medical Education and Hospitals, which also approved a plan to allow civilian institutions to conduct 6 months of theoretical instruction, followed by 6 months of supervised apprenticeship in selected Army hospitals.

On 1 July 1941, the first Army emergency course was initiated at Walter Reed General Hospital. Every 3 months, a class of 10 students was authorized. The 26-week program included intensive study in anatomy, physiology, pathology, kinesiology, therapeutic procedures, and their application to military medicine. Emphasis was placed on the treatment of patients with combat injuries. Additional courses were established in October 1942 at the Fort Sam Houston Station Hospital; Army and Navy General Hospital, Hot Springs, Ark.; O'Reilly General Hospital, Springfield, Mo.; and Fitzsimons General Hospital. All were conducted on the same plan as the course at Walter Reed General Hospital.

Following this expansion, the number of civilians in Army physical therapy training courses increased, but the authorized capacities of these courses could not be maintained because college graduates with a physical education background were being offered increasingly attractive positions by industry and by the other military services. A series of meetings held in 1944, in San Francisco, Calif., Los Angeles, Calif., Chicago, Ill., Boston, Mass., and New York, N.Y., featuring talks and War Department films, resulted in renewed interest in the Army physical therapy training programs. In January 1944, there were only enough eligible civilian applicants to fill one class of trainees, but the increasing number of certified applicants in the succeeding months justified further expansion of the program. Additional courses for civilian students were established at Bushnell General Hospital, Brigham City, Utah, on 10 July 1944, and at Ashford General Hospital, White Sulphur Springs, W. Va., on 10 August 1944.

Civilian students enrolled after August 1944 were required to meet the physical standards for commissioned officers. This policy was recommended by the Physical Standards Division, Surgeon General's Office, to reduce the number of students who could not meet the physical requirements for commissioning.

Military students.—In July and August 1943, the director of physical thera-

pists initiated conferences between the Training Division and the Women's Army Corps to discuss the possibility of making Army physical therapy courses available to enlisted women. Such a program would not only assist in meeting the procurement requirements for physical therapists, but it would also offer these women an opportunity for professional and military advancement. The program was approved in August 1943,¹² and Stanford University, Palo Alto, Calif., the University of Wisconsin, Madison, Wis., and the D. T. Watson School of Physiotherapy, Leetsdale, Pa., were selected to conduct the program. These courses began in October 1943 and continued until October 1944 when the expansion of courses in Army general hospitals enabled the Army to discontinue training at civilian institutions. While training was conducted at civilian institutions, the War Department paid tuition, room, and board, and provided textbooks and other teaching aids. An officer in the Women's Army Corps, assigned with each group of students, was responsible for military administrative procedures. Army physical therapy training was available to enlisted women who were under 44 years of age, who had no dependents under 14 years of age, and who had an Army General Classification Test score of 110 or over.

In December 1943, the Secretary of War authorized direct recruitment of women qualified for the Women's Army Corps for the purpose of attending physical therapy training courses, with the assurance of a commission as a physical therapist upon completion of the course.¹³ Women recruited for this specific program comprised more than half of the total military enrollment in these courses.

In June 1944, the maximum age for enrollment was reduced from 44 to 37 years. This change resulted from a study which revealed that trainees in the upper age group often experienced difficulty in adjusting to intensive academic study and to living and working in close association with groups of younger women. A similar change was made in the age requirement for applicants for these courses from within the ranks of the Women's Army Corps.

The establishment of two all-Negro station hospitals in the United States and the activation of three such hospitals for overseas duty raised the question of supplying physical therapists for these hospitals. A physical therapy training course for Negro students was established at the Fort Huachuca Station Hospital, Ariz., on 1 October 1943 (fig. 16). When the requirement for Negro physical therapists was met by commissioning trainees in October 1944, the training of both military and civilian Negro students at Fort Huachuca was terminated.

The enrollment for five courses conducted in Army general hospitals was changed from civilian trainees to military trainees in January and February 1944. Two additional courses for military trainees were established at Lawson General Hospital and at Percy Jones General Hospital, Battle Creek, Mich. An additional number of students were enrolled after July 1944 when concurrent classes at quarterly intervals were authorized. This plan was put into effect in all general

¹² War Department Memorandum No. W635-18-43, 22 Aug. 1943.

¹³ Letter, The Adjutant General to Commanding General, First Service Command, Army Service Forces, 14 Dec. 1943, subject: Recruitment of Physical Therapy Aides.



FIGURE 16.—Enlisted student physical therapist adjusting infrared lamp in preparation for treatment of patient's left shoulder, Fort Huachuca Station Hospital, Ariz.

hospitals conducting courses except Percy Jones, where housing facilities were inadequate.

All assignment to physical therapy training courses was terminated in October 1945.¹⁴ The 325 physical therapy students then enrolled were allowed to complete their training.

Apprentice training program.—The program of apprentice training for graduates of the 6-month civilian emergency physical therapy courses developed slowly. Because civilian apprentices were assigned through the service commands

¹⁴ Memorandum, Maj. Emma E. Vogel, WMSC, Director of Physical Therapists, Office of The Surgeon General, for Col. Floyd L. Wergeland, MC, Director, Training Division, 9 Oct. 1945, subject: Termination of Physical Therapy Training.



FIGURE 17.—Apprentice physical therapists in training, Fletcher General Hospital, Cambridge, Ohio. (Top) Civilian apprentice receives instruction in massaging scar tissue. (Bottom) Enlisted apprentice learns to apply shortwave diathermy apparatus. (Courtesy of National Library of Medicine.)

with the program, they were too often assigned on the basis of personnel requirements, with little consideration given to their need for continued instruction and supervised practice. Management of this program improved when centralized control was vested in the Surgeon General's Office late in 1942.¹⁵

Subsequently, The Surgeon General directed that training would consist primarily of supervised clinical practice in the treatment of patients, both in the physical therapy clinic and in hospital wards (fig. 17). Emphasis was placed on the treatment of combat injuries, such as peripheral nerve, brain, spinal cord, chest and vascular injuries, and amputations. The program included attendance at conferences, participation in ward rounds, and at least 1 hour daily of roundtable discussion of treatment programs and current medical literature. Apprentices were also trained in the administration of physical therapy clinic, the preparation of records and reports, and the procedures for requisitioning supplies. For the on-the-job phase of training, enlisted apprentice physical therapists were assigned to 20 general hospitals and civilian apprentices were assigned to 31 other general hospitals.

After V-J Day, the directors of the civilian emergency physical therapy courses were advised that the 6-month applicatory training in selected Army hospitals would be terminated. Since the Army apprentice program for civilian students was terminated, arrangements were made for students enrolled in the 6-month emergency civilian course to have their apprenticeship experience elsewhere. On 10 October 1945, The Surgeon General wrote to the directors of civilian courses expressing his recognition of the valuable contribution these schools had made to the war effort.¹⁶ Although a large number of emergency courses were conducted in civilian institutions, enrollment in these courses was far below expectations except in the two schools where training was tuition free.

Experience in this program clearly demonstrated that in order to train apprentice physical therapists in the treatment of patients with combat injuries, clinical experience should be afforded in general hospitals where patients could be observed in large numbers. Station and regional hospitals proved inadequate for this training, and after 1943, there was a decrease in use of station and regional hospitals and greater utilization of general hospitals. It was demonstrated also that the efficiency of the apprenticeship program depended not only on the clinical experience available but also on the supervision exercised by the chief physical therapist and by the Physical Therapy Branch, Surgeon General's Office.

Occupational Therapists

At the outbreak of World War II, eight qualified occupational therapists and four occupational therapy assistants were on duty in five Army hospitals. By V-J Day, 899 occupational therapists and apprentices were working in 76 hospitals in the continental United States.

¹⁵ Memorandum, The Adjutant General for Commanding Generals, All Service Commands, 24 Oct. 1942, subject: Dietetic and Physical Therapy Personnel in Army Hospitals.

¹⁶ Letter, Col. Floyd L. Wergeland, MC, Director, Training Division, Office of The Surgeon General, to Dr. Frank H. Krusen, Mayo Clinic, Rochester, Minn., 10 Oct. 1945.

Recruitment problems.—The Surgeon General's decision to appoint occupational therapists as civilian employees without commissions and to limit the establishment of occupational therapy clinics to Army hospitals in the Zone of Interior proved a serious handicap to recruiting and training.¹⁷ These decisions made it clear that occupational therapy was considered more valuable for convalescent patients evacuated to the Zone of Interior than for patients with acute injuries and illnesses hospitalized in the Communications Zone.

Lack of recognition and lack of status, however, were the least of the Medical Department's recruiting problems. Far more serious was the close approximation of the Army's estimated need and the total number of registered occupational therapists. By early 1944, so many new Army hospitals had been built or planned for priority construction that the target for personnel was set at 1,000.¹⁸ Yet, there were scarcely 1,300 graduates in the professional registry. Since the Army could not hope to recruit over 75 percent of the total civilian supply of occupational therapists, the best solution seemed to be the establishment of an emergency training program.

Design and purpose of War Emergency Course.—The War Emergency Course was outlined by the Occupational Therapy Branch of the Surgeon General's Office, in collaboration with the War Manpower Commission and the Committee on Education of the American Occupational Therapy Association. The latter body reviewed course plans at a special meeting on 21 March 1944 and found that they satisfied minimum standards established by the American Medical Association. Civilian schools had, for several years, qualified college graduates in an 18-month course. Prerequisites for these courses included a college degree with a specified number of hours in biology, psychology, and sociology. With this background, schools were able to telescope the required professional curriculum into 9 months of academic work and 9 months of supervised clinical experience.

In an effort to further shorten professional education, the Army singled out skills and techniques as the most time-consuming part of the curriculum and added these to the prerequisites for the War Emergency Course. The qualifications of applicants thus became a bachelor's degree, with a course in basic psychology, and a major in arts and crafts, industrial art, home economics, or fine or applied arts.¹⁹ All were required to possess at least three manual skills and were required to be citizens of the United States and between the ages of 21 and 35 years. The course plan provided a 4-month academic curriculum of medical subjects and occupational therapy, followed by 8 months of apprenticeship in Army general hospitals. By raising admission standards, the academic phase of the emergency course was shortened by 5 months, and the clinical phase was reduced by 1 month. Together, these accounted for a 6-month, or 33 $\frac{1}{3}$ percent, reduction in course length.

The Surgeon General's request to establish an emergency course to train 600

¹⁷ (1) Letter, Everett S. Elwood, President, American Occupational Therapy Association, to Maj. Gen. James C. Magee, The Surgeon General, 20 Mar. 1940. (2) Letter, Maj. Gen. James C. Magee, The Surgeon General, to Everett S. Elwood, President, American Occupational Therapy Association, 1 Apr. 1940.

¹⁸ Willard, Helen S., and Spackman, Clare S. (editors): *Principles of Occupational Therapy*, 1st edition. Philadelphia: J. B. Lippincott Co., 1947.

¹⁹ Memorandum, The Surgeon General for Commanding General, Army Service Forces, 26 Apr. 1944, subject: Occupational Therapists.

civilians yearly was approved by the Army Service Forces in May 1944.²⁰ The circular authorizing this course and specifying the civilian schools to participate appeared a month later.²¹ By the terms of contracts negotiated with civilian schools participating in this Government subsidized program, The Surgeon General retained authority to prescribe curriculum, teaching methods, classroom materials, and class schedules. Representatives of his office could inspect school facilities and courses at any time and require periodic progress reports on each student. Schools were required to remove any student from the course who failed to maintain a satisfactory standing or who The Surgeon General, for any reason, desired withdrawn.

The War Emergency Course was accelerated from 18 to 12 months by the requirement of additional prerequisites. Each applicant accepted for training was required to have at least three manual skills, but the average possessed was even greater because most of the candidates either had majored in art or home economics or had supplementary experience in teaching creative and manual skills. The general level of education allowed many courses to be eliminated from the academic phase of the traditional curriculum. Over 90 percent of the students had bachelor's degrees, and over 3 percent had master's degrees. The average educational level of nondegree students was 3.8 years beyond high school.

In contrast to the limited number of crafts was the time devoted to the sciences, clinical conditions, and the theory of occupational therapy. Schools taught only two of the major arts and crafts, which they selected to conform with their facilities and the skills of their staff. The list of crafts drawn up by the Army was headed by woodworking and printing, and most schools selected these subjects. Several schools offered weaving or radio and electrical repair in lieu of printing. Science and occupational therapy accounted for two-thirds of the total curriculum. Conspicuously absent from the wartime curriculum were psychology—a prerequisite—and pediatrics. Weekly schedules included 24 hours of classes and 12 hours for visits, field trips, collateral reading, and study. Upon completion of the academic phase of training, The Surgeon General assigned trainees to selected general hospitals for 8 months of clinical affiliation.

The clinical program was designed to provide orientation to the Army and an opportunity to apply the principles, processes, and techniques studied during the 4-month academic phase. Modifications of the standard program were permitted to adapt it to local facilities. Forty Army general hospitals were designated to conduct the clinical phase. A detailed program of instruction for the period of clinical affiliation was published by The Surgeon General in October 1944. Eighty-seven hours were devoted to craft activities to perfect or supplement skills learned in the academic phase. Additional practice and exploration of craft techniques were provided by work experience periods. In this way, time removed from the academic phase was made up in the clinical phase.

In August 1944, the clinical portion of the War Emergency Course was opened to students who had completed the equivalent of the academic portion of regular

²⁰ Memorandum, William H. Kushnick, Director of Civilian Personnel and Training, Civilian Personnel Division, Office of The Secretary of War, for Office of The Surgeon General, thru Army Service Forces, Headquarters, Industrial Personnel Division, 9 May 1944, subject: Approval of Contract for Training of Occupational Therapists.

²¹ Army Service Forces Circular No. 189, 22 June 1944.



FIGURE 18.—Classes for occupational therapy apprentices, Battey General Hospital, Rome, Ga. (Top) Anatomy. (Bottom) Kinesiology.

civilian training courses.²² Students who had satisfactorily completed some part of the apprentice period in accredited civilian hospitals became acceptable for completion of this period in selected Army hospitals. By extending subsidized training to students in regular civilian courses, approximately 150 additional apprentices were enrolled and employed in Army hospitals as graduate occupational therapists (fig. 18).

APPOINTMENTS, CLASSIFICATIONS, AND SALARIES OF TRAINEES

In February 1939, all civilian positions in Army hospitals, including student dietitians at Walter Reed General Hospital, were brought into the Civil Service.²³ The Surgeon General's Office was authorized to give classified status to the 10 student dietitians who entered training on 1 September 1939 and who were appointed without civil service examinations. However, students remained ungraded for another 5 years. After deductions for quarters, subsistence, and retirement, take-home pay from a salary of \$420 was approximately \$45 per annum.

In 1941, when the emergency training program in physical therapy was initiated, physical therapy students were also classified in ungraded civil service positions, received the same salaries as student dietitians, and were subject to the same deductions. At this time, the Civil Service Commission authorized the additional training position of apprentice physical therapist and provided for reallocations from the position of student to that of apprentice and ultimately to that of graduate without approval of examination by the Commission. The positions of apprentice physical therapist and apprentice dietitian were subprofessional and were designated SP-3. The salary for these positions was \$1,440, less \$180 for quarters and subsistence.

By 1944, when the emergency course in occupational therapy was initiated, classification and salary for Medical Department trainees had improved even further. Ungraded students (dietitians, physical therapists, or occupational therapists) were changed to SP-3, at \$1,440 per annum, and the position of apprentice in each of these categories was upgraded from SP-3 to SP-4, at \$1,620 per annum. Both salaries were enhanced by 20-percent overtime pay for schedules in excess of 40 hours per week. However, both were still subject to a deduction of 5 percent for retirement and \$180 for quarters and subsistence. Civilian students and apprentices were required to furnish their own uniforms, textbooks, and incidentals. Uniforms authorized for wear were the same as those for graduates.

TRAINING PERFORMANCE REPORTS

During the clinical phase of training, performance reports were required for all apprentices. Reports on apprentice dietitians were completed 1 month before the end of the training period and forwarded to the Surgeon General's Office. A record

²² Army Service Forces Circular No. 263, 15 Aug. 1944.

²³ Executive Order 7916, 24 June 1938.

of final physical examination, a photograph, and an application for appointment accompanied the report. Final performance reports for physical therapy apprentices were completed after the training period by the clinical supervisors and forwarded to The Surgeon General. These reports provided information about the trainee's proficiency, the amount of clinical practice completed, personality traits, and adaptability for commissioned military service and were retained as a part of the trainee's permanent record. Reports on occupational therapy apprentices were completed by the hospitals at periodic intervals during the 34-week program and submitted to The Surgeon General. One copy was sent to the schools in which apprentices received their academic instruction and from which they would be certified eligible for registration on completion of the course. The Surgeon General was authorized to separate an apprentice from a course at any time for failure to maintain satisfactory clinical performance, for inability to adjust to hospital service, or for other cause.

MAINTENANCE OF EDUCATIONAL AND PROFESSIONAL STANDARDS

Emergency training programs in dietetics, physical therapy, and occupational therapy developed as a result of cooperation between the Medical Department and officials or committees of professional organizations. Courses met the minimum educational requirements of the American Dietetic Association and, for physical and occupational therapists, the Council on Medical Education and Hospitals of the American Medical Association. Throughout the war, The Surgeon General maintained these educational standards. Each group, however, had its own problems.

In the fall of 1944, the Civil Service Commission questioned the need for the strict educational requirements for student dietitians. The question arose because of the Commission's interpretation of a provision in the Veterans' Preference Act of 1944 which eliminated minimum educational requirements as a qualification for other than scientific, technical, or professional positions. The Civil Service Commission's interpretation came as a surprise to the Surgeon General's Office. In a letter of protest, Maj. Gen. George F. Lull, Deputy Surgeon General, stated:²⁴

The dietitian in the Medical Department of the Army is a commissioned officer. She assists the medical officer by filling his diet prescriptions. It is, therefore, most important that the best qualified individuals be obtained for training. It is highly improbable that this type of personnel could be secured if the educational requirements are discontinued.

A favorable reply was received from the Commission:²⁵

In certifying persons for the position of student dietitian, apprentice dietitian, student physiotherapy aide and apprentice physiotherapy aide, only those eligibles will be certified who meet the requirements prescribed by the War Department as necessary for commissioned officers.

²⁴ Memorandum, Maj. Gen. George F. Lull, Deputy Surgeon General, to U.S. Civil Service Commission, 12 Sept. 1944, subject: Educational Requirements for Dietitians.

²⁵ Letter, M. L. A. Mayer, Executive Director, Civil Service Commission, to Maj. Gen. George F. Lull, Deputy Surgeon General, 24 Oct. 1944.

Occupational therapists had problems with both educational and physical standards. Although the majority of applicants for the War Emergency Course were qualified, a small percentage was found unacceptable because of poor academic records, physical conditions, or personality disorders. The Surgeon General's struggle to maintain professional standards was complicated by Civil Service Commission policies giving preference to veterans, the disabled, wives, and widows, which required the acceptance of several candidates neither physically nor educationally qualified for training. Another problem was created by extremely liberal substitution of experience for education. Occasionally, The Surgeon General contested decisions and won his argument against unqualified certifications. Too often, they had to be accepted and disqualified later for failing to meet physical or academic standards.

The prerequisite of a college degree in physical education for civilian students taking the physical therapy course was established by the Medical Department as the entrance requirement before 1941. In May 1944, the Medical Department requested authority to change the educational requirement to include a major field in biology. This revision was not published until October, but it was informally approved in the selection of students enrolled after August 1944.

Military applicants for the physical therapy course were required to have completed not less than 2 years in an approved college with satisfactory courses in biology and other sciences. The term "satisfactory course in biology and other sciences" was interpreted as a minimum of 15 semester hours selected from anatomy, bacteriology, biology, chemistry, hygiene, kinesiology, physics, physiology, psychology, and zoology. This departure from the established standards roused fears that the Army would jeopardize professional standards. While the Army did depart from its previously established prerequisites, it still conformed to the minimum standards established by the American Medical Association.

In October 1944, the minimum requirement in science hours was increased from 15 to 26 semester hours, with 6 hours as the minimum in biology. The remaining hours were selected from courses in anatomy, bacteriology, chemistry, entomology, hygiene, kinesiology, parasitology, physics, physiology, psychology (maximum 3 semester hours), zoology, or other courses in biology or natural science. This change was necessary because many 2-year college students with only 15 hours in the sciences were not academically prepared to cope with the Army's intensive training program. The number of students with a 2-year college background constituted only 9 percent of the total number of enlisted students enrolled from October 1943 to November 1945. The average number of college years for the overall total of these students during this period was 3.7 years.

The training period (student and apprentice phases) for civilian physical therapy students was 12 months, while training period for enlisted students was 9 months. The shorter training period for military students was justified by their previous military orientation and the number of patients available for therapy in Army general hospitals. During 1944, enlisted apprentice physical therapists were given training far in excess of the 400 clinical hours required by the American Medical Association.

SCHOOLS AND HOSPITALS CONDUCTING TRAINING COURSES FOR THE ARMY

Emergency training programs to increase the number of dietitians, physical therapists, and occupational therapists were established at educational institutions and at civilian and military hospitals. Fifteen civilian hospitals conducted the student phase for dietitians, 33 Army hospitals conducted the apprentice phase, and 4 Army hospitals conducted both phases. The first emergency course began in August 1942. Civilian institutions completed their Army courses in 1945, and all Army accelerated programs, except one, came to a close in March 1946.

The 6-month academic phase of emergency physical therapy training was conducted in 38 courses at 15 civilian institutions. In addition, 10 Army hospitals conducted 33 emergency academic courses for civilian students and 28 for enlisted students. The first emergency course was started in July 1941, but the courses in civilian schools did not start until 1942. Emergency physical therapy training programs were discontinued soon after V-J Day. However, Army hospitals conducting the academic phase continued classes until 10 February 1946 and hospitals accepted these students for on-the-job training for another 6 months.

Twenty-one emergency courses for occupational therapists were given at eight civilian schools, while the clinical phase of this program was conducted at 40 Army hospitals. School courses started in July 1944 and ended in November 1945. The clinical phase of training extended 8 months beyond the war. The last 51 apprentices, scheduled to graduate in July 1946, were transferred to Veterans' Administration hospitals for pay and training.

RESULTS OF EMERGENCY TRAINING PROGRAMS

Without emergency training programs, the Army could not have recruited enough qualified medical specialists to meet wartime requirements. Both dietitians and physical therapists numbered approximately 1,600 at the peak of their strengths. Only 21 percent of the Medical Department dietitians were trained through Army programs, but Army training qualified approximately 55 percent of the physical therapists. Occupational therapists, the smallest group numerically, trained 78 percent of their peak strength of approximately 900 through emergency courses. In each instance, the professional group concerned thought that the apprentice phase of training in military hospitals was valuable in familiarizing students with Army procedures. Experience in treatment of war injuries was especially valuable for physical and occupational therapists. Emergency training courses for dietitians, physical therapists, and occupational therapists expanded educational programs for the whole profession. The demand in all three of these health fields during the war resulted in the number of civilian schools offering dietetic internships increasing from 38 to 60; in physical therapy, from 15 to 36; and in occupational therapy, from five to 21.

Both during and after the war, the fear was expressed that a lowering of

standards was inherent in the Army's accelerated physical therapy training program. In 1945, Dr. Frances A. Hellebrandt, Medical Director, Baruch Center of Physical Medicine, Medical College of Virginia, Richmond, Va., made a careful analysis of the 6-month academic phase of the Medical Department physical therapy course. Doctor Hellebrandt, who had served as medical director of the physical therapy training course for enlisted members of the Women's Army Corps conducted at the University of Wisconsin from October 1943 to October 1944, concluded that:

* * * Careful study of the scope and content of the WAC course suggests that in reality it surpasses anything previously attempted by the average apprentice type of approved hospital technician training school.

* * * * *

The Army has demonstrated that the essentials of subject matter in a variety of technical fields can be taught effectively by new methods which drastically shorten the learning period. * * * We would be short sighted indeed if we failed to study the pedagogical experiments of the war * * * ²⁶

TRAINING ENLISTED PHYSICAL THERAPY TECHNICIANS

The Medical Department had long recognized that trained enlisted assistants were necessary in the operation of a physical therapy clinic. Until late in the war, male enlisted assistants were trained on-the-job. Because of increasing patient loads and the loss of male technicians to combat units, The Surgeon General directed the service commands, in a telegram dated 28 February 1945, to estimate their requirements for enlisted women trained as physical therapy technicians. On the basis of this information, a formal training program was established. Applicants for these courses were required to have completed 2 months of training at the Medical Department Enlisted Technicians School. Those selected were carefully screened by the staff of the school, the medical director of physical therapy, and the chief physical therapist, Brooke General Hospital.

The program of instruction consisted of a 4-week course (192 hours) in selected physical therapy procedures and a general orientation in this field of therapeutics. To prepare enlisted women for hospital assignment as rapidly as possible, courses were established in 13 general hospitals. Graduates were eligible for the classification of enlisted physical therapy technician.²⁷ The last class enrolled on 9 July 1945. Four hundred and thirteen enlisted women were trained in this program.²⁸

COURSE FOR OCCUPATIONAL THERAPY ASSISTANTS

If graduate occupational therapists could have been recruited in larger numbers or if the War Emergency Course had begun earlier in the war, a course for occupa-

²⁶ Hellebrandt, F. A.: Analysis of the WAC Emergency Physical Therapy Training Program. Arch. Phys. Med. 26: 507, 514, August 1945.

²⁷ War Department Technical Manual 12-427, 12 July 1944; Change 1, 12 Apr. 1945.

²⁸ Memorandum, Maj. Emma E. Vogel, WMSC, Director of Physical Therapists, to Col. Harold C. Lueth, Military Personnel Division, Office of The Surgeon General, 6 Aug. 1945.

tional therapy assistants would have been unnecessary. However, in June 1944, only 180 occupational therapists were on duty in Army general hospitals,²⁹ and more than a year would elapse before graduates of the War Emergency Course could be qualified for staff appointments. On 2 October 1944, the director of the Reconditioning Consultants Division, Surgeon General's Office, reported to The Surgeon General that a program for training enlisted women as occupational therapy assistants had been submitted to Army Service Forces.³⁰ The 1-month course was approved by the Army Service Forces on 16 November 1944.³¹

In January 1945, recruiting for this course ended, and, during the remaining 10 months of its operation, students were drawn exclusively from the Women's Army Corps. Halloran General Hospital, Staten Island, N.Y., was selected and Capt. Josephine E. Springer, WAC, chief occupational therapist at Tilton General Hospital, Fort Dix, N.J., was transferred to Halloran General Hospital and placed in charge of the program. The Surgeon General's Office approved candidates, allotted quotas to the service commands, and returned trainees to service commands for assignment to hospitals. Applicants for training were required to have completed basic military training and to have either a civilian background of teaching experience and some knowledge of a handicraft or an expert ability in some handicraft plus a high school education and an aptitude for teaching.

On 9 December 1944, 14 students reported for the first class. By April 1945, 141 students had attended the course. That same month, the course was discontinued because the training requirements for occupational therapy assistants had been met. The following month, a request for reestablishment of the course had to be submitted because enlisted assistants were needed for the expanding convalescent hospital program. Army Service Forces approved The Surgeon General's request.³² The promptness of Army Service Forces in approving the Medical Department's request enabled classes to run consecutively until 27 October 1945, when the 11th class graduated and the occupational therapy assistants training course for enlisted members of the Women's Army Corps was discontinued. Of the 295 students enrolled in this course, 278 satisfactorily completed requirements and were subsequently assigned to selected Army hospitals where they assumed much of the burden of diversional activity programs.

²⁹ Memorandum, Maj. Henry B. Gwynn, MC, for The Surgeon General, 17 June 1944, subject: Semimonthly Report of the Reconditioning Division for the Period 1-17 June 1944.

³⁰ Memorandum, Col. Augustus Thorndike, MC, for The Surgeon General, 2 Oct. 1944, subject: Semimonthly Report of the Reconditioning Consultants Division for the Period 16-30 September 1944.

³¹ Memorandum, Brig. Gen. R. W. Bliss, Chief, Operations Service, Office of The Surgeon General, for Commanding General, Army Service Forces, 4 Nov. 1944, subject: Orientation Training for Occupational Therapy Assistants (WAC), with 1st indorsement thereto, 16 Nov. 1944.

³² (1) Letter, Brig. Gen. R. W. Bliss, Chief, Operations Service, Office of The Surgeon General, to Commanding General, Army Service Forces, attention: Director of Military Training, 13 Apr. 1945, subject: Orientation Training for Occupational Therapy Assistants (WAC), with 1st indorsement thereto, 23 Apr. 1945. (2) Letter, Brig. Gen. R. W. Bliss, Chief, Operations Service, Office of The Surgeon General, to Commanding General, Army Service Forces, attention: Director of Military Training, 28 May 1945, subject: Orientation Training for Occupational Therapy Assistants (WAC). (3) Transmittal Sheet, Col. S. M. Prouty, GSC, Executive, Office of the Director of Military Training, Army Service Forces, to The Surgeon General, 7 June 1945, subject: Orientation Training for Occupational Therapy Assistants (WAC), with inclosure 1 thereto, 28 May 1945.

CHAPTER VI

Medical Replacement Training Centers¹

A high quality of professional care for an army in the field can be provided only when the skills of doctors, dentists, veterinarians, and administrators are supported by trained enlisted personnel. The training of a particular Medical Department soldier varies with the demands placed upon him, but in all cases, it must be detailed, intensive, and diversified. To train medical surgical, X-ray, laboratory, pharmacy, dental, and veterinary technicians, schools were established at general hospitals, military posts, civilian colleges, and commercial institutions. In addition, medical soldiers were also trained to work as part of a unit or team, ranging from an optical detachment of two enlisted men to a 2,000-bed numbered general hospital with 898 officers, nurses, and enlisted men. In short, men had to be trained to perform special duties in a multitude of medical units in a chain of evacuation stretching from the frontlines to general hospitals in the Zone of Interior.

This bewildering array of individual and team specialties was held together by a common bond of training designed to produce basic medical soldiers and administrative (or common) specialists. Regardless of later specialization, all medical soldiers had to be acquainted with a body of medical and military knowledge basic to their duties. Because they might be stationed in a Zone of Interior hospital or a frontline aid station, medical soldiers were trained to work either independently or with a group. First aid under fire, evacuation of the wounded over difficult terrain, and the recognition of wounds and disease were routine work. Despite their status as noncombatants, medical soldiers had to be trained to protect themselves, their units, and their patients. This common bond of training was provided by Medical Replacement Training Centers.

Medical Department soldiers of World War II came from all walks of life. Medical Replacement Training Centers, and those of other arms and services, applied the techniques of mass production to military training. In the image of the industrial process, centers took raw material from reception centers, forged a standardized product, and fed their output into medical units where the separate parts were finished and linked into the working whole. The accent was on economy, speed, uniformity, and volume production. The balance between factors such as housing and classroom facilities, cadre ratios, training aids, the flow of trainees from reception centers, and the rate of unit activations had to be continuously adjusted. Bottlenecks at any stage in the process were immediately reflected through the system.

¹ Unless otherwise indicated, this chapter is based on: (1) Goodman, Samuel M.: History of Medical Department Training, United States Army, U.S. Army World War II. Volume V. The Training of Replacements, Fillers, and Cadres, 1939-1945. [Official record.] (2) Zimmermann, Edward A.: Training in the Medical Department During World War II, pt. I, ch. VII. Training of Enlisted Individual Fillers and Replacements. [Official record.]

The successful operation of replacement training centers required continuous planning. Preparations for the establishment of Medical Replacement Training Centers² began almost immediately after the publication of The Surgeon General's Protective Mobilization Plan of 1939. In the spring of 1940, the Medical Department conducted studies of potential sites, training loads, construction costs, and cadre requirements. In addition to sites at Fort Meade, Md., Fort Oglethorpe, Ga., and Fort Warren, Wyo., specified in The Surgeon General's Protective Mobilization Plan of 1939, the Medical Department also considered sites at posts in Indiana, New York, Missouri, Texas, Oklahoma, and California.³ In the fall of 1940, while these studies were being conducted, the War Department issued specific instructions for the establishment of training centers. These instructions spelled out the type, number, and size of buildings to be constructed for replacement training and emphasized the need for rigid economy in construction programs.⁴

In mid-October 1940, War Department and Medical Department training policies were reviewed and discussed at a conference of Corps Area Surgeons. Topics included in the agenda drawn up by the Director of Training, Surgeon General's Office, ranged from methods of constructing plans for the operation of training centers to techniques for preparing Reserve officers to train conscripts. Participants in the conference were briefed on the requirements of Mobilization Training Program No. 8-1, which had been published on 9 September, and oriented to policies governing the training of officers and enlisted men for duties as administrative or common specialists.⁵

It was not until January 1941, however, that the War Department authorized The Surgeon General to establish two Medical Replacement Training Centers—one at Camp Lee, Va., and the other at Camp Grant, Ill. A third was authorized on 1 November of that year at Camp Barkeley, Tex.⁶ At this juncture, the Medical Department began translating theory into practice.

TRAINING CENTERS

Camp Lee and Camp Pickett

When the Medical Replacement Training Center at Camp Lee was activated in January 1941, on the site of a World War I training camp, little remained of the

² The official title of Medical Replacement Training Centers changed several times during World War II. When the centers were first established, they were most commonly referred to as medical training centers. On 15 December 1941, they were designated as Medical Replacement Training Centers. In April 1944, the designation was changed to ASF (Army Service Forces) Training Center. For the purpose of this study, only the last two designations will be used.

³ (1) Memorandum, Maj. F. B. Wakeman, MC, for Col. Albert G. Love, 14 Sept. 1940, subject: Enlisted Replacement Centers. (2) Memorandum, Maj. Arthur B. Welsh, MC, to Brig. Gen. Albert G. Love, 11 Mar. 1941, subject: MD ERC's. (3) Memorandum, Maj. Arthur B. Welsh, MC, to Brig. Gen. Albert G. Love, 29 Mar. 1941, subject: Replacement Centers.

⁴ (1) Letter, The Adjutant General to Chiefs of Arms and Services, Commanding Generals of All Corps Areas, and Commanding Officers of Exempted Stations, 15 June 1940, subject: War Department Construction Policy. (2) Letter, The Adjutant General to Chiefs of Arms and Services, Commanding Generals of All Corps Areas, and Commanding Officers of Exempted Stations, 7 Oct. 1940, subject: War Department Construction Policy Supplement No. 5.

⁵ Memorandum, Maj. F. B. Wakeman, MC, for Executive Officer, Office of The Surgeon General, 5 Oct. 1940, subject: Agenda for Discussion at Meeting of Corps Area Surgeons, Week of 14 October 1940.

⁶ Letter, The Adjutant General to Commanding Generals, Seventh and Eighth Corps Areas, Chief Signal Officer, The Surgeon General, and Chief of Infantry, 23 Oct. 1941, subject: Activation of Replacement Training Centers.

earlier center except some gunpits and a few emplacements. The site, 25 miles from Richmond, was relatively flat and partially wooded, with few streams that could be used to add realism to exercises, and the climate permitted year-round training. Since the Medical Department shared the camp with a Quartermaster Replacement Training Center, room for long term expansion was limited.

From the beginning, little went according to plan. When Lt. Col. (later Maj. Gen.) Paul R. Hawley, MC, Lt. Col. (later Col.) Frank S. Matlack, MC, and S. Sgt. (later Lt. Col.) Philip E. G. Fleetwood arrived to activate the center on 3 January 1941, construction was only partially completed. On 16 January 1941, the center was officially activated as the 1308th Service Unit, Medical Department Replacement Center, Camp Lee. The time between then and mid-March, when the first trainees arrived, was used to organize and activate subunits, procure supplies, and receive personnel assigned to the center.

Officers were assigned to the center from Regular Army posts, private medical practice, or civilian jobs, and the enlisted cadre came from posts scattered throughout the United States. Most of the officers assigned to the training battalions had completed the monthlong refresher course at the Medical Field Service School, or attended the Cooks and Bakers School at Fort Meade, Md. All lacked experience in handling large groups of trainees.⁷

The medical training center was designed to house seven training battalions each containing approximately 1,000 men. The quarters provided for trainees were two-story, 63-man, cantonment barracks, grouped on a battalion pattern. The barracks for two companies of each battalion were alined side by side, facing the battalion's remaining two companies. The battalion headquarters and supply buildings were separated from troop housing areas by a road constructed through the battalion area. Buildings designed as recreation halls and regimental headquarters were converted into classrooms.⁸

In common with other training centers during the first year of mobilization, the medical training center at Camp Lee reported a chronic shortage of training equipment, and even simple housekeeping stores. At one point, Colonel Hawley, the training officer, complained bitterly to the Surgeon General's Office that "the Quartermaster supply * * * is little short of scandalous. There have been times when we could not get enough food to feed our men * * *. There is no soap, scrubbing brushes, other cleaning materials and toilet paper to be had at this writing. Clothing is exhausted except in abnormal sizes. We have many selectees wearing nondescript civilian shoes because they cannot be fitted from Quartermaster supply."⁹ Training equipment was even more difficult to obtain and often had to be improvised or simulated. The shortage of equipment and specialized classrooms made it difficult to establish a training program for common specialists, and the schedules set up in mobilization training programs often had to be adapted to existing facilities.

⁷ Annual Report, Medical Replacement Training Center, Camp Pickett, Va., fiscal year 1942.

⁸ A History of the Medical Replacement Training Center at Camp Lee, Va., and Camp Pickett, Va., From Activation in 1941 to Inactivation in 1943. [Official record.]

⁹ See footnote 1 (1), p. 173.



FIGURE 19.—Trainees from Camp Lee, Va., marching to Camp Pickett, Va., to establish the new Medical Replacement Training Center.

The training of specialists, as well as basic medical soldiers, was disrupted by the irregular arrivals and departures of trainees. Fluctuations in enrollment led alternately to slack periods when supplies and equipment were underutilized or wasted and heavy training loads taxed facilities and led to unnecessary requests for expansion.

Early in February 1942, the War Department concluded that further expansion of both the Medical and Quartermaster Replacement Training Centers would grossly overtax the resources of Camp Lee and decided to transfer the Medical Department center to Camp Pickett. To avoid interrupting the program, the War Department suggested moving the medical battalions one by one as they completed their training cycles and turning the vacated areas over to the quartermaster center. Battalion cadre and overhead could then be sent to Camp Pickett to begin training a new complement of trainees.

Brig. Gen. William R. Dear, the Commanding General of the Medical Replacement Training Center at Camp Lee, objected to the War Department plan, arguing that it would take 10 weeks to complete the transfer to Camp Pickett, and during this period, his command would be divided and administrative complications would be inevitable. As an alternative, he proposed that all medical battalions be moved at the same time, regardless of their state of training. The troops could



FIGURE 20.—Tent housing used at Camp Pickett, Va.

be marched from Camp Lee to Camp Pickett, and the property of at least one battalion could be moved each day by truck.¹⁰

The War Department accepted this alternative, and in mid-June, medical trainees began a 3-day march over the 42 miles separating the two camps. The center at Camp Lee was officially closed at midnight on 19 June 1942 and reopened a minute later at Camp Pickett (fig. 19).¹¹ To ease the transition, the Medical Replacement Training Center transferred all of its training aids, supplies, and equipment to Camp Pickett.¹² Even then, training was disrupted while new permanent training aids, such as a sanitary area, an obstacle course, mapping areas, and drill fields, were constructed.

Camp Pickett, located near Blackstone, Va., was initially the home of the 79th Infantry Division and other Second U.S. Army units. The prevailing weather was the same at both camps, but the terrain at Camp Pickett was better suited to a varied training program. The surrounding countryside was rolling and wooded, with numerous lakes and streams. The soil was a red clay that became a quagmire

¹⁰ See footnote 8, p. 175.

¹¹ (1) Memorandum, Col. John A. Rogers, MC, Executive Officer, Office of The Surgeon General, to All Services, Surgeon General's Office, 22 June 1942. (2) See footnote 8, p. 175.

¹² Letter, The Surgeon General to The Adjutant General, 26 Feb. 1942, subject: Movement of Medical Replacement Training Center From Camp Lee to Camp Pickett, Va.

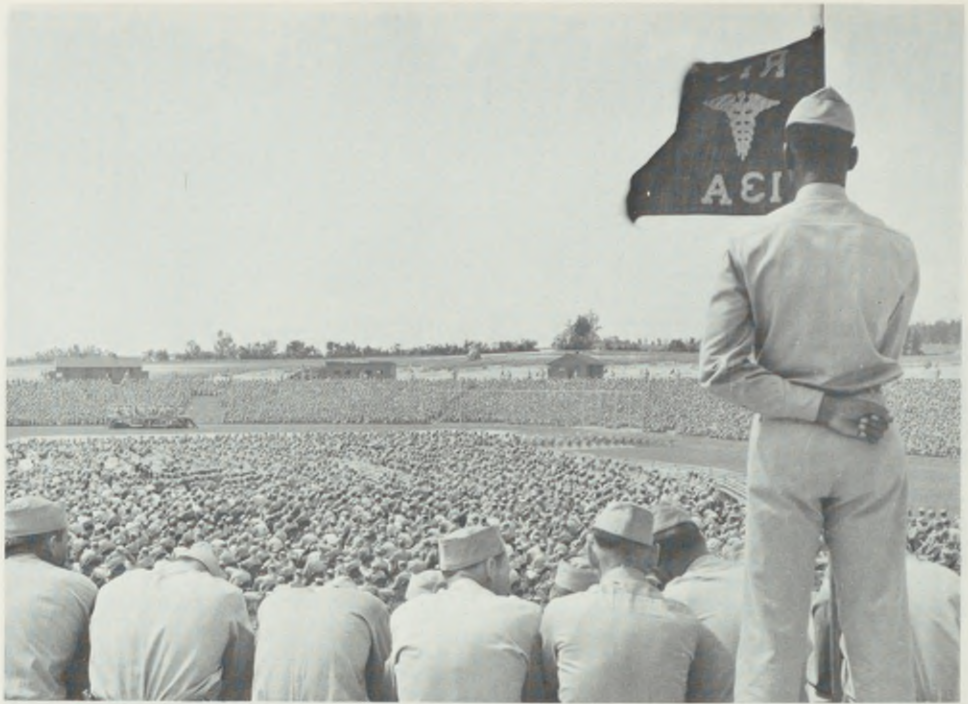


FIGURE 21.—This gathering of troops at the Camp Pickett, Va., stadium on Memorial Day illustrates the size of the Medical Department training effort.

after every rain. Initially, trainees were housed in a new, improved type of cantonment barrack.

In June 1942, the War Department authorized the center to expand enrollment by 5,000 trainees per cycle. On 5 August, the center was reorganized to absorb its new capacity. Negro trainees, who had previously been assigned to companies C and D of the 8th Medical Training Battalion, were organized in battalion strength, and four white battalions were added, bringing the total to one Negro and 13 white battalions. Each battalion was placed under the control of one of four newly activated training regiments. On 14 December 1942, one white battalion was converted to a Negro battalion to accommodate the increasing number of Negro trainees assigned to the center.¹³ The five training battalions added on 5 August, however, had to be quartered in hutments and tents (fig. 20) winterized with scrap lumber left over from the construction of the camp.

The training center at Camp Pickett (fig. 21) continued to enroll trainees until mid-1943, when the declining rate of activations reduced the Medical Department's demand for fillers and replacements, and the Medical Replacement Training

¹³ Annual Report, Medical Replacement Training Center, Camp Pickett, Va., fiscal year 1943.

Center was ordered to close. In October, after the last class graduated and property accounts were cleared, the center was officially deactivated.¹⁴

Camp Grant and Fort Lewis

Preparations for the establishment of a Medical Replacement Training Center at Camp Grant began early in the fall of 1940, under the supervision of the commanding general of the Sixth Corps Area. The reservation, then under the control of the Illinois National Guard, was located on the east bank of the Rock River, 3 miles south of Rockford, Ill. The eastern half of its approximately 3,500 acres of rolling terrain was unusually well suited for field operations. At times, however, the climate made training difficult; the temperature varied from 20° below zero in winter to as much as 104° above in summer, and between December and March, snow and cold weather made meaningful outdoor training a near impossibility.

Many difficulties had to be overcome before the center could begin enrolling trainees. Although the Medical Replacement Training Center was to be the major activity at Camp Grant, with plans calling for a center headquarters and seven training battalions of 1,000 men each, a reception center with facilities for 2,500 men was also planned. Since the reception center was slated to open on 15 January 1941, 2 weeks before the Medical Replacement Training Center, it was given priority. Despite the center's low priority and delays in construction, work was completed on 24 March 1941, 10 days behind schedule, but in time to house the first shipment of trainees.

The site assigned to the Medical Department at Camp Grant also proved difficult to manage. Even before the reservation was surveyed, the commander of the Sixth Corps had decided not to allow construction in areas occupied by buildings belonging to the Illinois National Guard. This restriction left little space for building in areas with easy access to facilities for sewage and waste disposal and added to the cost of the center. The construction of hard-surfaced roads, and the ditching and leveling of the grounds had to be postponed when expenditures exceeded appropriations. Hard-surfaced roads and walks could not be provided until the autumn of 1941, and the ditching required for surface drainage was delayed even longer.

Buildings at the center were arranged to increase control by the company commander. Each training company was assigned four barracks, one administration building, and one messhall, grouped so that the company commander could keep close watch over all activities in the company area. When selectees arrived at the center, they were assigned to standard, semipermanent barracks, designed to house 63 men. Later, at the direction of the War Department, 77 men were housed in each barrack. This was accomplished by using a metal adapter to hold one bunk on top of another, an arrangement which proved quite satisfactory since it actually increased the floor space available to the men. During the summer months, the camp could accommodate an additional 6,000 trainees in tents.

¹⁴ See footnote 8, p. 175.

Spring brought with it the unwelcome discovery that every roof in the center leaked profusely. The problem was traced to composition roofing, installed during subzero weather to meet construction deadlines, that failed with the first spring rains. Damage to ceilings was extensive, not to mention the discomfort, and repairs could not be completed until fall.

Housing was less of a problem than classroom facilities, however. Initially, each battalion was provided with one recreation building, type RB-1, which could be adapted for use as a classroom. An administration building, type A-12, was later authorized for each battalion, but this provided only two additional classrooms. As a result, classes had to be held in barracks and messhalls throughout the winter and during inclement weather. The shortage of classrooms was not eased until late 1942 when an additional recreation building was authorized for each battalion.

The pressure for classroom space was even more acute in programs for common and administrative specialists and in the special training unit for illiterate, non-English speaking, and mentally deficient trainees. When the center was designed, plans did not include classrooms for either group, and there was no provision for housing the special training unit. Extra housing was provided by converting barracks and messhalls originally designed for men assigned to regimental headquarters. Efforts to provide additional classrooms for common specialists were only partially successful, and National Guard buildings requiring extensive structural changes had to be pressed into use.

Requisitions for the equipment and supplies required for basic military and technical training were submitted in December 1940. Between January and April 1941, the center received a few trucks, most of the training equipment required for two medical regiments, and seven sets of hospital training equipment. Since training programs focused on the operation of a medical battalion, training equipment for the center had to be improvised from hospital and regimental sets.

Supplies and instructors for the common specialist schools and the special training unit were provided by the U.S. Office of Education, through the Illinois Board of Vocational Education. Instructors for the Cooks and Bakers School, the Clerical School, the Motor Mechanics School, and the special training unit were hired on the recommendation of a civilian liaison agent assigned to the center by the Board of Vocational Education. The board also furnished tools and garage supplies for the Mechanics School, and most of the typewriters and machinery used by the Clerical School. This cooperative effort continued until 1 December 1941, when the commandant of the center was notified that supplies and instructors would have to be withdrawn because the U.S. Office of Education could not provide funds for their support. Through special arrangements, the equipment provided by the board was retained until February 1942 when the War Department was able to fill requisitions for replacements. Of the 23 civilian instructors, 15 were retained as civil service employees for the duration of the war. The remaining vacancies were filled by military personnel with civilian teaching experience.¹⁵

¹⁵ Annual Report, Medical Replacement Training Center, Camp Grant, Ill., fiscal year 1942.

By mid-1942, the problems that developed during the activation of Camp Grant were under control, and the center was able to settle into the routine of training. Cadre problems, however, continuously plagued the program. On 19 April 1943, control of the Medical Replacement Training Center was transferred from the War Department to the Sixth Service Command, and shortly thereafter, the center was ordered to replace at least 80 percent of its cadre with limited service personnel. Many of the replacements were found to have received only 5 weeks of training at Camp McCoy and to be limited mentally as well as physically. The new system proved far less satisfactory than did its predecessor, which allowed the center to select cadre from among its own trainees.

At the same time, officials at the center were favorably impressed by the performance of a company of enlisted women—members of the Women's Army Auxiliary Corps (usually called Wacs)—assigned to replace men in administrative positions. Under the terms of their assignment, each woman replaced one enlisted man, and the vast majority were reported to be both capable and industrious workers.

After June 1942, Camp Grant also reported a marked reduction in the number of doctors and dentists assigned to serve as training officers. In most instances, these positions were filled by young officers in the Medical Administrative Corps. Although many of these new officers lacked experience, they became accomplished instructors under the proper supervision, and their performance was considered highly satisfactory.

In December 1942, a special program was established to train sanitary technicians and meat and dairy technicians for the Army Air Forces. Under this program, the center was capable of training 55 sanitary technicians every 4 weeks, and 175 meat and dairy inspectors every 8 weeks. New housing and classrooms were not authorized, but the center was allowed to add 11 officers and 42 enlisted men to the cadre. In July 1943, quotas for the Sanitary Technicians Course were reduced to 20 technicians per cycle, and the quota for meat and dairy inspectors was reduced to 12.¹⁶

In May 1944, after the establishment of the preactivation system, the Medical Replacement Training Centers were redesignated as ASF (Army Service Forces) Training Centers to symbolize the transition to the new system.¹⁷ At this juncture, Camp Grant was one of three centers training troops for the Medical Department, and all were being taxed to provide a combined capacity of 50,000 trainees. When troop requirements were increased to 70,000 in mid-1944, Camp Grant was unable to provide facilities for further expansion. In June 1944, the medical training center began the process of transferring to Fort Lewis where additional training facilities were available. As classes graduated, buildings were closed, and the cadre and equipment were shipped to Fort Lewis. The last of the staff departed for Fort Lewis on 30 September 1944, and on 15 October, the center at Camp Grant was officially disbanded.¹⁸

¹⁶ Annual Report, Medical Replacement Training Center, Camp Grant, Ill., fiscal year 1943.

¹⁷ Army Service Forces Circular No. 135, 11 May 1945.

¹⁸ (1) Annual Report, Army Service Forces Training Center, Camp Grant, Ill., fiscal year 1944. (2) Report, Regular Training Branch. In Annual Report, Training Division, Office of The Surgeon General, fiscal year 1945.

Fort Lewis, bordering on Puget Sound, was originally the home of the 3d Infantry Division. At the time the medical section of the ASF Training Center at Camp Grant moved to its new site, Fort Lewis housed a number of activities, including a Corps of Engineers training section. The surrounding terrain was flat, but wooded, and provided natural features well suited to a diversified training program. The weather was cold and fogs were frequent, but the climate did not seriously limit activities.

Troop housing and fixed training aids, however, posed special problems. At a conference at Fort Lewis on 1 July 1944, the capacity of the engineer training section was set at 18,000, and the medical training section was authorized a capacity of 30,000 trainees. Housing in north Fort Lewis was assigned to the Engineer Corps, and the medical training section was to occupy quarters, as required, in the southern and northeastern sections of the post. Quarters in south Fort Lewis, which housed approximately 60 percent of the medical training section, consisted of a few three-story, brick barracks of varying capacity; some one-story, hollow-tile barracks, with a capacity for 58 men each; and a large number of two-story, 63-man cantonment barracks. In northeast Fort Lewis, trainees were housed in one-story, theater-of-operations barracks with concrete floors.

Since these areas were separated by a distance of almost 4 miles, separate training facilities had to be constructed at both sites. Few fixed training aids existed in the areas assigned to the medical training section, and those available required extensive repairs. The problem was further complicated by the fact that the post engineer could not provide manpower for construction. Almost without exception, training aids were built by personnel from the medical training section, with the post engineer supplying only the material. Facilities constructed by the medical training section included classrooms for the common specialist schools and fixed training aids ranging from rifle and carbine ranges to bayonet courts, gas chambers, obstacle courses, and demonstration areas. In short, the medical training section had to build almost every facility required by the center except housing.

During the period that the center was being transferred from Camp Grant, the medical training section at Fort Lewis temporarily experienced a shortage of cadre. The initial cadre, consisting of 100 officers and 250 enlisted men, arrived at Fort Lewis between the fifth and 10th of June. Trainees began to arrive almost immediately, and within a month, more than 1,000 were enrolled. The first training cycle began shortly before the end of June. On 26 June, a contingent of 97 officers arrived from Camp Berkeley, followed still later by 70 officers from the Tank Destroyer School, Camp Hood, Tex., who were assigned to the center for 2 months to help set up the military training program. Cadre strength gradually increased throughout the summer of 1944 as instructors and overhead personnel were transferred from Camp Grant. By the beginning of October, the transfer was complete.

The medical training section at Fort Lewis reached its peak strength at the end of September 1944 when more than 24,000 enlisted men were being trained. Four general hospitals, the first table-of-organization units established at the center under the new system of training, were activated during the same month. After October 1944, the level of training activity at Fort Lewis gradually declined. Train-

ing continued on a reduced basis until February 1946, when the medical training section was notified that it would be transferred to Fort Sam Houston, Tex., to become part of Brooke Army Medical Center. The last unit was transferred late in March, and on 1 April 1946, the medical training section at Fort Lewis was officially closed.¹⁹

Camp Barkeley and Camp Crowder

Early in March 1941, while the Medical Replacement Training Centers at Camps Lee and Grant were still under construction, War Department General Staff, G-3, Operations and Training, began to prepare plans for expanding the Army to 2,800,000 men. Initially, The Surgeon General considered creating two new centers, one in central California, with a capacity of 6,000, and another in Texas, with a capacity of 8,000.²⁰ A second study of training center requirements, prepared at the end of March, suggested expanding the capacity of Camp Lee, and the establishment of three new centers: One in Texas or Oklahoma with a capacity of 10,000; a second at Fort Leonard Wood, Mo., with a capacity of 5,000; and a third on the west coast, with a capacity of approximately 4,200. Anticipating the possibility of further expansion, the War Department authorized the establishment of a third Medical Replacement Training Center with a capacity of 4,000 trainees at Camp Barkeley on 12 July 1941.

The new Medical Replacement Training Center was located 11 miles southwest of Abilene, Tex., approximately 120 miles north of the geographic center of the state. The main camp covered approximately 2,500 acres of land and was located at an altitude of 1,870 feet. Hills to the south and west, which were approximately 400 feet higher, contained over 58,000 acres of bivouac and maneuver areas. Combat ranges were located in a 9,400-acre tract to the west. The climate permitted training to continue throughout the year, although the absence of shade and continuous duststorms made the camp disagreeable during the spring and summer. At the time the center was being established, Camp Barkeley was also being used to train elements of the 45th Infantry Division.

During the early months of operation, the center at Camp Barkeley encountered problems similar to those experienced by other Medical Replacement Training Centers during their initial stages of mobilization. On 15 August, the War Department directed the commanding generals of the Medical Replacement Training Centers at Camps Lee and Grant to select a specified number of enlisted men and train them for cadre assignments at Camp Barkeley. These centers provided a total of 519 of the 640 enlisted men authorized for the new center, and the remainder were selected from trainees completing the basic training course. Officers selected for the center were sent to the Medical Field Service School, Carlisle Barracks, Pa. for special training in August 1941, and then assigned to Camp Grant for on-the-job

¹⁹ (1) Remarks, Brig. Gen. James E. Baylis, "Training Center Commander's Problems." *In* Notes, Army Service Forces, 5th Training Conference, ASFTC, Camp Barkeley, Tex., 25 Oct. 1944. (2) History, Medical Training Section, Army Services Force Training Center, Fort Lewis, Wash., June 1944 to March 1946.

²⁰ See footnote 3 (2), p. 174.



FIGURE 22.—Camp Barkeley, Tex., December 1941.

training. Initially, this cadre proved adequate, but as the center began to grow, it reported a chronic shortage of staff.

The commanding general of the Medical Replacement Training Center, Brig. Gen. Roy C. Heflebower, reported at Camp Barkeley on 10 September, and on 1 November 1941, the center was officially activated. Heavy rains delayed construction, and when the first trainees arrived in mid-November, the building program was several weeks behind schedule. Despite cold, rainy weather, inoperative heating systems, and incomplete classrooms, the first training cycle began on 1 December. Since outdoor training was impractical, classes were held in the barracks, where men wrapped in overcoats sat on the floor. Trainees accepted these conditions with good spirits, however, since the first cycle coincided with the Japanese attack on Pearl Harbor.

Construction was completed a few weeks after the beginning of the first cycle, but the initial shortage of individual, organizational, and training equipment proved more difficult to overcome. Although equipment provided by the Medical Department usually arrived on time, and in adequate quantities, other classes of equipment were usually in short supply. As late as June 1942, General Heflebower reported that the center was still awaiting supplies ordered in October 1941 and stated that: "In this connection there is one practice which is not only a cause for annoyance, but results in a waste of time and effort, as well as delay in the ultimate receipt of supplies. This is the return of requisitions by intermediate headquarters asking for explanation as to the need for certain items, or questioning the quantities



FIGURE 23.—Hutments used to house trainees at Camp Barkeley, Tex.

of these items requested, when the items appear on a table of allowance issued by the War Department.”²¹

The facilities constructed at Camp Barkeley in the fall of 1941 were designed for the housing and training of 4,000 enlisted men. The original center, located in the northeastern section of the camp, contained standard two-story cantonment barracks and one-story general purpose buildings (fig. 22). In addition to standard barracks and administration buildings, each battalion quadrangle contained two large RB-1 classroom buildings and a large recreation hall. Other classroom buildings in the center were assigned to specialist schools.

Early in 1942, wartime growth began to produce a shortage of quarters and classrooms. When the capacity of the center was increased from 4,000 to 7,600 in February 1942, the additional trainees were housed in an adjacent hutment area previously occupied by the 158th Infantry Regiment of the 45th Infantry Division. The one-story 15-man hutments (fig. 23) provided adequate housing, and trainees seemed to prefer these quarters to the more modern, two-story barracks. As classrooms, however, these long, narrow buildings with their low ceilings were totally unsatisfactory. The lack of essential classrooms and training aids in this area, and the assignment of similar facilities at Camp Robinson, Ark., brought forth an official protest from The Surgeon General. Expressing a belief that these expedients might jeopardize the Medical Department's chances of obtaining permanent facilities, The Surgeon General warned the Director of Training, ASF, that this places “the Medical Department in the position of qualifying trainees toward

²¹ Annual Report, Medical Replacement Training Center, Camp Barkeley, Tex., fiscal year 1942.

mediocrity rather than balanced training, due to the fact that administrative and occupational specialists cannot be properly trained."²²

The shortage of housing and facilities was aggravated at the end of June 1942 when the center was again ordered to double its capacity. The initial plans for housing the additional 7,000 trainees provided that two battalions would be located to the north of the center in hutments vacated by the 45th Infantry Division, and the remaining five battalions would be placed in a tent camp that was to be erected to the southeast of the original center. Before the tent camp could be completed, however, plans were altered to convert it into a hutment area capable of housing all 7,000 trainees. As a result of changes and delays, this area was not completed in time to house the center's increasing capacity. The additional trainees had to be quartered wherever space was available, often in tents at the construction site, and battalions had to be moved repeatedly to permit the construction of hutments. The problem was further complicated by the expansion of the special training unit which was supposed to contain approximately 350 men but grew to a strength of about 2,000. The center was unable to provide any of the special facilities required for their training. Construction in the hutment area was not completed until January 1943.

Classroom facilities in the new hutment area were barely adequate. When the area was being planned, the center recommended that classrooms be provided at a ratio of one large classroom and two small rooms per battalion and that an additional classroom be provided for the Cooks and Bakers School. It gained approval, however, to construct only 15 small buildings (20 by 136 feet) and four large ones (one RB-1 and three RB-2 buildings). The larger buildings were capable of seating two companies for a lecture or film and one for a demonstration or practical exercise. A company could be squeezed into the smaller classrooms, but the buildings were so long and narrow, and the ceilings so low, that they were little better than hutments.

Camp Barkeley, the first Medical Replacement Training Center to be relieved of its exempted status, was placed under service command control in December 1942.²³ In August 1943, as Camp Pickett was being closed, the training center at Camp Barkeley was assigned responsibility for training Negro troops. During the following year, the number of Negro trainees assigned to the center varied between 1,000 and 1,400. In March 1944, Camp Barkeley was again expanded, this time to a capacity of more than 17,000 trainees. The camp again reported a shortage of housing and serious overcrowding, but no further construction was authorized. In April 1944, the Medical Replacement Training Center was incorporated into the preactivation system and designated an ASF Training Center. The capacity of the center, including units, replacements, and preactivation fillers, was increased to 37,150. The additional trainees were housed in quarters vacated by units of the Army Ground Forces.²⁴

²² Memorandum, The Surgeon General for Brig. Gen. C. R. Huebner, Training Division, Services of Supply, 25 Mar. 1942, subject: Temporary Increase in Training Facilities at Medical Replacement Training Center, Camp Grant, Ill.

²³ Annual Report, Medical Replacement Training Center, Camp Barkeley, Tex., fiscal year 1943.

²⁴ (1) Annual Report, Army Service Forces Training Center, Camp Barkeley, Tex., fiscal year 1944. (2) Annual Report, Army Service Forces Training Center, Camp Barkeley, Tex., 1 July 1944 to 1 April 1945.

When Medical Department training requirements began to decline late in 1944, Camp Barkeley was gradually phased out of the program. In September, the training load was reduced to 24,894, followed in November by a cut of 10,000. As training requirements declined still further, the Army Service Forces decided to consolidate the center at Camp Barkeley with the Signal Corps training center at Camp Crowder. The transfer took place between the 11th and 17th of March, and on 1 April, the center was officially closed. Training at Camp Crowder continued on a reduced scale until early 1946 when the Medical Replacement Training Center was finally deactivated.²⁵

Camp Joseph T. Robinson

By the time the fourth Medical Replacement Training Center was authorized on 20 December 1941, experience gained at Camps Lee and Grant provided the answers to many problems of center activation. The rolling, wooded plateau occupied by Camp Joseph T. Robinson, site of the new center, was ideally suited for basic enlisted training. Trees were scattered throughout the center, and the thick woods surrounding the camp provided areas for outdoor classrooms (fig. 24), field problems, and bivouacs. The sandy soil dried quickly after rains, and the climate permitted year-round training without hardship to trainees.



FIGURE 24.—Open-air classrooms used extensively at Camp Joseph T. Robinson, Ark.

²⁵ Annual Report, Army Service Forces Training Center, Camp Crowder, Mo., for period 1 July 1945 through 26 Feb. 1946.

The area assigned to the medical training center had formerly been occupied by artillery, engineer, and quartermaster units of the 35th Infantry Division. Hard-surfaced roads, gravel walks, and gravel- or clay-surfaced drill fields had been constructed, and there were enough gas-heated, one-story buildings to provide each company with its own messhall, dayroom, and classroom, and each battalion with a recreation building, branch camp exchange, officers' club, and infirmary. Each company was also provided with one outdoor classroom. Since the units for which the area was originally constructed varied in size, the organization and strength of training units had to be adapted to existing utilities. This, however, proved only a minor inconvenience.

On 9 January 1942, an advance party of officers reported at Camp Robinson and began setting up the center. By 15 January, when the center was activated, departments were organized, buildings were allotted, and supplies were being requisitioned. About 50 percent of the initial officer cadre arrived on the day the center was activated, along with a complement of enlisted cadre sent by Camp Lee. Enlisted cadre from Camps Grant and Berkeley reported a few days later. The first contingent of trainees arrived on 4 February 1942, and by 23 February, 5,508 men were enrolled for training.

The first trainees were housed in tents and shifted to hutments as rapidly as they could be constructed. By 15 August 1942, the transition had been completed. A steady stream of supplies and equipment flowed into the center, allowing training to proceed without interruption. Aside from needing more vehicles to perform routine administrative duties, such as drawing rations and distributing supplies, the center did not report any major problems.

Between February 1942 and October 1943, seven training cycles were completed at Camp Robinson. The center reached its peak capacity on 23 July 1942 when it was authorized to enroll approximately 7,000 trainees per cycle. During the following year, enrollment ranged between 5,000 and 7,000. On 24 June 1943, the center was notified that it was to be phased out of the program. On 14 October 1943, after the last battalion graduated, the Medical Replacement Training Center at Camp Robinson was officially deactivated.²⁶

Camp Ellis

On 1 February 1943, Camp Ellis was activated and designated as an ASF unit training center. Initially, the post served as a center for training units of the Quartermaster Corps, the Corps of Engineers, the Signal Corps, and the Medical Department. After the preactivation system was established, Camp Ellis also served briefly as a replacement training center. Under the new program, medical trainees assigned to Ellis were assigned to the 30th, 31st, and 32d Medical Training Regiments for 6 weeks of basic military training under ASF programs at facilities controlled by the post commander. After completing this phase, they were transferred to the 28th and 29th Medical Training Regiments, activated on 23 June 1944 under

²⁶ (1) Annual Report, Medical Replacement Training Center, Camp Joseph T. Robinson, Ark., fiscal year 1942. (2) Annual Report, Medical Replacement Training Center, Camp Joseph T. Robinson, Ark., fiscal year 1943.

the control of the medical group, for technical and tactical training under Medical Department programs. On 10 November 1944, the 28th Medical Training Regiment was disbanded, followed on 16 December by the 29th. During this period, the two units were each able to complete two 8-week training cycles, and a total of 15,531 men were trained.²⁷

MOBILIZATION TRAINING PROGRAMS

From the beginning of limited mobilization to the end of World War II, nine major mobilization training programs governed the training of Medical Department enlisted men.²⁸ As the war changed complexion and generated fresh requirements, the length, scope, and mission of basic training programs had to be adjusted to strike a new balance between objectives and resources, and incorporate the lessons of combat.

Mobilization Training Program No. 8-1 (9 September 1940)

When war broke out in Europe in September 1939, Medical Department basic training was governed by a program issued in 1935 for use by medical regiments supporting infantry divisions. As the war in Europe intensified, the Medical Department began to prepare a program for enlisted training, and on 9 September 1940, MTP (Mobilization Training Program) No. 8-1 was published.²⁹ In contrast to its predecessor, the program provided guidelines not only for training units but also for training individuals who were destined to become fillers in newly activated units. This combination of unit and individual training was designed to meet the requirements of an expanding army in which field medical units needed to support newly activated combat divisions, as well as training centers, would be receiving raw recruits and draftees.

Under MTP No. 8-1, enlisted men were to receive 13 weeks of basic training. As in the plan of 1935, the training cycle was divided into two phases: The first, a period of basic military training; and the second, a period of basic technical and tactical training. After 2 weeks of basic military training at the beginning of the cycle, the trainee was expected to be able to display and care for his uniform and equipment, to understand military courtesy, and to have acquired a fundamental knowledge of such basic military subjects as individual defense and march discipline.

The third to 13th weeks of the program were devoted to basic technical and tactical training. Training in basic military subjects continued, but after the second week of the cycle, the program stressed basic technical subjects that would

²⁷ Annual History of Headquarters Medical Group for 1944, 1644th Service Unit, Camp Ellis, Ill.

²⁸ (1) Mobilization Training Program No. 8-1, 9 Sept. 1940. (2) Mobilization Training Program No. 8-5, 5 Aug. 1941. (3) Mobilization Training Program No. 8-5, 17 Nov. 1941. (4) Mobilization Training Program No. 8-5, 2 Jan. 1942.

²⁹ This program superseded all similar programs distributed with cover letter, Gen. Douglas MacArthur, Chief of Staff of the Army, 1 Aug. 1935, subject: Sixteen-Week Training Schedule Effective Upon Mobilization (Medical Regiment).



FIGURE 25.—Trainees set up and operate an aid station as part of their tactical training at Camp Grant, Ill.

prepare men either for specific duties or for further training at a medical unit or installation (fig. 25). During this period, men were also trained to march and execute tactical movements, to establish and operate battalion or regimental dispensaries, and to maneuver with the combat arms in the field.

At the same time, men selected to become common or administrative specialists were trained at schools established at a center. The range of common specialists to be trained was limited to clerks, mess sergeants, and cooks. The program was vague as to the means by which common specialists would be trained and the amount of training required. Commanders were simply notified that a training requirement existed and were allowed a high degree of autonomy in establishing procedures.

Individuals qualified to be trained as technicians were selected at the end of the fourth, eighth, and 12th week of the cycle and sent to Medical Department special service schools or to enlisted technician schools for 8 to 12 weeks of technical training.

Since the first increments of trainees sent to Medical Replacement Training Centers were earmarked for assignment to specific units, the centers organized them in groups that could be provided with special training. Trainees being ordered to numbered general hospitals, for example, were assigned to one battalion, and



FIGURE 26.—Class for clerk-typists at a common specialists school, Camp Pickett, Va.

those being assigned to numbered station hospitals or evacuation hospitals were assigned to still other battalions. Through this kind of grouping, battalion commanders were able to tailor the program to the trainee's assignment.

Mobilization Training Program No. 8-5 (5 August 1941)

By mid-1941, the Medical Department was able to turn its attention from the training of selectees earmarked for units activated under the limited mobilization of September 1940 to the training of individual fillers and replacements. On 5 August 1941, the program issued in September 1940 was superseded by MTP No. 8-5, which focused exclusively on the training of individuals. The new program retained the 13-week cycle, and provided 2 weeks of basic military training, 8 weeks of basic technical training, and 3 weeks of basic tactical training. These periods remained essentially unchanged. There were slight variations in the number of hours allotted to each subject but none of major significance.

In contrast to its predecessor, MTP No. 8-5 emphasized the training of common and administrative specialists. In addition to training clerks (fig. 26), cooks, and mess sergeants, centers were authorized to provide courses for shipping and

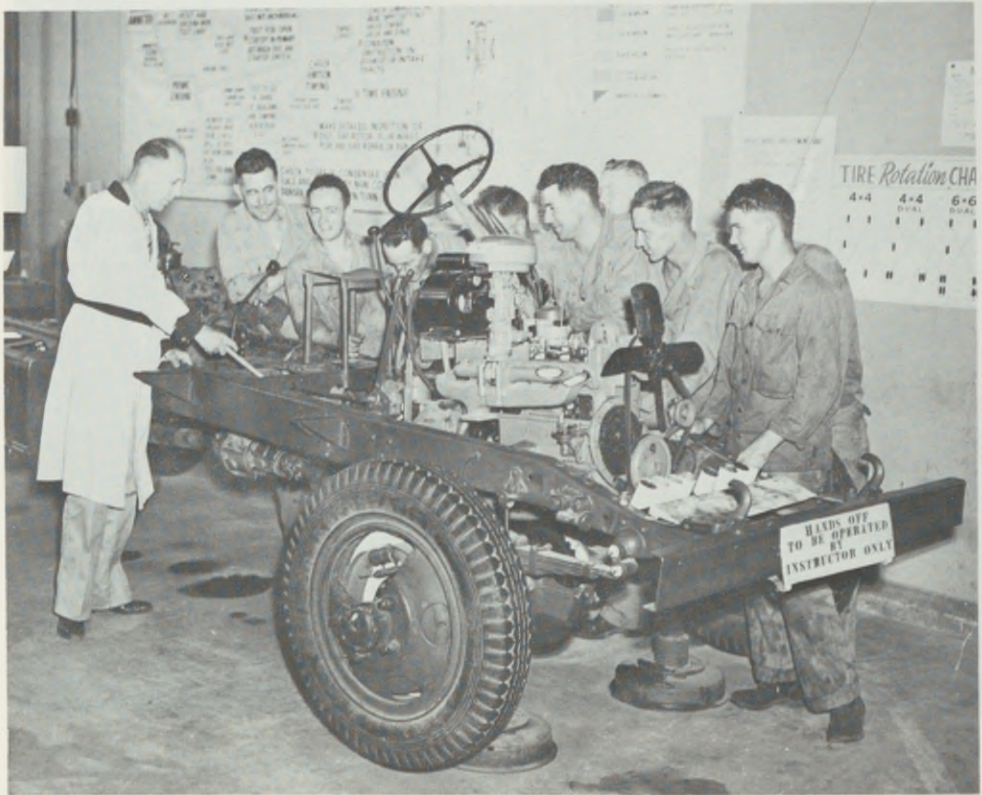


FIGURE 27.—A class for motor mechanics at Camp Barkeley, Tex., in 1943.

receiving clerks, supply sergeants, bandsmen, truckmasters, mechanics (fig. 27), truckdrivers, and motorcyclists. Common specialties were more clearly defined, and training procedures for specialists were more precisely formulated. The program also authorized the centers to provide special training for junior medical and surgical technicians (fig. 28). Such technicians were to be trained to fill an intermediate level of specialization between basic medical soldiers and the graduates of enlisted technicians schools. Soldiers trained through these programs were not considered eligible for a rating higher than fifth class.

Mobilization Training Program No. 8-5 (17 November 1941)

The accelerated pace of unit activation in the fall of 1941, after Congress voted to extend the tours of men on active duty and continue selective service for an additional year, produced a demand for basic soldiers and common specialists beyond the capacity of existing training centers. This demand could be filled in one of two ways: by expanding existing centers and activating new ones; or by shortening the



FIGURE 28.—Unrated surgical technicians view a demonstration of operating room procedures with a simulated patient during training conducted by the Medical Training Section, Fort Lewis, Wash., in 1944.

training cycle. In November 1941, the Army adopted both techniques. On 1 November, the third Medical Replacement Training Center was activated at Camp Barkeley, and on 17 November, a new mobilization training program was put into effect which shortened the training cycle to 11 weeks. As in previous programs, 2 weeks were allotted for basic military training, and 3 weeks for basic tactical training. The time devoted to technical training, however, was reduced from 8 to 6 weeks. The reduction was achieved by decreasing the time devoted to each subject in the program.

Mobilization Training Program No. 8-5 (2 January 1942)

The pace of unit activation was even further accelerated after the United States entered World War II. To meet the demand for trained medical soldiers and common specialists, the fourth Medical Replacement Training Center was activated at Camp Joseph T. Robinson, and the capacity of existing centers was expanded. At the same time, the period of basic training for fillers and replacements was reduced to 8 weeks. Under the 8-week training program, Medical Replacement Training Centers continued to provide recruits with 2 weeks of basic military training, but the technical training phase was shortened from 6 to 4 weeks, and the tactical

phase was reduced by a week. Specifically, the program was shortened by decreasing the time devoted to subjects such as interior guard, drill, marches and bivouacs, physical conditioning, anatomy and physiology, field sanitation, medical aid, night combat, and the technical and tactical employment of arms.

Mobilization Training Program No. 8-5 (1 August 1943)

Between January 1942 and August 1943, two additional programs governed basic training at Medical Replacement Training Centers.³⁰ The first, issued on 15 November 1942, when the pace of unit activations was beginning to decline, returned the centers to an 11-week training cycle. The second, published on 12 May 1943, restored an additional week to the program.

While these changes were taking place, the Allied war effort moved from the defensive to limited offensives in North Africa and the South Pacific, and combat tests of the training provided Medical Department enlisted men produced changes in organization and doctrine. On 1 August 1943, when training requirements were



FIGURE 29.—Trainees negotiating the obstacle course at Camp Pickett, Va., under live machine-gun fire.

³⁰ (1) Mobilization Training Program No. 8-5, 15 Nov. 1942. (2) Mobilization Training Program No.8-5, 12 May 1943.

at an ebb, a new training program was published that reflected both the reduced demand for fillers and lessons learned in combat.

Under the new program, trainees were provided with 17 weeks of basic training: 6 weeks of basic military training, followed by 8 weeks of technical and tactical training, and 3 weeks of intensive field training. Experience in the theater was reflected by the addition of subjects such as hand-to-hand combat, demolition, boobytraps and mines, infiltration, village fighting, and knots and lashings. Commanders were urged to move trainees into the field whenever possible and to train them under simulated combat conditions (fig. 29).

Mobilization Training Program No. 8-1 (1 June 1944)

On 15 April 1944, training centers under the jurisdiction of Army Service Forces were revamped to shift emphasis from training fillers for newly activated units to providing replacements for units in the theater.³¹ Before this revision, ASF medical units were activated wherever adequate housing and training facilities were available. While units were supposed to be assigned fillers who were graduates of replacement training centers, they were frequently required to provide basic training for a few who were shipped directly from reception centers. This burden grew heavier after October 1943, when the capacity of the Medical Replacement Training Centers was reduced to the point that only replacements could be trained. By this time, Camps Pickett and Robinson had been deactivated, and the flow of trainees through Camps Barkeley and Grant was reduced to a prescribed number of replacements. Medical Replacement Training Centers could no longer serve as "feeder belts" providing trained enlisted men to newly activated units, and units were required to assume almost the entire burden of conducting basic military and technical training.

In April 1944, the Army Service Forces attempted to eliminate this problem by transforming Medical Replacement Training Centers into ASF Training Centers. Under their new designation, training centers were to act as "collecting points" for the training of all medical personnel and units and as "pools" providing units with trained enlisted men.

The men assigned to the center for basic training were to include the following: Selectees from reception centers, surplus personnel from service command or Zone of Interior installations, surplus personnel from table-of-organization units and deactivated units, designated personnel from the Army Specialized Training Program, men from War Department reassignment centers who required retraining, and unassigned personnel from ASF schools and general hospitals. ASF Training Centers, in turn, were to train these men for assignment as loss replacements, rotational replacements, cadre, and fillers for ASF table-of-organization units and Zone of Interior installations. Centers were required to keep 95 percent of their trainees available for assignment as replacements. Whenever the number available fell below 95 percent of the input allotment, enlisted men being trained for other purposes had to be reassigned.

³¹ Army Service Forces Circular No. 104, 15 Apr. 1944.

On 1 May 1944, the Army Service Forces issued MTP No. 21-3 which governed the training of all male enlisted personnel under its jurisdiction. The ASF program continued the 17-week cycle established by MTP No. 8-1 on 1 August 1943: 6 weeks of basic military training, followed by 8 weeks of basic tactical and technical instruction, and concluded by 3 weeks of basic team training. For the first time, however, the programs controlling basic military training, and the technical training of nonmedical common specialists, were standardized throughout the Army Service Forces. In sum, the Army Service Forces took over the responsibility for writing training programs for common specialists such as mechanics, drivers, and cooks, and the Medical Department was limited to writing programs for such medical specialists as sanitary and veterinary technicians. The framework of documents governing the system was completed when a Medical Department program for the training of units and medical common specialists was published on 1 June 1944.³²

Under the standardized basic program prescribed by Army Service Forces, Medical Department enlisted men were required to participate in 96 hours of training in the use of weapons, including the rifle, the carbine, the bayonet, and grenades.³³ Field training was increasingly emphasized, and commanders were urged to conduct as many night exercises as possible. During the last year of the war, emphasis was placed on conditions likely to be encountered in the Pacific, and information from that theater was made available to all training centers, regardless of whether it conformed to doctrine.³⁴

After completing their basic military training, most enlisted men were required to participate in some form of technical training. The new system, however, had greater flexibility than the one it replaced. Men who were disqualified for overseas assignment were given as much basic military and technical training as they were capable of absorbing, and those who possessed usable occupational skills could be assigned appropriate duties after their basic military training. Men selected for training as enlisted technicians, who formerly would have been assigned to a unit or installation after graduating from Medical Department Enlisted Technicians Schools, were returned to the training center and credited with completing the technical phase of instruction.³⁵ At the end of this phase, all men were required to complete 3 weeks of unit or team training.

While the program at ASF Training Centers was established primarily to train enlisted replacements, it was also used to guide the training of fillers and cadre for Medical Department units being activated under ASF control. Men earmarked as fillers and cadre were separated from the basic training program at the end of the 14th week of the cycle, along with men who had completed their training for enlisted technicians schools, and assigned to units scheduled for activation at the centers. When such units were activated, they were required to complete 3 weeks of field training comparable to the team training phase of the replacement program,

³² Mobilization Training Program No. 8-1, 1 June 1944.

³³ Mobilization Training Program No. 21-3, 1 May 1944.

³⁴ Memorandum, Lt. Col. Charles H. Moseley, MC, Deputy Director, Training Division, Office of The Surgeon General, to Commanding General, Army Service Forces Training Center, Camp Grant, Ill., 15 July 1944, subject: Information From the Field.

³⁵ See footnote 33.

and 3 weeks of special unit training. Because of its special provisions for training units, the program was commonly referred to as "preactivation training" or the "preactivation system."

As the war entered its final phases, the program at ASF Training Centers was revised to provide even greater flexibility. Medical sections of ASF Training Centers were receiving enlisted men from a variety of sources, and constant adjustments were necessary to provide each man with training suited to his needs. Enlisted men sent to medical training centers from other arms or services, for example, usually did not need to repeat the basic military phase of the program. By the same token, many Medical Department technicians who were being sent overseas as loss replacements after long periods of service in the Zone of Interior needed only military and team training. These were only minor problems, however, compared to those encountered in the retraining of enlisted men who were returning from duty overseas. Frequently, such men had more experience than their instructors and were inclined to take a dim view of anything that smacked of basic training.

On 5 February 1945, the War Department took an important step toward increasing the flexibility of the system by urging commanders at all echelons to give personal attention to the training and assignment of men who had returned from the theaters. Commanders were reminded of their responsibility for evaluating the background, experience, and physical and mental capacity of enlisted men before committing them to a program of training. In addition, the War Department made it clear that soldiers with combat experience did not automatically have to satisfy requirements written into programs for newly inducted trainees. Men who had been returned to the Zone of Interior for redeployment were to be trained separately from inexperienced replacements, so they would not feel that they were repeating basic training.

Mobilization Training Program No. 8-1 (15 April 1945)

Special retraining programs for enlisted men were formally established by a revised basic military training program published by the Army Service Forces on 10 March 1945 and by a Medical Department technical and team training program issued on 15 April.³⁶ Under these procedures, ASF Training Centers were required to screen the records of men sent for retraining and evaluate each individual's qualifications. Men who had completed mobilization training at an Army Service Forces or AGF (Army Ground Forces) training center, or who had participated in redeployment training within 6 months before being transferred to the Army Service Forces, were exempted from further basic military training. Men who could not satisfy these qualifications, and those who had been trained at AAF (Army Air Forces) training centers, were required to complete basic military refresher courses. The qualifications of men from both groups were then evaluated to determine whether they should be retained at the center for technical and team training, or

³⁶ (1) Mobilization Training Program No. 8-1, 15 Apr. 1945. (2) Mobilization Training Program No. 21-4, 10 Mar. 1945.

assigned directly to a unit or Zone of Interior installation. The program for newly inducted trainees remained unchanged.

The revised mobilization training programs also allowed the Medical Department to regain control over the training of all its common specialists. Courses for these specialists, and all other enlisted men trained by the Medical Department, were refocused to prepare trainees for service in the Pacific theater. Special training was provided, for example, in the prevention and control of tropical diseases such as malaria, dengue, filariasis, typhus, and plague. Periods were also set aside for instruction in subjects such as the protection of equipment from moisture and fungus, stream crossing, and the identification of Japanese uniforms and equipment. Emphasis on realism, field experience, and night training reached its wartime peak.

By the end of World War II, a highly flexible and refined system had been developed for training Medical Department enlisted men. Training cycles could be lengthened or shortened to meet the demand of the moment, and course content could be adjusted to meet the needs of the theater. Individual and unit training had been linked together under the preactivation system, and many of the problems of unit activation had been minimized. Finally, a working system was developed for retraining men who were being rotated to and from the Zone of Interior.

TRAINING PROGRAMS FOR ARMY AIR FORCES ENLISTED PERSONNEL

Until the reorganization of the War Department in 1942, enlisted medical personnel serving in the Army Air Corps received their basic training at Medical Replacement Training Centers along with men scheduled for assignment to all other components of the Army. Requisitions for personnel required by Army Air Corps units and installations were submitted to the War Department, which allocated the output of centers on the basis of need. In November 1941, for example, the Chief of Staff approved a plan that required the Medical Department to provide the Army Air Corps with 11,282 white and 844 Negro medical soldiers by the end of February 1942. Approximately two-thirds of these men were to be provided by Medical Replacement Training Centers, and the balance were to be reassigned from medical units.³⁷

During the reorganization of 1942, responsibility for training men assigned to ASWAAF (Arms and Services With the Army Air Forces) was transferred to the Air Forces. For several months after the reorganization, the War Department assigned arms and services personnel trained by the Army Service Forces to the Army Air Forces by redesignating replacements who were not needed in the theater as fillers. Army Service Forces could not hope to fill AAF requirements through this system, however, since the War Department refused to allow further expansion of its already strained facilities, and the Air Forces would not allow trainees earmarked for Army Air Forces to be diverted through ASF centers. By August 1942, Army Air Forces was reporting a shortage of more than 97,000 ASWAAF fillers. When the Chief of Staff of the Army Air Forces, Maj. Gen. (later Lt. Gen.) George

³⁷ Memorandum, Lt. Col. C. H. Karlstad, GSC, Chief, Mobilization Branch, for Chief, Operations Branch, 26 Nov. 1941, subject: Personnel for Arms and Services with the Army Air Forces.

TABLE 10.—Output of Medical Replacement Training Centers, 1942-45

Trained personnel	Fiscal year 1942	Fiscal year 1943	Fiscal year 1944	Fiscal year 1945	Total
Medical Replacement Training Centers:¹					
Camps Lee and Pickett.....	39,492	44,922	8,903	-----	93,317
Camp Grant.....	26,566	31,672	21,323	-----	79,561
Camp Berkeley.....	11,322	45,256	21,320	-----	77,898
Camp Robinson.....	2,384	36,325	4,081	-----	42,790
Total.....	79,764	158,175	55,627	-----	293,566
Men shipped to Enlisted Technicians Schools, discharged, and so forth².....					
	(3)	³ (21,259)	37,459	-----	37,459
Total.....	79,764	158,175	93,086	-----	331,025
Common or occupational specialists.....	14,615	41,957	14,588	9,368	80,528
Preactivation, loss, rotational, and others ⁴				40,482	40,482
Grand total.....	94,379	200,132	107,674	49,850	452,035

¹ Basically trained Medical Department enlisted men.

² Of this number, approximately 58,718 were sent to Enlisted Technicians Schools, 4,534 to Army Specialized Training Units, and others to Officer Candidate Schools just before, or soon after, completion of basic training.

³ Included in total figure immediately above.

⁴ Includes personnel trained under Army Service Forces Circular No. 104, 15 Apr. 1944.

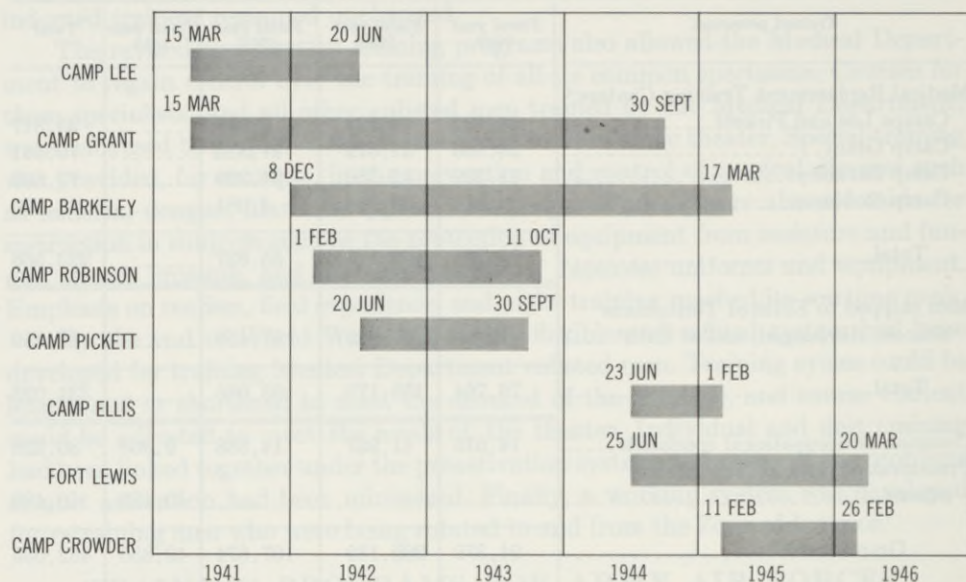
Sources: (1) Annual Report, Training Division, Office of The Surgeon General, fiscal year 1944. (2) Annual Report, Training Division, Office of The Surgeon General, fiscal year 1945.

E. Stratemeyer, complained to War Department General Staff, G-3, on 3 October 1942, that Army Service Forces had failed to provide Army Air Forces with an adequate number of enlisted men, and demanded authority to establish AAF training programs for arms and services personnel, the Director of Training, ASF, pointed out that such training had been an Air Forces responsibility for more than 5 months, and agreed that Army Air Forces should, indeed, establish training programs.³⁸ For the remainder of the war, medical soldiers serving with the Army Air Forces were provided with basic training centers under adaptations of technical training programs designed by the Medical Department. The Surgeon General continued to coordinate all training policies, plans, and activities within Army Service Forces, Army Ground Forces, and Army Air Forces, and to train replacements and fillers for Army Ground Forces and Army Service Forces.³⁹

³⁸ (1) Memorandum, Maj. Gen. George E. Stratemeyer, Chief of the Army Air Forces, for Chief of Staff, 3 Oct. 1942, subject: Assumption of Responsibility for Training ASWAAF Personnel by AAF. (2) Memorandum, Brig. Gen. C. R. Huebner, Director of Training, Services of Supply, for Commanding General, Army Air Forces, 7 Oct. 1942, subject: Assumption for Training ASWAAF by the AAF.

³⁹ (1) Annual Report, Training Division, Operations Service, Office of The Surgeon General, fiscal year 1943. (2) Memorandum, Maj. William A. Moore, MC, to Col. Wood S. Woolford, MC, Acting Air Surgeon, 4 Dec. 1942, subject: Training of Medical Department Enlisted Men. (3) Memorandum, Maj. William A. Moore, MC, to Col. Wood S. Woolford, MC, Acting Air Surgeon, 9 Dec. 1942, subject: Report of Conference on Training at Hq. T.T.C., Knollwood Airport, Southern Pines, N.C. (4) Letter, Col. Wood S. Woolford, MC, Acting Air Surgeon, to Director of Individual Training, Headquarters, Army Air Forces, 11 Dec. 1942, subject: Basic Medical Training for Medical Department Enlisted Men at Basic Training Centers of the Air Force Technical Training Command.

CHART 3.—Periods of training, Medical Replacement Training Centers, 1941-46



Source: Goodman, Samuel M.: Charts on Emergency Training Agencies and Courses. Volume X. [Official record.]

OUTPUT OF MEDICAL REPLACEMENT TRAINING CENTERS

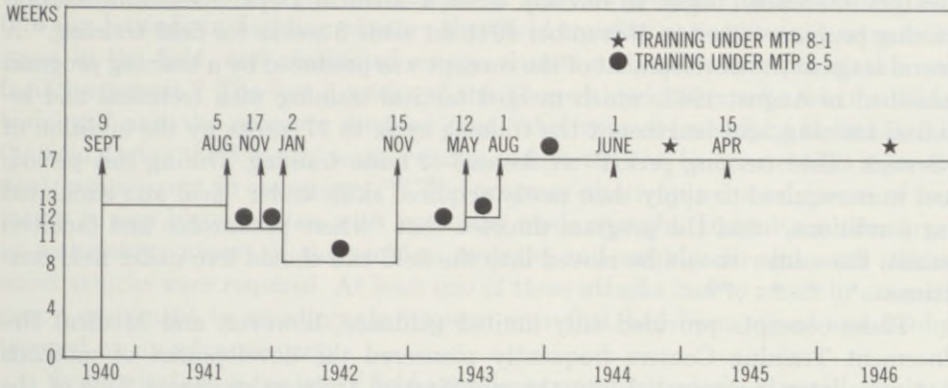
The rate at which the Medical Department was able to train fillers and replacements was governed by three major factors: (1) The supply of trainees provided by induction centers; (2) the combined capacity of the centers per cycle, usually expressed in terms of housing; and (3) the length of the training cycle. In the course of World War II, each of these factors had to be adjusted to enable the Medical Department to meet War Department training quotas. For more than a year after the first training centers were established, for example, Medical Replacement Training Centers were unable to come to capacity training levels because reception centers could not fill their quotas. The trainees who were shipped were usually behind schedule, producing a lag between cycles and idle capacity.⁴⁰ It was not until mid-1942 that training centers reported a relatively constant flow of inductees from the reception centers.

The output of Medical Replacement Training Centers was most frequently altered by adjustments in the length of the training cycle. Output per cycle could be increased only by providing additional facilities, and construction could not keep pace with demand. By shortening the training cycle, however, the War Department could increase the number of cycles in any given period.

The interaction of physical capacity and cycle length can be illustrated by a comparison of the Medical Department's annual training capacity in mid-1942

⁴⁰ Annual Report, Medical Replacement Training Center, Camp Grant, Ill., fiscal year 1941.

CHART 4.—Length of training cycles, Medical Replacement Training Centers, 1940-46



Source: Goodman, Samuel M.: *The Training of Replacements, Fillers, and Cadres, 1939-1945*. Volume V. [Official record.]

and mid-1943. On 30 June 1942, Medical Replacement Training Centers had a combined capacity for training 36,000 enlisted men every 10 weeks, or an annual capacity for training 187,200.⁴¹ By June 1943, these centers were capable of training more than 44,349 enlisted men per cycle. At this point, however, the length of the cycle had been increased by 4 weeks, and the annual capacity was reduced to 164,091.⁴² The reverse effect was produced whenever the cycle was shortened. The annual output of training centers, the length of the training cycle, and the centers in operation during World War II are illustrated in table 10 and charts 3 and 4.

TRAINING PROCEDURES

Three parallel trends are evident in the development of procedures for training Medical Department soldiers: ever greater "realism," increased emphasis on the principle of "learning by doing," and continuous growth in the amount of time devoted to field problems. These trends developed, in part, through changes in the mobilization training programs, but they were shaped as well by developments at the Medical Replacement Training Centers and the Office of The Surgeon General.

Field Training

Changes in the mobilization training programs guiding the training of enlisted men provide an index to trends in Medical Department training procedures. The first mobilization training programs did not set aside an unbroken period for field exercises. Subjects included in the tactical phase of training were simply enumerated, and the individual training centers were allowed to determine how and where the subjects would be taught.⁴³

⁴¹ Annual Report, Training Division, Operations Service, Office of The Surgeon General, fiscal year 1942.

⁴² See footnote 39 (1), p. 199.

⁴³ See footnotes 28 (1) and (2), p. 189.

The concept of a tactical training period "largely devoted to field and applicatory exercises" began to develop when a Medical Department mobilization training program issued in November 1941 set aside 3 weeks for field training.⁴⁴ A second stage in the development of the concept was produced by a training program published in August 1943, which merged tactical training with technical and logistical training, and lengthened the training cycle to 17 weeks by the addition of a 3-week "field training period" at the end of basic training. During this period; men were required to apply their newly acquired skills under "field and simulated war conditions," and the program directed that "where practicable and facilities permit, the soldier should be moved into the field and should live under field conditions * * *."⁴⁵

These concepts provided only limited guidance, however, and Medical Replacement Training Centers frequently pioneered the development of methods that were later incorporated into the mobilization training programs. One of the first steps was taken at Camp Lee, where a specially designed orientation program dramatically presented the mission of the Medical Department to trainees a few days after their arrival. Unaware of their destination, trainees were marched under cover of darkness to a natural amphitheater in the woods, where they watched the staging of a mock battle in which aidmen moved forward to treat simulated casualties. Sound effects were provided by dynamite blasts and amplified recordings of bombs, artillery, and small arms fire, and while the cast played its part, a narrator indoctrinated trainees in the combat mission of medical soldiers.⁴⁶ When Camp Robinson adopted this technique, attacks by low flying aircrafts and chemical attacks with smoke and tear gas were added to the simulated battle conditions. Camp Robinson also constructed an infiltration course before one was required in medical programs, so that trainees could practice emergency treatment and evacuation of casualties under enemy observation and fire.⁴⁷

The emphasis on field training was carried still further at Camp Barkeley in 1942 and 1943, when each battalion was required to complete a 5-day field exercise at the end of the training cycle. During this period, the battalion marched to a maneuver area, set up field kitchens, slept in shelter tents, and functioned as regimental medical detachments, or as medical battalions responsible for operating aid stations, collecting stations, and clearing stations. Simulated casualties of all types were used to provide experience in diagnosis, treatment, and the transportation of patients in the field. Emphasis was placed on the selection of sites; camouflage; cover and concealment; individual security; defense against air, mechanized, chemical, and airborne attacks; the care and handling of equipment; and personal hygiene and sanitation. During the course of the problem, trainees were rotated so that each man assisted in the operation of each type of station. All trainees, whether they were basic medical soldiers or common specialists such as motor mechanics, chauffeurs, and cooks, were required to participate in the exercise.⁴⁸

⁴⁴ See footnote 28 (3), p. 189.

⁴⁵ Mobilization Training Program No. 8-5, 1 Aug. 1943 (Tentative).

⁴⁶ (1) See footnote 8, p. 175. (2) Letter, Brig. Gen. W. R. Dear, Medical Replacement Training Center, Camp Pickett, Va., to Col. Frank B. Wakeman, MC, Office of The Surgeon General, 11 Nov. 1942.

⁴⁷ See footnote 26 (2), p. 188.

⁴⁸ Annual Report, Army Service Forces Training Center, Camp Barkeley, Tex., fiscal year 1944.

Wartime trends in technique reached their culmination on 15 April 1945, when the final program of the war was published. The new program denied training centers any latitude in deciding whether the "field training period" would actually be spent in the field, and eliminated escape clauses such as "where practicable and facilities permit." The last 3 weeks of the 17-week cycle were set aside for "team training," and the program directed that "the trainees [would] be bivouacked in the field during the 3 weeks' team training and [would not] be quartered in a permanent camp except in emergency."⁴⁹ The program also required a minimum of four moves to new bivouac sites, with two being made at night. Instructors were urged to make every aspect of the problem realistic, and surprise air, gas, and mechanized attacks were required. At least one of these attacks had to result in an emergency movement to an alternate bivouac area that had been mined and booby-trapped by an advance party.

Improvisation in the use of field expedients was particularly stressed. Trainees were required to mess on emergency field rations for at least 48 hours, and dehydrated foods were prepared for other meals. During these periods, the unit was not allowed to operate a field mess. Maneuvers were not to be halted merely because they interfered with a scheduled meal. Trainees were expected to perform for long periods under continuous pressure and to exert maximum effort for short periods.

To produce these effects, a master field problem encompassing the medical support of an infantry division was incorporated into the training program. The problem was designed for one training battalion and required a maneuver area with sufficient depth and frontage to permit the installation of medical units performing first and second echelon evacuation. During the first of four phases of the problem, one company of the training battalion acted as infantry, while a second played the part of medical detachments supporting infantry regiments. A third company was cast in the role of a collecting company, and the fourth acted as a clearing company. Each training company was called upon to select sites, set up its equipment, and function as it would in combat. At the end of each period, the companies were rotated, and the trainees changed jobs, so that every man would have an opportunity to practice a job in each unit. Specialists such as mechanics, truckdrivers, clerks, and medical technicians performed the job for which they were being trained.

At the beginning of the problem, the unit received a complete written field order covering the first period of operation. Trainees were then marched from the camp to bivouac areas under simulated combat conditions. Front and rear guards were posted, and march discipline was enforced. The problem opened with an attack in which trainees became simulated casualties and were given emergency medical treatment by other trainees acting as company aidmen. Treatment at this echelon consisted of controlling hemorrhage, treating shock, applying improvised or issued splints, bandaging, giving plasma, and preparing slings. Litter bearers then evacuated casualties to the battalion aid station where they were checked and given additional treatment. After treatment, records were initiated, and casualties were sorted for further evacuation. Collecting company litter bearers evacuated casualties to a collecting station, where more elaborate treatment was provided,

⁴⁹ Mobilization Training Program No. 8-1, 15 Apr. 1945.

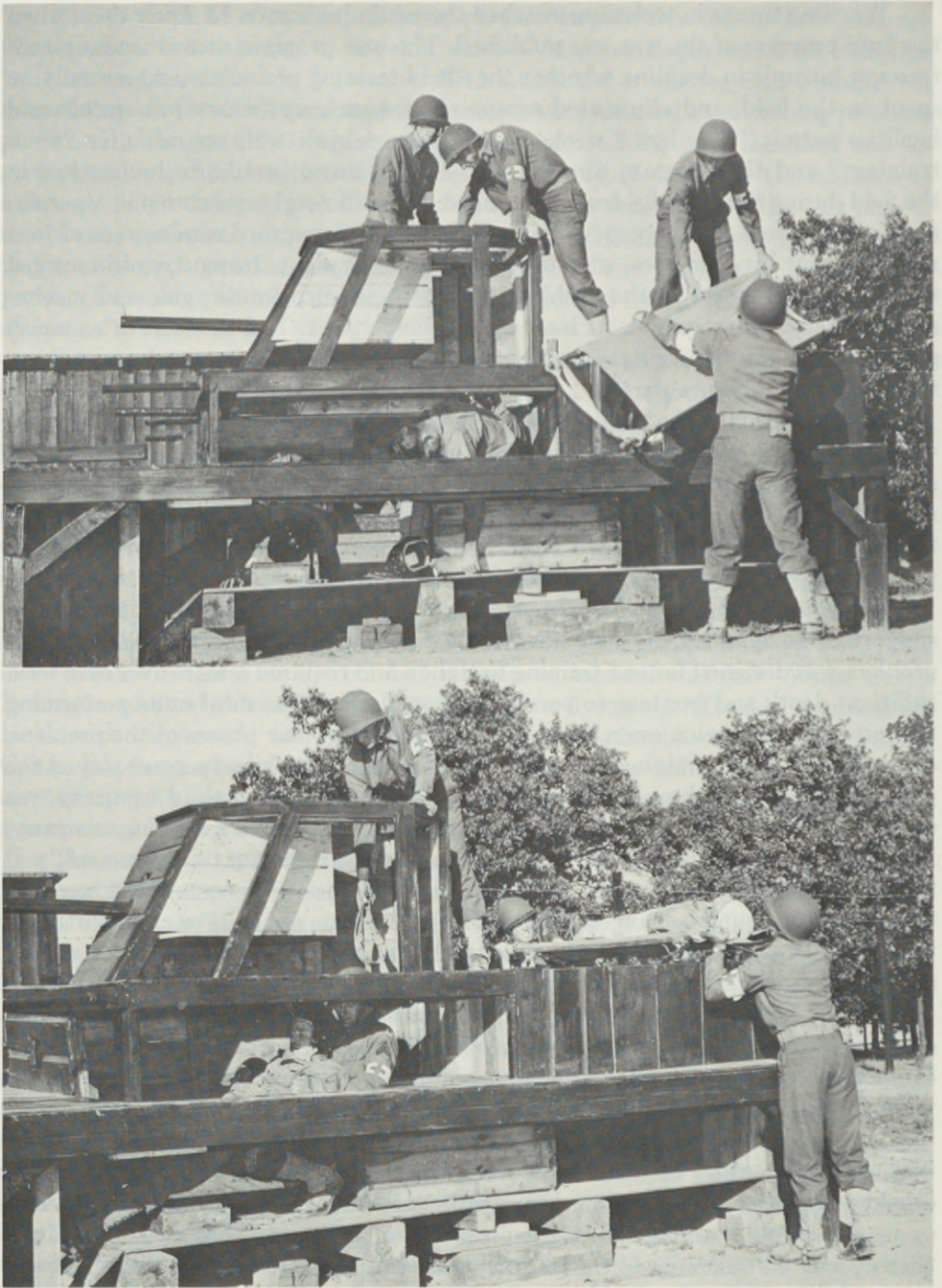


FIGURE 30.—See legend on opposite page.



FIGURE 30.—Trainees at Camp Joseph T. Robinson, Ark., learn to evacuate wounded men from tanks by practicing on wooden models.

and the system of property exchange was put into operation. After being treated at the collecting station, casualties were evacuated by ambulance to a clearing station, where additional treatment was provided, and mock surgical operations were performed. After additional records had been initiated and an emergency medical tag had been filled out, the problem was terminated.

While the maneuver was in progress, instructors were required to provide close supervision and make on-the-spot corrections of errors. Trainees were expected to handle casualties by approved techniques and to use field expedients whenever patients had to be transported over difficult terrain. Commanders were encouraged to add any difficulty they thought might be encountered in combat to the program.

Training Aids

The use of training aids to provide vicarious experience grew apace with emphasis on "realism" and "learning by doing." In the early years of the war, training centers had to rely almost exclusively on their own resources. Higher authorities usually confined themselves to preparing manuals and rationing supplies needed for the program. Medicines and equipment were in such short supply that the pace of training could often be maintained only by rotating them between battalions. Training sets were few in number, and those that were issued to the centers frequently had to be adapted to uses for which they were not originally intended.

Under these conditions, centers had to devise their own training aids. Every center contained a carpentry shop and an art shop that could be turned to the task, and these shops produced a wide range of devices, some of which were later perfected and issued as standard training equipment. At Camp Lee, for example, skilled enlisted men made plaster casts of the body, and painted them to show all types of fractures and injuries. Cross-sectional models were similarly constructed to show the location of muscles and organs. Store mannequins were used to depict war scenes, and puppet shows were occasionally used to illustrate lessons in military courtesy. At some centers, miniature battlefields were constructed to demonstrate the deployment of medical installations in combat. Murals designed to impress the medical soldier with the importance of his mission were painted in dayrooms, recreation buildings, and other areas where trainees gathered, and posters were used to reinforce this indirect indoctrination. Terrain features such as streams and lakes were employed not only to train men in methods of transporting the wounded over water barriers but also to train them in the use of landing nets and in methods for boarding and disembarking from transport vessels.⁵⁰ Mock hospital trains, tanks (fig. 30), and C-47's were also constructed at the centers to provide equipment for training in the evacuation and transportation of the wounded.

In mid-1942, the Surgeon General's Office began to take a more active role in the development of training aids. A set of three-dimensional training aids and rubber moulages designed by the Training Division were used extensively to orient trainees to the wounds they would encounter in combat. The Training Division also made a large number of graphic materials available, including training films, filmstrips, and still prints, and a series of sketches on first aid.⁵¹ When medical supplies became available for training purposes, the Training Division recommended that first aid packets be distributed to enlisted men so that exercises in the use of the packet could be incorporated into all basic training programs. By the end of the war, the Surgeon General's Office had also developed a training set for use in teaching the administration of blood plasma and a simulated morphine Syrette.

By mid-1944, when the Medical Replacement Training Centers were integrated into ASF Training Centers, the supply of training equipment had increased to the point that units undergoing preactivation training could be provided with a substantial portion of the equipment they would use in the theater of operations. Individuals and units were no longer trained to use equipment they saw only in diagrams. At each center, a field hospital was permanently set up for use in demonstrations, and on two occasions, hospital trains were routed through the centers so they could be examined by trainees.⁵² During the last year of the war, training aids were available to supplement almost every phase of instruction.

CADRE AND STAFF TRAINING

Medical Replacement Training Centers were plagued by cadre problems throughout World War II. Inadequate numbers, lack of training, the loss of quali-

⁵⁰ See footnotes 8, p. 175; 16, p. 181; and 26 (2), p. 188.

⁵¹ See footnote 39 (1), p. 199.

⁵² See footnote 18 (2), p. 181.

fied instructors to other units, and frequent expansion and contraction of the training program combined to create a seemingly unending personnel problem. Prewar plans provided little guidance. The Surgeon General's Protective Mobilization Plan of 1939, for example, placed a higher priority on assigning cadres to newly activated units than to training centers, and then made the centers responsible for cadre training.⁵³ With the onset of mobilization, the shortcomings of prewar planning came sharply into focus.

The pioneer centers established at Camps Lee and Grant early in 1941 ran headlong into the problem of creating a training staff. A majority of the officers sent to Camp Lee had attended a monthlong refresher course at Carlisle Barracks, Pa., before their arrival at the center, but their preparation proved inadequate to qualify them either as instructors or as commanders of training units. Few Regular Army officers had either commanded units or trained green troops, and the preparation of most of the Reserve officers assigned to the center was limited to ROTC (Reserve Officers' Training Corps), correspondence courses, and an occasional 2 weeks at summer camp.⁵⁴

The first group of officers assigned to Camp Lee so unsettled Colonel Hawley, the Director of Training, that 5 days before the first shipment of trainees was due to arrive, he fired off a tart letter to the Training Division, Surgeon General's Office, stating that "if the new officers have no more experience and training than the ones just sent us, they will be utterly worthless for at least one month. The Surgeon General's Office could help a little by getting this green material in as early as possible so that we can do something with it before the selectees arrive."⁵⁵ The commanding general of Camp Grant, after encountering similar problems, stated flatly that "without exception, company commanders were unqualified for their work." Both centers established special cadre schools to indoctrinate officers in the fundamentals of instruction and responsibilities of leadership. At Camp Grant, however, weather closed in before the center opened, confining the school to indoor instruction.

If the Medical Department was hard pressed to furnish qualified training officers, it found it even more difficult to provide enlisted training cadre. War Department mobilization plans gave the formation of tactical units priority over the training of selectees, and the few Medical Department enlisted men who had received military training before the war had been assigned to newly activated units. Frequently, Medical Replacement Training Centers appeared to be taking the leftovers. The enlisted men sent to Camps Lee and Grant as cadre were supposed to have been trained, but they were described by the commanding general of Camp Grant as "a conglomerate mass" and a "pitiful group."⁵⁶ Both centers attempted to train these men for their duties before opening, but at Camp Grant, weather kept both officers and enlisted men indoors.

⁵³ (1) The Surgeon General's Protective Mobilization Plan, 15 Dec. 1939, with annexes. (2) Goodman, Samuel M.: *History of Medical Department Training, U.S. Army World War II. Volume I. Draft of Introductory Chapter.* [Official record.]

⁵⁴ See footnote 15, p. 180.

⁵⁵ See footnote 1 (1), p. 173.

⁵⁶ See footnote 15, p. 180.

During the first few months that the centers were in operation, War Department replacement policies made it difficult to eliminate useless and unfit enlisted men from the cadre. Under the existing system, centers were required to submit requisitions for personnel to The Adjutant General 3 months in advance of their assignment. While the system was adequate for long-range planning, it created serious problems for agencies charged with training peacetime draftees during their single year of service.

In mid-1941, the War Department began to reconsider its unit activation policies. In July 1941, the Assistant Chief of Staff, G-3, informed the chiefs of the arms and services that the establishment of cadre training camps and special service schools was being considered and invited them to comment.⁵⁷

In reply, The Surgeon General strongly endorsed the establishment of cadre training schools. The Medical Department's experience indicated that only basic medical soldiers and lower administrative specialists could be trained during a 13-week cycle. A few men with technical skills acquired in civilian life might be qualified for the third and fourth grades of enlisted rank, but too few to meet cadre requirements. The capacity of the Medical Field Service School noncommissioned officers' course was only 200 per year and obviously inadequate for mobilization. To break this bottleneck, The Surgeon General recommended the establishment of noncommissioned officers' schools at replacement training centers. By careful selection and an additional 6 to 10 weeks of training, he thought the Medical Department would be able to qualify at least part of the corporals and duty sergeants required in nontechnical positions.

Officers, The Surgeon General believed, should undergo similar training. During the first year of mobilization, the Medical Department had been able to qualify commissioned cadres through refresher courses at the Medical Field Service School. Once the pool of Reserve Corps and National Guard officers was exhausted, however, the Medical Department would have to commission recent graduates of medical schools who had no previous military training. The basic course at the Medical Field Service School would have to be extended to 3 months, and the facilities of the school expanded. These men could then be qualified for service in tactical units and installations by a month or two of service at replacement training centers.⁵⁸

While these schools were originally intended to prepare enlisted men to staff newly activated units, they also became a major source of training center cadre. On 25 September 1941, after Selective Service and the terms of men already drafted were extended for an additional year, the War Department exempted replacement training centers from the restrictions of the standard replacement system and authorized them to select men necessary to replace cadre losses from qualified graduates of the center.

Long before this policy was announced, Medical Replacement Training Centers began using their graduates to replace cadre losses. Training centers adopted

⁵⁷ Memorandum, Brig. Gen. Harry L. Twaddle, Assistant Chief of Staff, War Department General Staff, G-3, for The Surgeon General, 17 July 1941, subject: Training of Cadres for New Units at Replacement Training Centers.

⁵⁸ Memorandum, The Surgeon General for the Assistant Chief of Staff, War Department General Staff, G-3, 26 July 1941, subject: Training of Cadres for New Units at Replacement Training Centers.

this policy shortly after the beginning of the first training cycle, when it was discovered that trainees with ROTC and CMTC (Civilian Military Training Camp) experience were often better prepared to conduct classes and act as squad and section leaders than the Regular Army enlisted men assigned to serve as cadre. Following the exchange of communications between The Surgeon General and the Assistant Chief of Staff in July 1941, noncommissioned officers' schools were established at both Medical Replacement Training Centers. Because a special training program had not been authorized, classes were held at night or between training periods. A measure of their effectiveness can be found in the experience of Camp Grant, where, in the period immediately following the establishment of the schools, approximately 20 percent of the cadre were graduates of the center.⁵⁹ By continuing the process of replacing inefficient cadre members with graduates of the schools, centers were able to develop a highly competent staff. These schools continued to be a major source of cadre replacements until 15 March 1944 when they were replaced by leadership training courses.

Once Camps Lee and Grant had lifted themselves by their bootstraps, they were able to supply cadre for the new centers that were being activated. In November 1941, for example, the two centers sent a total of more than 560 officers and enlisted men to staff Camp Barkeley, and a similar number were sent to Camp Robinson when it was activated early in 1942.

For a time, cadre schools provided an answer to the problem of securing a training staff. While quality improved, quantity remained a problem, and during periods of expansion, almost every replacement center reported a shortage of cadre and overhead personnel. Beginning in April 1943, however, a struggle to provide a qualified cadre was renewed. This time, the problem resulted from a War Department policy requiring Medical Replacement Training Centers to replace 80 percent of their enlisted cadre strength with limited service personnel.⁶⁰ Highly qualified enlisted men suitable for overseas duty had to be replaced at a rate of not less than 5 percent a month, and their replacements were not necessarily qualified as instructors. Indeed, a large proportion of the replacements sent to the centers were limited not only physically but also mentally. At Camp Grant, for example, over 50 percent of the 451 limited service personnel sent as replacements were found to have scored in the lower two classes on the Army General Classification Test.⁶¹

Even limited service men who were mentally alert required extensive training before they could be used as instructors. Camp Barkeley had to arrange with the Eighth Service Command to transfer permanent general service personnel from center and regimental headquarters to cadre positions and to replace them with branch immaterial limited service personnel. Since most of these men were familiar with Medical Department doctrines, it proved less difficult to train them as instructors. Unfortunately, only a small number of such men were available. Early in 1944, Camp Barkeley also obtained permission to conduct 4 weeks of training

⁵⁹ See footnote 15, p. 180.

⁶⁰ (1) See footnotes 16, p. 181; and 23 (1), p. 186. (2) Letter, The Adjutant General to The Surgeon General, 7 Apr. 1943, subject: Utilization of Limited Service Personnel.

⁶¹ See footnote 16, p. 181.

for limited service personnel sent as replacements. Those who proved acceptable could be retained, and the remainder were to be returned to the Eighth Service Command for reassignment. The course began on 13 March, but was discontinued on 28 May, when it was concluded that the low quality of the men being sent to the school made its continuation uneconomical.⁶²

War Department rotation policies also made it difficult to retain competent training officers. By careful selection and supplementary training, centers had been able to overcome initial difficulties and develop a skilled officer cadre. Beginning in mid-1943, however, an increasing number of experienced training officers were sent overseas as replacements for officers scheduled for rotation, and training centers were required to train a growing volume of returnees as instructors.⁶³

In July 1944, Army Service Forces directed schools and training centers to review the qualifications of all instructors and to revise their instructor training and guidance programs to meet minimum ASF standards.⁶⁴ Standards outlined in the directives were considered minimal, and commanders were urged to expand their programs to meet local needs. As a result, course length and content varied from center to center. The shortest course established lasted 2 weeks, and the longest was 1 month. Content was divided between military techniques of instruction, and specific military subjects. Classes in military techniques of instruction included topics such as training literature, lesson preparation, lecture preparation, demonstration methods, training films, filmstrips, and the preparation and use of sand tables. Specific military subjects included map reading, first aid, military sanitation, malaria control, and other topics of military importance.⁶⁵ The purpose of these programs was to qualify officers as instructors before they were assigned to any particular unit. Almost all pool officers participated in the program, and those who demonstrated their proficiency were retained as instructors.⁶⁶

In March 1944, Army Service Forces directed the establishment of troop leadership schools for enlisted personnel at all ASF training centers and authorized commanders to enroll 3 percent of the strength of the center. Men attending these schools were chosen from trainees who had completed basic training and demonstrated a capacity for leadership and from enlisted men permanently assigned to the cadre. The 9-week program at troop leadership schools was divided into two phases. During the first phase, which lasted 3 weeks, students received formal instruction in teaching methods and in the duties of noncommissioned officers. The second 6 weeks of the program was devoted to the application of these principles. In this phase, students were assigned the rank of acting corporal and were attached to companies undergoing their first 6 weeks of basic training. By serving as section leaders, students were given an opportunity to develop leadership qualities. After completing the course, men were either retained at the center as cadre

⁶² See footnote 24 (1), p. 186.

⁶³ Annual Report, Army Service Forces Training Center, Camp Grant, Ill., as of 15 October 1944.

⁶⁴ (1) Army Service Forces Circular No. 201, 1 July 1944. (2) Army Service Forces Circular No. 220, 14 July 1944.

⁶⁵ Officer Instructor Guidance Program, Army Service Forces Training Center, Camp Barkeley, Tex., 26 July 1944.

⁶⁶ See footnote 18 (1), p. 181.

replacements, assigned as cadre for newly activated units, or sent overseas as replacements.⁶⁷

By the end of World War II, the Medical Department had developed a highly flexible and refined system for training cadre, fillers, and replacements. Training centers were no longer plagued by shortages of housing and equipment, and training aids were abundantly available. Cycles could be lengthened and shortened to meet the demands of the moment, and content could be adapted to meet the needs of the theater. By integrating lesson plans, training aids, and maneuvers, centers were able to develop a highly realistic training program for Medical Department enlisted men. And by the same token, the training of draftees, returnees, and rotational replacements had been combined, under the preactivation system, into a highly efficient mechanism for filling Medical Department units and installations in the theater and in the Zone of Interior.

⁶⁷ (1) Letter, Commanding General, Army Service Forces, to Commanding General, Sixth Service Command, 15 Mar. 1944, subject: Establishment of a Leadership Training Course. (2) Letter, Commanding General, Army Service Forces, to Commanding General, Sixth Service Command, 11 Apr. 1944, subject: Establishment of a Leadership Training Course. (3) Memorandum, Col. R. G. Melin, GSC, to Colonel Sanford, Director, Military Training, 13 May 1944. (4) Army Service Forces Circular No. 150, 20 May 1944.

CHAPTER VII

Enlisted Technicians¹

Medical activities at all echelons required the services of skilled technicians. To keep pace with expansion, the flow of trainees was accelerated from a bare trickle in 1939 to nearly 6,000 graduates a month at its peak in 1943. By the end of the war, more than 120,000 men and women had been trained for specialized positions in Army medical units.²

PREWAR EXPANSION

The blueprint for accelerating the training of enlisted technicians was provided by The Surgeon General's Protective Mobilization Plan of 1939.³ During the first 30 days of mobilization, schools for enlisted technicians were to be established at the Army Medical Center, Washington, D.C., and at four general hospitals: William Beaumont, El Paso, Tex., Fitzsimons, Denver, Colo., Letterman, San Francisco, Calif., and Army and Navy, Hot Springs, Ark. Each was to be prepared to initiate large-scale training in six enlisted specialties on 10 days' notice. In addition to the laboratory, X-ray, dental, and pharmacy technicians courses that were part of the peacetime program, training was to be expanded to include courses for medical and surgical technicians who had previously been trained on-the-job. All courses were to be of 3 months' duration, and new classes were to enroll monthly. The combined enrollment of all schools was to exceed 1,000 during the first month, and in subsequent months, enrollment was to expand to meet the requirements of troop units.

When The Surgeon General's Protective Mobilization Plan was published in December 1939, installations charged with responsibility for training technicians were directed to prepare their own mobilization plans. Training programs were not included in the plan, and each school was required to prepare a tentative course of instruction. Program guidance was provided by Mobilization Training Program

¹ Goodman, Samuel M.: History of Medical Department Training U.S. Army World War II. Volume IV: A Report on the Schooling of Enlisted Personnel, 1 July 1939-30 June 1944. [Official record.] (2) Goodman, Samuel M.: History of Medical Department Training U.S. Army World War II. Volume VI: A Report of the Training of ASF-Type Medical Department Units, 1 July 1941-30 June 1945. [Official record.] (3) Goodman, Samuel M.: History of Medical Department Training U.S. Army World War II. Volume VII: The History of the Training of Medical Department Female Personnel, 1 July 1939-31 December 1944. [Official record.] (4) Stapleton, James B., and Chapele, Francis O.: Enlisted Technicians. [Official record.]

² (1) Johnson, John B.: The Medical Department Enlisted Technicians Training Program, 1 July 1944-1 July 1945. A Supplement to Goodman, Samuel M.: History of Medical Department Training U.S. Army World War II. Volume IV. A Report on the Schooling of Enlisted Personnel, 1 July 1939-30 June 1944. [Official record.] (2) Goodman, Samuel M.: History of Medical Department Training U.S. Army World War II. Volume IX. Medical Department Training Activities, 1 July 1945-2 September 1945. A Supplement to Historical Monographs and Supplements Covering the Period 1 July 1939-30 June 1945, table 3. [Official record.]

³ The Surgeon General's Protective Mobilization Plan, 1939.

TABLE 11.—Capacity of Medical Department Enlisted Technicians Schools, 1 July 1941

Installation	Monthly quotas of enlisted students									Peak-load ¹
	Laboratory	Dental	Medical	Pharmacy	Surgical	Veterinary	X-ray	Sanitary	Total	
Medical Field Service School								100	100	100
Army Medical Center	25	25	55	25	55	30	35		250	625
Army and Navy General Hospital	10	5	50	10	15		10		100	250
William Beaumont General Hospital	15	25	100	20	100	25	15		300	750
Station Hospital, Fort Sam Houston	15	25	125	20	100		15		300	750
Fitzsimons General Hospital	15	25	125	20	100		15		300	750
Letterman General Hospital	6	10	50	8	40		6		120	300
Total	86	115	505	103	410	55	96	100	1,470	

¹ Total capacity during a single, 3-month period. Not necessarily the sum of three individual classes because of limits created by housing and facilities.

Source: Annual Report of The Surgeon General, U.S. Army. Washington: U.S. Government Printing Office, 1941.

No. 8-1, dated 9 September 1940, when the War Department published outlines specifying the scope of instruction and text references for each course.

Plans for the establishment of enlisted technicians schools were put into effect late in 1940, when it became apparent that existing schools could not fill the requirements of a partially mobilized Army. During the fall and winter of 1940, contracts were let for construction of the five schools specified in The Surgeon General's Protective Mobilization Plan, and an additional school at the Station Hospital, Fort Sam Houston, Tex. As provided by the plan, a course for sanitary technicians was scheduled at the Medical Field Service School. Construction of the six new Medical Department Enlisted Technicians Schools began in the fall of 1941, and by 1 April, all were in operation.⁴ The capacity of these schools in mid-1941 is summarized in table 11.

WARTIME EXPANSION

The schools established in 1941 were built during the first of three phases of school expansion. The second began immediately after American entry into the war, when it became evident that "the June 1941 level of training facilities * * * would be grossly inadequate."⁵ Construction began on schools at the following general hospitals: Billings, Indianapolis, Ind.; O'Reilly, Springfield, Mo.; Lawson, Atlanta, Ga.; and Fitzsimons; and by 1 July 1942, they had enrolled their first class of trainees. The four new Medical Department Enlisted Technicians Schools were identical in size and capacity, each capable of training a peakload of 1,000 students. At Fitzsimons General Hospital, the new school was combined with one already in operation, bringing capacity to 1,847. By October 1942, the monthly

⁴ Annual Report of The Surgeon General, U.S. Army. Washington: U.S. Government Printing Office, 1941.

⁵ Annual Report, Training Division, Operations Service, Office of The Surgeon General, fiscal year 1942.

TABLE 12.—Capacity of Medical Department Enlisted Technicians Schools, 1 July 1942

Installation	Entering quotas first of each month								Peakload of students ¹
	Laboratory	Dental	Medical	Pharmacy	Surgical	Veterinary	X-ray	Total	
Army Medical Center.....	30	25	55	30	55	25	40	260	670
Army and Navy General Hospital..	15	12	40	20	20	-----	12	119	297
Fitzsimons General Hospital.....	67	75	295	22	257	-----	67	783	1,847
Letterman General Hospital.....	6	7	65	7	50	-----	5	140	300
William Beaumont General Hospital.	20	20	125	20	125	25	15	350	800
Brooke General Hospital.....	20	20	145	20	125	-----	25	355	770
Billings General Hospital.....	50	50	125	-----	125	-----	50	400	1,000
O'Reilly General Hospital.....	50	50	125	-----	125	-----	50	400	1,000
Lawson General Hospital.....	50	50	125	-----	125	-----	50	400	1,000
Total.....	308	309	1,100	119	1,007	50	314	3,207	

¹ Total capacity during a single, 3-month period. Because of limits created by housing and facilities, it is not necessarily the sum of three individual classes.

Source: Annual Report, Training Division, Operations Service, Office of The Surgeon General, fiscal year 1942.

output of technical schools had more than doubled. Training capacities resulting from the second expansion are summarized in table 12.

Despite their increased capacity, Medical Department Enlisted Technicians Schools were unable to meet the demand that developed late in 1942.⁶ In October 1942, Maj. Gen. George E. Stratemeyer, Chief of Staff of the Army Air Forces, demanded control of the technical training of all personnel assigned to the Air Forces except medical specialists, and requested that the Medical Department train at least 2,000 specialists a month for the AAF (Army Air Forces).⁷ Shortly thereafter, the Medical Department was notified that it would be required to train more than 34,000 technicians during 1943.⁸

Training facilities for the third phase of expansion were provided by scheduling instruction in two 8-hour shifts at five general hospitals: Billings, Fitzsimons, Lawson, O'Reilly, and William Beaumont. Students were housed in training areas vacated by theater-of-operations hospitals that had been shipped overseas. These expedients swelled the capacity of Medical Department Enlisted Technicians Schools by nearly 2,500 trainees a month (tables 13 and 14).

In the months between December 1942 and September 1943, technical training reached its wartime peak; Medical Department Enlisted Technicians Schools were filled to capacity, and courses at other installations expanded proportionally.⁹ In December 1942, the Roentgenology Section of the Army Medical Center became

⁶ Memorandum, Brig. Gen. C. R. Huebner, Director of Training, Services of Supply, for The Surgeon General, 2 Nov. 1942, subject: Technical Training of Enlisted Personnel, Arms and Services With the Army Air Forces.

⁷ Memorandum, Maj. Gen. George E. Stratemeyer, Chief of Staff of the Army Air Forces, for the Chief of Staff, 3 Oct. 1942, subject: Assumption of Responsibility for Training ASWAAF Personnel by the AAF.

⁸ (1) See footnote 6. (2) Memorandum, The Surgeon General, U.S. Army, for the Commanding General, Services of Supply, 4 Nov. 1942, subject: Training of Medical Department Technicians for Duty With the Army Air Forces.

⁹ Annual Report, Training Division, Operations Service, Office of The Surgeon General, fiscal year 1944.

TABLE 13.—Capacity of Medical Department Enlisted Technicians Schools, 1 July 1943

Installation	Monthly entering quotas										Total	
	Veterinary (SSN 250)	X-ray (SSN 264)	Medical (SSN 409)	Dental (SSN 855)	Laboratory (SSN 858)	Pharmacy (SSN 859)	Surgical (SSN 861)	Sanitary (SSN 196)	Meat and dairy inspector (SSN 120)	Equipment and maintenance technician (No SSN assigned)		Orthopedic (SSN 366)
Enlisted technicians schools:												
Army and Navy General Hospital		10	62	10	10		27					119
Army Medical Center	25		60	25	25		60					195
William Beaumont General Hospital	25	15	245	40	20		375					720
Billings General Hospital		65	160	100	100		310					735
Brooke General Hospital		15	162	20	20		143					360
Fitzsimons General Hospital		137	351	185	81	20	436					1,210
Lawson General Hospital		60	232	106	100		382					880
Letterman General Hospital		7	68	12	7		63					157
O'Reilly General Hospital		100	122	100	100		377					799
Army School of Roentgenology (enlisted)		85										85
St. Louis Medical Depot										100		100
Medical Replacement Training Centers (Camps Berkeley, Grant, Pickett, and Robinson)								320	100			420
Named general hospitals											114	114
Total	50	494	1,462	598	463	20	2,173	320	100	100	14	5,794

1 Monthly average.

Source: Annual Report, Training Division, Operations Service, Office of The Surgeon General, 1943.

TABLE 14.—*Annual capacity, Medical Department Enlisted Technicians Schools, 1942 and 1943*

Course	Annual capacity, 30 June 1942 ¹	Annual capacity, 30 June 1943
Veterinary technician (SSN 250).....	600	600
X-ray technician (SSN 264).....	1,368	5,928
Medical technician (SSN 409).....	7,200	17,544
Dental technician (SSN 855).....	1,308	7,176
Medical laboratory technician (SSN 858).....	1,296	5,556
Pharmacy technician (SSN 859).....	1,428	240
Surgical technician (SSN 861).....	6,084	26,076
Sanitary technician (SSN 196).....	1,200	3,840
Meat and dairy inspector (SSN 120).....		1,200
Equipment maintenance technician (No SSN assigned).....	156	1,200
Orthopedic mechanic (SSN 366).....	48	168
Total.....	20,688	69,528

¹ Does not include the capacity of schools opened on 1 July 1942.

Source: Annual Report, Training Division, Operations Service, Office of The Surgeon General, fiscal year 1943.

the Army School of Roentgenology and was transferred to the University of Tennessee, Memphis, Tenn., where it harnessed the classrooms and laboratories of the university for training officers and enlisted students. In addition, the training of X-ray technicians at enlisted technicians schools continued unabated. Early in 1943, the number of general hospitals conducting the 3-month course for orthopedic mechanics was increased from three to 12, and the capacity of the program was expanded from 13 to 41 trainees per cycle.¹⁰ Finally, in June 1943, training activities at the St. Louis Medical Supply Depot, St. Louis, Mo., were organized into the Medical Supply Services School, and the capacity of the school for training enlisted technicians was expanded from 50 to 300.¹¹

Enrollment at Medical Department Enlisted Technicians Schools passed its wartime peak in the summer of 1943, when schools were capable of enrolling almost 6,000 new students each month. By mid-1943, the rate of unit activations was declining, and demand for enlisted technicians temporarily abated. On 19 July 1943, the Director of Training, ASF (Army Service Forces), instructed the Medical Department to sharply curtail enrollments until the end of the year. Quotas were reduced by 50 percent for the Army Air Forces, 25 percent for the AGF (Army Ground Forces), and approximately 33 percent for all other components and commands. The total number of trainees enrolled from components other than the Army Air and the Army Ground Forces between 1 August and 31 December 1943 was not to exceed 9,343.¹²

By the time this directive was issued, the Air Forces had withdrawn its trainees

¹⁰ Annual Report, Training Division, Operations Service, Office of The Surgeon General, fiscal year 1943.

¹¹ History of the St. Louis Medical Depot, 7 Dec. 1942 through 7 Dec. 1943.

¹² Memorandum, Commanding General, Army Service Forces, for The Surgeon General, 19 July 1943, subject Specialists Schools. Inclosures thereto.

from the program. In November 1942, quotas demanded by the Army Air Forces threatened to consume all but a small fraction of the capacity of enlisted technicians schools. The Medical Department harnessed every available resource to meet these demands, and by May 1943, it began to appear that AAF medical activities had reached their capacity to absorb technicians. On 24 May 1943, the Medical Department notified the Air Surgeon that the Surgeon General's Office was being flooded by letters from disgruntled technicians in the Army Air Forces, and informed him that:¹³

This office is interested in the assignment of graduates of our Enlisted Technicians Schools because of the highly adverse effect on the morale of Air Force trainees in the schools of letters from recent graduates telling them not to take their work too seriously, that once they are assigned to an Air Force station they will be broken to a private and never engage in the specialty for which they were trained anyway.

On 22 June 1943, the Air Forces notified Army Service Forces that it no longer required quotas at Medical Department Enlisted Technicians Schools; any further training would be assumed by the Army Air Forces.¹⁴ Commanders of AAF medical activities were informed that quotas at ASF schools were no longer available, and they furnished specifications for on-the-job training programs. The capacity of these programs was limited, however, and the results often disappointing.

Fortunately for AAF medical units, the Air Surgeon's decision to withdraw from the MDETS (Medical Department Enlisted Technicians School) program did not produce a serious shortage of technicians in the Air Forces. Indeed, the Air Forces remained so heavily overstocked with technicians that, in September 1944, the Air Surgeon agreed to release approximately 1,100 enlisted technicians to Army Service Forces in exchange for an equal number of limited-service personnel with AGCT (Army General Classification Test) scores of 100 or better.¹⁵ In October 1944, AAF medical activities were notified that it was again possible to send trainees to schools under the control of Army Service Forces.¹⁶

In the autumn of 1943, schools were able to abandon the double-shift plan and return to normal scheduling. Training continued at a reduced pace until April 1944, when an increasing need for loss replacements and a spate of new unit activations under the preactivation program renewed the demand for trained technicians.¹⁷ For a short period, enrollment at the Medical Department Enlisted Technicians

¹³ Memorandum, Col. F. B. Wakeman, MC, Director, Training Division, for the Commanding General, Army Air Forces (attention: The Air Surgeon), 24 May 1943, subject: Misassignment of Graduates of Medical Department Enlisted Technicians Schools.

¹⁴ 2d Memorandum Indorsement, Brig. Gen. Robert W. Harper, Assistant Chief of Air Staff, Training Division, to Commanding General, Army Service Forces, Military Training Division, 22 June 1943, to Memorandum, Col. F. B. Wakeman, MC, Director, Training Division, Office of The Surgeon General, for Director of Military Training, Army Service Forces, 4 June 1943, subject: Technical Training for Enlisted Personnel, Arms and Services With the Army Air Forces.

¹⁵ (1) Memorandum, Col. Floyd L. Wergeland, MC, Director, Training Division, Office of The Surgeon General, for Director, Military Personnel, Army Service Forces, 6 Sept. 1944, subject: Medical Department Specialists for Numbered ASF Medical Units. (2) Letter, The Adjutant General to the Commanding General, Army Air Forces, 10 Sept. 1944, subject: Transfer of Medical Department Specialists to the Army Service Forces.

¹⁶ Letter, Col. O. K. Niess, MC, Director of Administration, Office of the Air Surgeon, to Commanding General, Personnel Distribution Command, Atlantic City, N.J., 14 Oct. 1944, subject: Training of Enlisted Personnel in Army Service Forces Medical Department Schools.

¹⁷ Army Service Forces Circular No. 104, 15 Apr. 1944.

Schools was restored almost to its former levels. After June 1944, however, enrollment continually declined.

After the invasion of Europe, the demand for general servicemen in the combat arms became so intense that few were available for technical training. In their place, the Medical Department accepted an increasing number of women, and by April 1945, more women than men were graduating from enlisted technicians schools.¹⁸

As the war neared an end, enrollments dwindled, and it became necessary to close many schools altogether. In October 1944, the course for X-ray technicians at the Army School of Roentgenology was discontinued. The Medical Department Enlisted Technicians School at Letterman General Hospital closed on 8 December 1944, followed by those at Billings and O'Reilly General Hospitals in March 1945. The schools at Army and Navy General Hospital and the Army Medical Center were discontinued a few weeks later. The Medical Department Enlisted Technicians School at Lawson General Hospital officially closed on 15 July 1945. By the end of the war, only the schools at Fitzsimons, William Beaumont, Brooke, and Wakeman (located at Columbus, Ind.) General Hospitals remained in operation. The numbers of enlisted technicians who graduated from Medical Department Enlisted Technicians Schools for the period June 1939–September 1945 are as follows:¹⁹

<i>Medical specialty</i>	<i>Number¹</i>
Medical.....	35,736
Surgical.....	43,587
Advanced medical and surgical.....	2,775
Dental.....	10,463
Laboratory.....	8,859
X-ray.....	8,537
Pharmacy.....	2,518
Veterinary.....	1,624
Total.....	114,099

¹ Totals include both men and women.

MEDICAL DEPARTMENT ENLISTED TECHNICIANS SCHOOLS

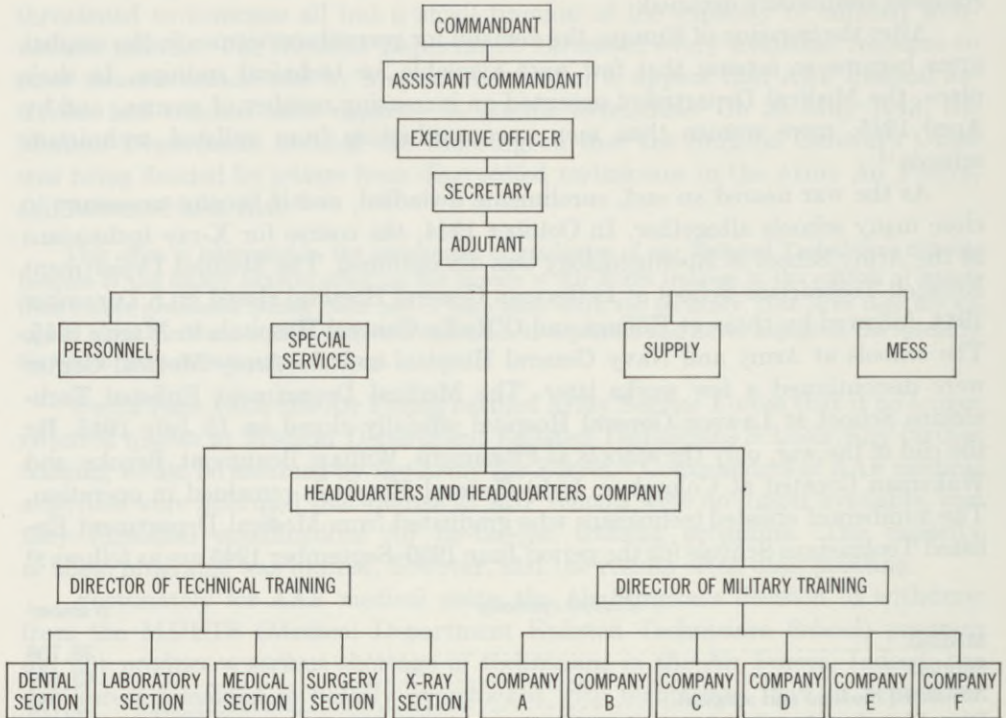
The organization and administration of Medical Department Enlisted Technicians Schools followed patterns established for Special Service Schools during the interwar years.²⁰ Variations in size resulted in a varying number of officers being assigned to administrative duties, and position titles were adjusted to reflect the degree of specialization. Variations in size and title, however, serve only to mask the basic similarity of administrative organization.

¹⁸ See footnote 2(1), p. 213.

¹⁹ (1) See footnotes 1(1) and 2(2), p. 213. (2) Annual Report, Training Division, Operations Service, Office of The Surgeon General, for fiscal year 1945.

²⁰ (1) Army Regulations No. 350-105, 1 Oct. 1938. (2) Army Regulations No. 350-110, 6 Oct. 1936. (3) Army Regulations No. 350-1000, 28 July 1933. (4) Army Regulations No. 350-1030, 28 June 1933.

CHART 5.—*Typical organization of a Medical Department Enlisted Technicians School, 1944*



Source: Annual Report, Medical Department Enlisted Technicians School, Billings General Hospital, Fort Benjamin Harrison, Ind., for fiscal year 1944.

Each school was under the direction of a commandant, who in every instance was the commanding officer of the installation to which the school was attached. The title is misleading for, with the exception of establishing post policies affecting the school, the post or hospital commander rarely took an active part in school administration. Responsibility for the operation of the school was vested in the assistant commandant and, under his jurisdiction, in the executive officer, the director of training, the battalion commander, and other administrative officers. The most important division of responsibility within the staff was between the director of training and the battalion commander or director of military training. The director of training was responsible for academic phases of instruction. He supervised the preparation of subject material, texts, training aids, and schedules. Under his guidance, the directors of academic divisions prepared programs and supervised training in their respective subjects. Typically, an academic division was created for each technical program, so that the training division was divided into X-ray, dental, laboratory, medical, surgical, and pharmacy sections. A second major administrative division, under the battalion commander or the director of military training, controlled students outside the classroom. Through student companies, this division was responsible for inspections, guidance, physical training, and discipline.

Officers responsible for other administrative functions, such as the mess officer, the housing officer, and the supply officer, were controlled by either the executive officer or the adjutant (chart 5).

The physical facilities housing Medical Department Enlisted Technicians Schools were similar to their administrative organization. Schools in buildings of prewar vintage, such as the Professional Service Schools at the Army Medical Center and the Army School of Roentgenology, varied widely, but those housed in new construction were much alike. Schools constructed in 1942 at Billings, O'Reilly, Fitzsimons, and Lawson General Hospitals were practically identical. Each was constructed according to a single master plan, consisting of from 11 to 16, 63-man barracks (63-M), five 63-man barracks modified as classroom buildings, one 1,000-man mess, one large recreation building (RB-1), six small recreation buildings (RB-4), one officers' quarters and mess (QM-40), a storehouse (SH-7), and an infirmary (I-2). Buildings were usually heated by individual hot-air, forced-circulation furnaces, although a few had steam heat or stoves. Academic buildings were divided into classrooms according to plans approved by The Surgeon General, and schools were permitted to make modifications to meet local requirements.

In most respects, school facilities proved adequate. The only complaint occurring repeatedly in annual reports centered on problems of heating and ventilation. Schools in the South were almost unbearably hot during the summer, and those in the North faced dual problems of winter cold and summer heat. The Medical De-

TABLE 15.—*Medical Department Enlisted Technicians Schools operated during World War II*

Installation	Date opened	Date closed
Army Medical Center.....	1 Apr. 1941	31 Mar. 1945
Army and Navy General Hospital.....	1 Apr. 1941	11 Aug. 1944
William Beaumont General Hospital.....	1 Apr. 1941	31 Dec. 1945
Fort Sam Houston (Brooke).....	1 Apr. 1941	Still in operation on 31 Dec. 1945
Fitzsimons General Hospital.....	1 Apr. 1941	Still in operation on 31 Dec. 1945
Letterman General Hospital.....	1 Apr. 1941	8 Dec. 1944
Army School of Roentgenology, Memphis, Tenn.	4 Jan. 1943	15 Oct. 1944
Medical Supply Service School, St. Louis Medical Depot. ¹	16 Feb. 1942	5 Jan. 1946
Billings General Hospital.....	6 July 1942	17 Mar. 1945
Lawson General Hospital.....	1 July 1942	15 July 1945
O'Reilly General Hospital.....	6 July 1942	17 Mar. 1945
Fitzsimons General Hospital.....	1 July 1942	Still in operation on 31 Dec. 1945
Station Hospital, Fort Huachuca.....	18 Nov. 1943	23 Sept. 1944
School of Reconditioning Instructors, Camp Grant and Fort Lewis.	5 June 1944	29 Sept. 1945
Wakeman General Hospital.....	11 Aug. 1944	Still in operation on 31 Dec. 1945
Optical Course School, St. Louis Medical Depot.	13 Sept. 1943	23 Sept. 1944

¹ Designated as a school on 3 June 1943.

partment Enlisted Technicians School at Lawson General Hospital, for example, reported that:²¹

An unsuccessful attempt was made prior to construction of the school to have some type of central heating or individual gas heating. Each building was equipped with individual hot air coal furnaces, and the buildings have not been satisfactorily or efficiently heated during the winter months. It is felt that this has interfered with the proper training of the students in classrooms and laboratories. All classroom buildings are poorly ventilated and should be equipped with ventilating fans such as have been recently obtained for the dental and laboratory buildings.

Schools frequently complained of poorly lighted classrooms and of the inconvenience of conducting classes in converted, temporary barracks.

Between 1940 and the end of the war, formal training of Medical Department enlisted technicians was conducted at 16 schools or installations (table 15).

PROGRAM GUIDES

All but one of the enlisted technicians schools activated in 1941 were under the direct control of The Surgeon General. Although not designated as Special Service Schools, they bore the same administrative relationship to The Surgeon General by virtue of being established at named general hospitals exempt from corps area control.²² The schools opened on 1 July 1942, at Billings, O'Reilly, and Lawson General Hospitals, were similarly under the control of The Surgeon General. The sole exception was the school activated at the Station Hospital, Fort Sam Houston. Not being located at an exempted station, the school fell under the jurisdiction of the VIII Corps Area, and all communications between The Surgeon General and the Medical Department Enlisted Technicians School at Fort Sam Houston were channeled through the VIII Corps.

The reorganization of Army Service Forces in August 1942 altered the administrative relationship between The Surgeon General and the Medical Department Enlisted Technicians Schools. Service Commands replaced the older Corps Areas, and were placed under the control of Army Service Forces. When named general hospitals lost their exempted status and were placed under Service Command control, the Medical Department Enlisted Technicians Schools also fell under their jurisdiction. The only exceptions were schools at the Army Medical Center and the St. Louis Medical Depot—installations which retained their exempted status.²³

The reorganization of August 1942 did not materially affect the influence of The Surgeon General over training programs and doctrine. These functions, as well as assignment and relief of instructors, were assumed by the Commanding General, ASF, and in turn delegated to the chiefs of the technical services. Although removed from direct command, The Surgeon General remained in control of doctrine and programs at Medical Department Enlisted Technicians Schools throughout World War II.

²¹ Annual Report, Medical Department Enlisted Technicians School, Lawson General Hospital, Atlanta, Ga., fiscal year 1943.

²² Army Regulations No. 170-10, 10 Oct. 1939.

²³ Army Regulations No. 170-10, 10 Aug. 1942.

The channels through which control was exercised were altered several times during the war. Before mobilization, draft outlines for technical courses were developed by the Professional Service Schools at the Army Medical Center and submitted to the Office of The Surgeon General for review. After being approved, they were forwarded to The Adjutant General for War Department review. Responsibility for drafting course outlines shifted, however, when the Medical Department began to gear its training program for mobilization. In August 1940, the Office of The Surgeon General completed the draft of a general program guide which was approved and published by the War Department on 9 September 1940 as Mobilization Training Program No. 8-1. A section of this publication established the training qualifications for Medical Department technicians, and outlined the major subjects to be included in technical courses. In November 1940, the Office of The Surgeon General issued a circular letter which outlined courses in greater detail. Together, these programs governed training at Medical Department Enlisted Technicians Schools until August 1943.²⁴

Since neither publication provided guidance beyond listing subjects required in each course and allotting time to major blocks of material, schools were responsible for developing their own schedules of instruction. As a result, courses devoted to a specific subject varied significantly from school to school. In 1942, for example, the number of hours scheduled for hematology in the Laboratory Technicians Course varied from as few as 16 to as many as 80. The time devoted to anatomy in the X-ray Technicians Course varied from 15 hours to 60, while in the Pharmacy Technicians Course, 68 hours were scheduled in prescriptions at one school, and 180 hours at another.

In April 1943, the Training Division, Office of The Surgeon General, began a study of course content at the Medical Department Enlisted Technicians Schools that revealed wide variations in emphasis within courses. That summer, the Training Division developed a program guide designed to insure standardization.²⁵ The guide was approved by the next highest echelon, and published on 29 August 1943, as an ASF (Army Service Forces) memorandum.²⁶ This program guide controlled training for male enlisted technicians through the remainder of the war. The program guide for female technicians was developed at the Army and Navy General Hospital.²⁷ While these guides reduced the amount of variation between courses, neither eliminated it entirely.

In developing courses, schools reduced lectures and emphasized "learning by doing." Following an introductory lecture, almost every school devoted the bulk of classroom time to on-the-job training. The school at the Army and Navy General Hospital reported in mid-1943 that "some months ago we requested all instructors to limit their straight lectures to twenty-five minutes, devoting the remainder of

²⁴ (1) Mobilization Training Program No. 8-1, 9 Sept. 1940. (2) Circular Letter No. 79, Office of The Surgeon General, 7 Nov. 1940, subject: Training of Medical Department Personnel.

²⁵ Memorandum, Col. R. W. Bliss, MC, for Director of Military Training, Army Service Forces, 4 Aug. 1943, subject: Training Program for Medical Department Technicians.

²⁶ Army Service Forces Memorandum No. S350-44-43, 29 Aug. 1943.

²⁷ Memorandum, Maj. John W. Graves, MC, Assistant to Chief, School Branch, Training Division, Office of The Surgeon General, for the Commandant, Medical Department Enlisted Technicians School, Army and Navy General Hospital, Hot Springs, Ark., 4 Nov. 1943, subject: Training Programs for Medical Department Technicians (WAC).

the hour to oral quiz and review."²⁸ Similarly, the school at William Beaumont General Hospital reported that demonstrations were included in almost all lectures. The Medical Department Enlisted Technicians School at Lawson General Hospital reported that "students are taught laboratory procedures by lectures, demonstration, and by actually performing over and over again the various procedures. Performance of the procedures, under close supervision, is the most important part of their training."²⁹ After a month of formal course work, student laboratory technicians spent a major portion of their time in training laboratories, where, under close supervision, they practiced procedures they would later perform independently. In courses for medical and surgical technicians, the latter part of training was devoted to practice in model hospital wards. In every course, emphasis was practical, rather than theoretical. The guiding principle was to teach a technician to perform a duty, without necessarily understanding why it was done in a given way. The short period of time allowed for training permitted no other approach.

Until August 1943, courses for medical, surgical, dental, X-ray, and laboratory technicians were divided into two major phases. The first phase was conducted in the school and included both formal and applied training. The second phase consisted of on-the-job training at the hospitals to which the schools were attached. At Fort Sam Houston, for example, student laboratory, dental, and X-ray technicians spent 2 months in the school, and a third month at the VIII Corps Area Laboratory, the Central Dental Laboratory, or the Station Hospital X-ray Clinic. Medical and surgical technicians spent the last part of their training working in hospital wards.³⁰

Under the training program published by Army Service Forces in August 1943, the length of the laboratory and X-ray courses was increased from 3 to 4 months, and of the medical and surgical courses from 2 to 3 months. Most schools used the added month to increase the proportion of time devoted to practical training; time spent in on-the-job training at hospitals remained unchanged. The Medical Department Enlisted Technicians School at Fitzsimons General Hospital, for example, increased the period of formal training for surgical and medical technicians by 6 days, and the period spent in model wards by 10 days.³¹ At Billings General Hospital, extra hours in the same courses were used, in part, to add a week of field training, so that students could practice operating aid stations and evacuating patients under adverse conditions.³²

The amount of field training varied both between schools and between courses. The Equipment Maintenance and Repair Course was marked by a total absence of field training, while more than one-third of the instruction scheduled for the

²⁸ Annual Report, Medical Department Enlisted Technicians School, Army and Navy General Hospital, Hot Springs, Ark., fiscal year 1943.

²⁹ See footnote 21, p. 222.

³⁰ Annual Report, Enlisted Technicians Service School, Medical Department Station Hospital, Fort Sam Houston, Tex., fiscal year 1942.

³¹ Annual Report, Medical Department Enlisted Technicians School, Fitzsimons General Hospital, Denver, Colo., fiscal year 1944.

³² Annual Report, Medical Department Enlisted Technicians School, Billings General Hospital, Indianapolis, Ind., fiscal year 1944.

Sanitary Technicians Course was conducted out-of-doors under field conditions. Most technical courses, however, fell between these extremes. A survey conducted early in 1945 indicated that two Medical Department Enlisted Technicians Schools conducted very little field training, primarily because facilities were not available. Five schools reported that student medical and surgical technicians participated in field exercises stressing the operation of battalion aid stations, emergency medical treatment, and the loading and unloading of ambulances.³³ More field training was included in the medical, surgical, and X-ray courses than in any of the others. Some courses, such as pharmacy, did not lend themselves to out-of-doors training, while others, such as the course for laboratory technicians, developed skills that were easily transposed to the field.

In addition to course-oriented field training, students at Medical Department Enlisted Technicians Schools were required by War Department and Medical Department directives to participate in "Concurrent Basic Military Training." The bulk of this training was designed to keep trainees in a state of physical fitness and to refresh their knowledge of subjects such as dismounted drill. A few subjects, such as sanitation, were also applicable in the field. In August 1943, the amount of time devoted to concurrent basic military training was standardized at 72 hours for 3-month courses, and 108 hours for 4-month courses. Each student was required to attend from 4 to 8 hours of field sanitation, emergency medical treatment, and individual security.

TECHNICAL TRAINING

Medical and Surgical Technicians

At most schools, the training of medical and surgical technicians was organized as a single program. Typically, trainees attended classes together during the first month or two of the course and were separated only during the final, on-the-job phase of instruction. At that point, medical technicians were assigned to medical wards, and surgical technicians to surgical wards or the surgical service. Initially, course length was set at 2 months, but this length proved inadequate to provide trainees with time to practice applying the knowledge they acquired in formal classes. In August 1943, when the Medical Department reorganized technical training, course length was extended to 3 months. The additional time was used to expand the scope of the course and to increase the amount of practical training provided in the classroom. Throughout the war, trainees were provided with a month of on-the-job training in hospital wards. At first, this phase of the program was conducted at the general hospital adjacent to the school, but in mid-1944, the program was expanded to include "satellite" hospitals in the same geographic area.³⁴

³³ Goodman, Samuel M.: *History of Medical Department Training U.S. Army World War II. Volume XI: Medical Department Enlisted Technicians Schools Special Reports. Questionnaire Returns on History of Schools 1 July 1939-30 June 1944.* [Official record.]

³⁴ (1) Letter, Lt. Col. Charles H. Moseley, MC, Deputy Director, Training Division, Office of The Surgeon General, to Director of Military Training, Army Service Forces, 24 June 1944, subject: *Applicatory Training for Medical and Surgical Technicians.* (2) Memorandum, Col. Floyd L. Wergeland, MC, Director, Training Division, Office of The Surgeon General, for Commandant, All Medical Department Enlisted Technicians Schools, 18 July 1944, subject: *Assignment of Medical and Surgical Technicians, and inclosures thereto.*

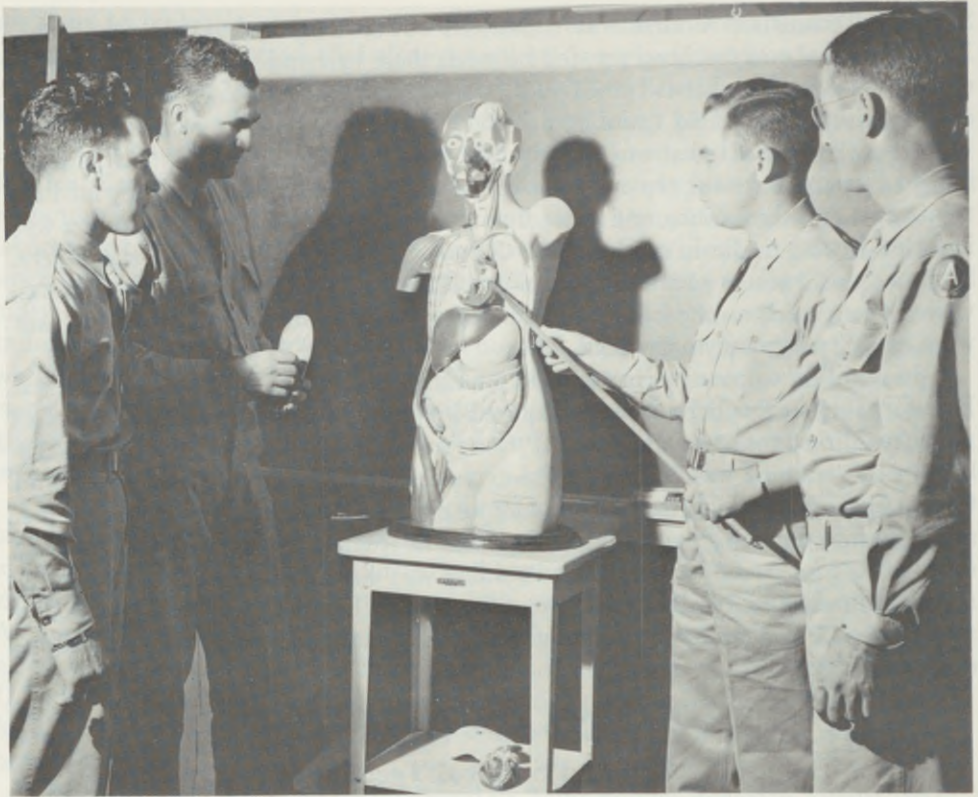


FIGURE 31.—Utilizing a mannikin which separates the organs of the body, a Medical Corps officer instructs medical technicians in anatomy at the Enlisted Technicians School, Brooke General Hospital, San Antonio, Tex., in 1942.

After August 1943, the program for medical and surgical technicians consisted of 12 weeks of intensive training designed to prepare soldiers for service at all types of medical units and installations. Lectures and demonstrations were most common during the first month of classes, when trainees were introduced to the fundamentals of their specialties. During this period, instruction focused on subjects such as anatomy and physiology, hygiene and disease prevention, ward procedure, ward management, and emergency medical treatment (fig. 31). Classes were designed to prepare the student for practical training during the last 2 months of the program. Subjects were introduced through lectures and demonstrations, but emphasis was placed on student participation and practical exercises in which classes were broken down into small groups so that each student would be able to practice procedures under an instructor's supervision.

During the second month, training centered on first aid and emergency care of all injuries and diseases common to wartime medicine. The topics studied included inflammation and infections, wounds and burns, gas casualties, and injuries to various regions of the body. The last half of the month was devoted exclusively

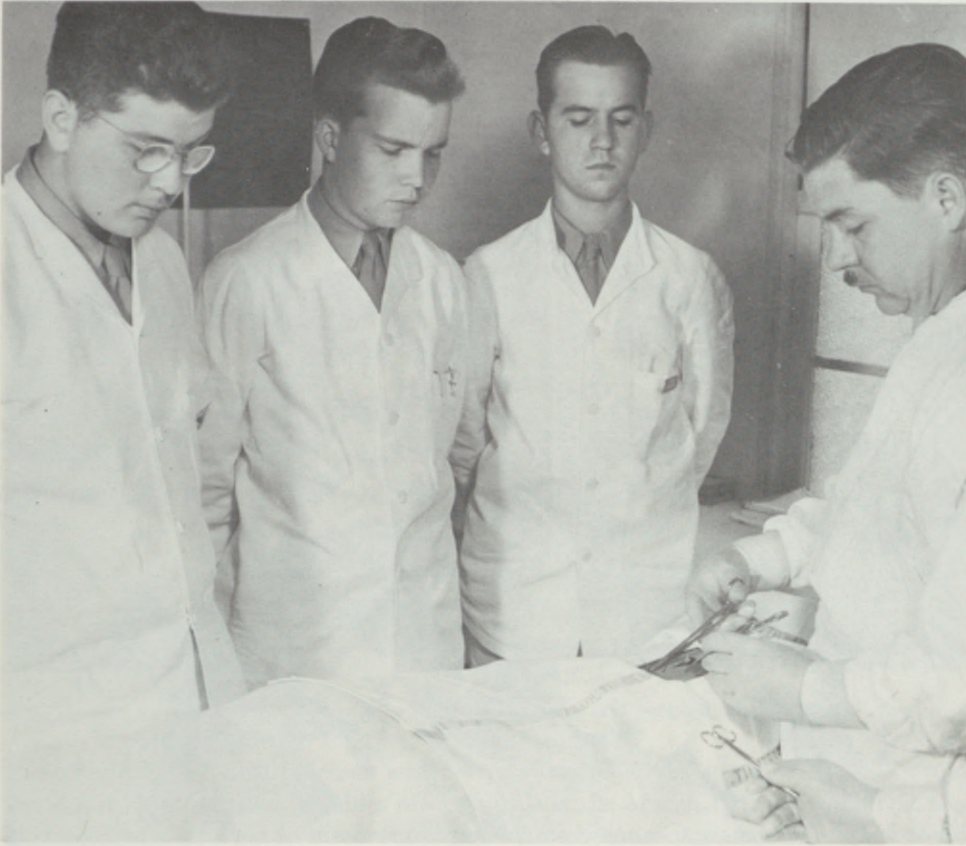


FIGURE 32.—Surgical technicians in training at the Medical Department Enlisted Technicians School, Letterman General Hospital, San Francisco, Calif., view a demonstration of operating room techniques.

to surgical and ward techniques (fig. 32). The final month of the program was spent working in hospital wards, learning the duties of a ward attendant under the supervision of a nurse.³⁵

Advanced Medical and Surgical Technicians

In August 1942, the Medical Department Enlisted Technicians School began to provide 3 months of advanced training for selected individuals who had completed the surgical and medical technicians courses.³⁶ The purpose of the course was twofold: to prepare male technicians to replace nurses in forward areas, and to train graduates of the basic courses who had been selected to remain at the

³⁵ See footnote 26, p. 223.

³⁶ See footnote 9, p. 215.



FIGURE 33.—Dental technicians study full dentures under close supervision of two Dental Corps officers. Such applicatory classes were part of the training of dental technicians in the Enlisted Technicians Schools of the Medical Department.

schools as instructors. A few lectures were included in the program, but the bulk of the training was conducted in hospitals, where trainees could understudy nurses on duty in the wards.³⁷ While the program was in operation, courses were established at all Medical Department Enlisted Technicians Schools except those at Wakeman and the Army and Navy General Hospitals. Training was temporarily halted in May 1944, but resumed in July to provide additional instructors for Medical Department Enlisted Technicians Schools. Despite the program's apparent success,

³⁷ Final Report, Medical Department Enlisted Technicians School, O'Reilly General Hospital, Springfield, Mo., 1 July 1944 to 15 March 1945.



FIGURE 34.—Class in dental hygiene and prophylaxis.

these highly trained technicians were never awarded an occupational specialty and could not be recognized in tables of organization. In March 1945, the Medical Department was directed to discontinue the course because it was not designed to fill table-of-organization vacancies and could not be justified by the troop basis.³⁸

Dental Technicians

The 12-week course for dental technicians was designed to prepare students to serve either in a dental laboratory as a prosthetic technician or in a dental clinic as a chair assistant. At most schools, the first 8 weeks of the course were devoted to the fundamentals and mechanics of dental laboratory procedures. Trainees in both subspecialties attended classes in dental and oral anatomy, prosthetic materials and metallurgy, tooth carving, full and partial dentures, and various aspects of tooth repair. During the final month of the program, trainees were split into two groups for on-the-job training. Those slated to become laboratory technicians worked in laboratories and attended extra classes in dental prosthetics (fig. 33). Those scheduled to become chair assistants received special training in roentgenology, dental records, dental hygiene, and chair assistance (fig. 34).³⁹

³⁸ Annual Report, School Branch, Part B. *In* Annual Report, Training Division, Operations Service, Office of The Surgeon General, fiscal year 1945.

³⁹ Medical Department, United States Army. *Dental Service in World War II*. Washington: U.S. Government Printing Office, 1955.

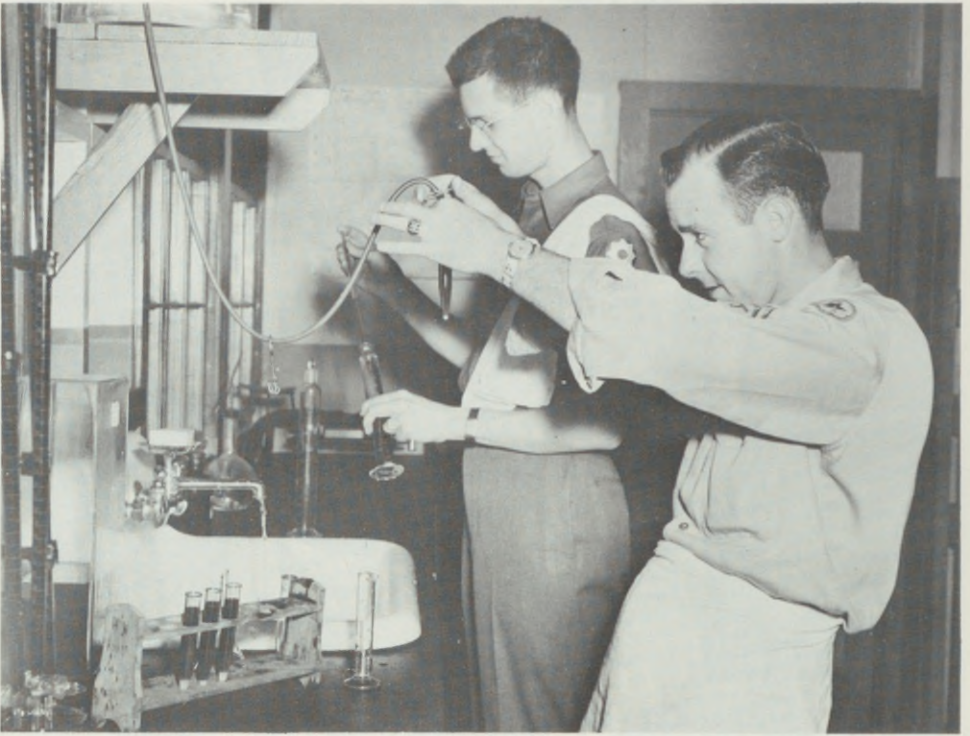


FIGURE 35.—Practical training in the laboratory.

Laboratory Technicians

In April 1941, a 3-month version of the prewar course for laboratory technicians was established at each of the Medical Department Enlisted Technicians Schools. The purpose of the course was to train enlisted men to perform routine laboratory tests at any type of medical unit. Their studies included bacteriology, parasitology, serology, hematology, and some entomology.⁴⁰ Emphasis was always on the practical exercise, and in August 1943, the course was lengthened to 16 weeks, to provide more time for practical training (fig. 35).

X-ray Technicians

In common with other technical courses, the program for X-ray technicians was divided into two phases. For the first 2 months, trainees attended lectures and participated in practical exercises designed to translate theory into technical ability. During this phase, their studies included anatomy, physics, fluoroscopy, radio-

⁴⁰ Final Report, Medical Department Enlisted Technicians School, Lawson General Hospital, Atlanta, Ga., 22 June 1945.



FIGURE 36.—Instruction in darkroom technique.

graphic materials, and darkroom techniques (fig. 36). By far, the largest single block of their time was spent in practicing the use of X-ray equipment. Students were trained to operate both the equipment common to fixed hospitals and the special equipment, darkrooms, and generators used in field units.⁴¹ During the final month of training, students were assigned to the local general hospital for on-the-job training. At the Army School of Roentgenology, which was not attached to a general hospital, students worked in the X-ray clinics of two nearby civilian hospitals. Toward the end of the war, they were also sent to Kennedy General Hospital, on the outskirts of Memphis, Tenn., and to the X-ray department of the U.S. Army General Dispensary in Memphis. When course length was extended from 3 to 4 months in 1943, the additional time was used to bolster the school phase of training.

Pharmacy Technicians

The Pharmacy Technicians Course was established in 1939 to improve the quality of enlisted men assigned to pharmacies in Army hospitals. The program of the new course included lectures and practical exercises in organic chemistry, pharmaceuticals, arithmetic, applied bacteriology, materia medica, toxicology, dispensing, drug identification, pharmacy administration, and Medical Department

⁴¹ See footnote 37, p. 228.

supply procedures. The course began on 15 September and the first class of 19 men was graduated on 31 May 1940.⁴²

In April 1941, when training began at the Medical Department Enlisted Technicians Schools, a 3-month course for pharmacy technicians was established at each school. Class capacities were never large, and by 1943, the relatively large number of pharmacists received by the Army through Selective Service had relieved the shortage of technicians. In March 1943, courses were discontinued at the Army Medical Center, and at Army and Navy, Letterman, and Brooke General Hospitals. Training continued on a reduced scale at the Medical Department Enlisted Technicians Schools at William Beaumont and Fitzsimons General Hospitals until May 1945, when the wartime program was discontinued. In contrast with most technical courses, the course for pharmacy technicians was conducted exclusively at the schools. Only one school reported sending technicians to work at a hospital, and in that instance, on-the-job training was limited to a single week.⁴³

Sanitary Technicians

The monthlong training program for sanitary technicians required by The Surgeon General's Protective Mobilization Plan was established at the Medical Field Service School on 9 September 1940,⁴⁴ and two classes graduated that fall. A third class was enrolled in April 1941, and classes continued to be held each month until November 1941, when the course was discontinued.⁴⁵ Responsibility for training sanitary technicians was then transferred to Medical Replacement Training Centers.⁴⁶

Medical Equipment Maintenance Technicians

The Medical Maintenance Technicians Course was established at the St. Louis Medical Depot in January 1942, and the first class began the following month. The directive establishing the program clearly outlined its scope and purpose. The course was to be of 3 months' duration, and cover packing, unpacking, assembly, installation, and care of X-ray equipment, sterilizers, and other expensive and highly technical items of Medical Department supply and equipment. In the selection of students, careful consideration was to be given to their adaptability, intelligence, and mechanical ability. The minimum educational qualification was a high school diploma. It was suggested that an officer be appointed who could con-

⁴² (1) Circular Letter No. 39, Office of The Surgeon General, 14 Aug. 1939. (2) Letter, Col. George R. Callender, MC, Director, Army Medical School, Army Medical Center, Washington, D.C., to The Adjutant General (through channels), 5 June 1940, subject: Report of Enlisted Technicians Course in Pharmacy.

⁴³ Annual Report, Medical Department Enlisted Technicians School, Brooke General Hospital, Fort Sam Houston, Tex., fiscal year 1943.

⁴⁴ Letter, Brig. Gen. Robert Brooke, Commandant, Medical Field Service School, to The Adjutant General, through The Surgeon General, 9 Aug. 1940, subject: Programs.

⁴⁵ 4th Indorsement, Letter, The Adjutant General, War Department, to the Commanding General, Fort Bragg, N.C., 22 Sept. 1942.

⁴⁶ Letter, The Surgeon General to Commanding Generals, All Medical Replacement Training Centers, 19 May 1942, subject: Sanitary Technicians.

tact the major suppliers of X-ray equipment and sterilizers and arrange for instruction from representatives of those concerns.

Almost without exception, the first instructors were provided by medical equipment manufacturers. In most instances, instructors even furnished the tool kits and instructional aids. By the end of the first year of operation, the course had stabilized into a 12-week program covering X-ray equipment, sterilizers, anesthesia apparatus, resuscitators, electronic equipment, and basic military training. The course consisted of practical exercises and on-the-job training, interspersed with a minimum of informal conferences and lectures. Classes were kept as small as possible, and many practical exercises were conducted in the maintenance and repair sections of the depot. Other exercises were conducted with nonserviceable equipment turned over to the school by the depot.

Veterinary Technicians

In common with other prewar courses, the length of the Veterinary Technicians Course was reduced to 12 weeks in August 1940. In April 1941, courses for veterinary technicians were established at the Enlisted Technicians Schools at the Army Medical Center (fig. 37) and at William Beaumont General Hospital. Training was confined to these two institutions throughout the war.



FIGURE 37.—A Veterinary Corps officer instructs a class of veterinary technicians at the Army Veterinary School, Army Medical Center, Washington, D.C.



FIGURE 38.—Technician practicing use of portable optical equipment.

The program in veterinary technology was designed to train enlisted men to perform a variety of duties. After courses were standardized in 1943, one-third of the program was devoted to meat and dairy hygiene. The second third was devoted to animal management. The remaining time was spent on subjects such as forage and grain inspection and administration.⁴⁷

Optical Technicians

The program for optical technicians was established on 13 September 1943. The course was designed to train students who had a civilian background in optical work to prepare and dispense optical equipment in the field. During their 6 weeks at the St. Louis Medical Depot, trainees learned to operate mobile and portable optical units, to fit lenses into both normal frames and gas masks, and to make emergency repairs and alterations (fig. 38).⁴⁸

⁴⁷ Program of Instruction for Veterinary Technicians at the School for Medical Department Technicians, 18 Mar. 1943. In Annual Report of Technical Activities, Medical Department Professional Service Schools, Army Medical Center, Washington, D.C., fiscal year 1943, Section V: School of Medical Department Technicians.

⁴⁸ Annual Report, Army Service Forces Medical Supply Service School, St. Louis Medical Depot, St. Louis, Mo., fiscal year 1944.

Orthopedic Mechanics

In contrast with other enlisted technicians, orthopedic mechanics were trained as apprentices. By understudying and assisting experienced craftsmen in orthopedic workshops, trainees learned to measure, fabricate, and fit belts, supports, braces, splints, and shoes for orthopedic patients.⁴⁹ The first course began in September 1940, when two enlisted men were enrolled at Walter Reed General Hospital for 12 months of on-the-job training. Their training was cut short after 9 months, however, and they were graduated in June 1940. During the next 2 years, course length was shortened to 3 months; the program was expanded to include two more general hospitals, but enrollment remained small. Between June 1941 and June 1943, only five mechanics graduated. Early in 1943, the demand for orthopedic mechanics grew steadily, and the number of hospitals conducting courses was increased from three to 13 by 1944. The capacity of the program was increased from 13 trainees per cycle in 1943 to 45 by 1944, where it remained until the end of the war.

Other Courses

The overwhelming majority of technicians trained during the war were graduates of the Medical Department Enlisted Technicians School, the Medical Supply Service School, and the apprenticeship for orthopedic mechanics. In addition to these programs, the Medical Department established courses to train small numbers of enlisted personnel in other specialties.

Typical of these courses was the 2-week Dental Equipment Course established at the Ritter Dental Manufacturing Co., Inc., Rochester, N.Y., in February 1942. The course was designed to train enlisted men to pack, unpack, install, and service dental equipment used by Medical Department units and installations. The first series of courses was conducted between 2 February and 25 April 1942, and the second series was held between 6 July and 12 September the same year. A total of 264 enlisted men were graduated.

Throughout the war, a course in blood plasma technique was conducted at the Army Medical Center for selected graduates of the Laboratory Technicians Course at the Center's enlisted technicians school. Since the purpose of the program was to train men to serve in plasma banks, instruction focused on the operation of blood donor centers and plasma laboratories. Course length was set at 4 weeks, and enrollment was irregular. Fewer than 50 technicians graduated during the war.⁵⁰

Beginning in June 1944, courses were established at the Army Medical Center, and at DeWitt, Brooke, and Mason General Hospitals to train small groups of enlisted technicians to operate and maintain electroencephalographs. The course was offered until November 1945 when it was discontinued. Course length varied between 8 and 14 weeks.

⁴⁹ See footnote 10, p. 217.

⁵⁰ Medical Department, United States Army. *Blood Program in World War II*. Washington: U.S. Government Printing Office, 1964.

In mid-1944, the Medical Department began to train men to serve as instructors in physical reconditioning programs. The School for Physical Reconditioning Instructors was established at the ASF Training Center, Camp Grant, Ill., on 3 May 1944, with a capacity for training 300 enlisted students every 6 weeks, and the first class enrolled at the beginning of June. The course was designed to familiarize students with the emotional and mental problems of convalescent soldiers, to provide a knowledge of games and recreational activities useful in rebuilding physical vigor, and to develop the trainee's leadership abilities. The program included subjects such as passive and active exercises, posture relaxation, gymnasium activities, games, relays, tournaments, swimming, and similar activities, as well as basic military subjects. When Camp Grant closed, the school was transferred to the training center at Fort Lewis, Wash., where it was discontinued on 29 September 1945.⁵¹ Between June 1944 and September 1945, 1,314 instructors had graduated from the program.

ENLISTED WOMEN

Despite being the last of the technical services to accept members of the Women's Army Corps, the Medical Department became their single largest employer. By the end of the war, some 20,000 Wacs (enlisted members of the Women's Army Corps), or more than one-fifth of the entire Corps, were employed by medical installations. As long as well-trained civilians and enlisted men were available, The Surgeon General was reluctant to accept enlisted women. In the autumn of 1943, the Medical Department began accepting about 200 women a month for training as enlisted technicians. Early in 1944, when the Medical Department suffered the loss of some 5,000 technicians to the Infantry, The Surgeon General asked for an extensive program to recruit Wacs for the Medical Department. Within months, more than 4,000 women had been recruited. From mid-1944 until the end of the war, Wacs played an increasingly important role in Army medical service.⁵²

Since one of the purposes of the program was to recruit skilled women from the civilian sector, many Wacs recruited for the Medical Department required no further technical training. In addition to recruiting technically skilled women, recruiters were authorized to accept high school graduates with an AGCT score of 100 or better for training as technicians. The program proved so popular that training facilities had to be continuously expanded.

The first Medical Department Enlisted Technicians School for members of the Women's Army Corps was established at the Army and Navy General Hospital on 9 September 1943, in facilities that had been used for 3 years by the school for male technicians.⁵³ Housing was remodeled to meet the standards of the Women's Army Corps, and, as far as possible, male instructors were replaced by qualified

⁵¹ Loughlin, Richard L.: *The Medical History of the United States Army in World War II. Reconditioning.* [Official record.]

⁵² Treadwell, Mattie E.: *The Women's Army Corps. United States Army in World War II. Special Studies.* Washington: U.S. Government Printing Office, 1954.

⁵³ Annual Report, Medical Department Enlisted Technicians School (WAC), Army and Navy General Hospital, Hot Springs, Ark., fiscal year 1944.



FIGURE 39.—Laboratory procedures. (Top) Enlisted WAC technician receives supervised on-the-job training in laboratory procedures. (Bottom) Dental Corps officer teaches WAC dental technician to make dental plates.

TABLE 16.—*Women's Army Corps technicians trained in Medical Department Enlisted Technicians Schools, 1 July 1943–30 June 1944*

Installation	X-ray (SSN 264)	Medical (SSN 409)	Dental (SSN 855)	Laboratory (SSN 858)	Surgical (SSN 861)	Total
Army and Navy General Hospital.	68	352	70	67	395	952
Station Hospital, Fort Huachuca, Ariz. (Negro only).	6	38	6	5	39	94
Total.....	74	390	76	72	434	1,046

Source: Annual Report, Training Division, Operations Service, Office of The Surgeon General, fiscal year 1944.

members of the Women's Army Corps. In January 1944, Negro enlisted women began attending classes at a school established for them at Fort Huachuca. Both schools provided courses for medical, surgical, X-ray, dental, and medical laboratory technicians (fig. 39) as shown in table 16. With one exception, courses for WAC (Women's Army Corps) technicians were a month shorter than those for men because they omitted the final 4 weeks of on-the-job training.⁵⁴ The programs for male and female dental technicians were identical.

As recruiting intensified in the summer of 1944, the facilities of the Medical Department Enlisted Technicians School at the Army and Navy General Hospital became increasingly inadequate. Since the school could not be expanded at the hospital, it was shifted to Wakeman General Hospital, where it was eventually expanded to a capacity of 790. The first classes enrolled on 11 August 1944.

During the final year of the war, separate training programs for Waacs were eliminated at Medical Department Enlisted Technicians Schools. In October 1944, the Medical Department Enlisted Technicians School at Fort Huachuca was discontinued, and the Army began training Negro women at the school at Wakeman General Hospital. The following month, coeducational training began at the schools at Fitzsimons and William Beaumont General Hospitals. In December, a month of on-the-job training was established for WAC medical and surgical technicians, making these programs identical with those for male technicians. Coeducational training was established at Brooke General Hospital in January 1945, and at Lawson General Hospital in March.

By January 1945, the influx of WAC trainees had created a shortage of WAC housing at all enlisted technicians schools. Eventually, the Medical Department was able to gain ASF authorization for a special 16-week combined medical and surgical technicians course at Northington and Foster General Hospitals, located at Tuscaloosa, Ala., and Jackson, Miss., respectively. The new program provided half a day of formal instruction, and half a day of on-the-job training. By July 1945, 105 technicians had been trained under the new program.

⁵⁴ See footnote 9, p. 215.

Women's Army Corps Hospital Orderlies

The only Medical Department training program that met with failure was the course for hospital orderlies. Women who enlisted for general service in the Women's Army Corps were not required to meet the same standards as those recruited for training as Medical Department Technicians, and by 1944, a large backlog of low-grade workers had accumulated in WAC training centers. At the request of the Women's Army Corps, an experimental program designed to train such women to replace male hospital orderlies was established in August 1944 at Nichols and Mayo General Hospitals, located at Louisville, Ky., and Galesburg, Ill., respectively. During the next few months, 140 women were enrolled in the 8-week program. In October, however, an inspection revealed that such women were incapable of performing heavy physical work and required so much supervision that they added to the nurses' workloads. In November, the course was discontinued.

Women's Army Corps Table-of-Organization Units for General Hospitals

Beginning in September 1944, operations in Europe placed increasing strain on Medical Department resources. Repeated transfers of enlisted men to the combat arms and mounting patient loads led the Surgeon General's Office to ask for 8,500 enlisted personnel—men or women—who could be trained as technicians. In addition, The Surgeon General asked for 5,000 civilian nurses' aides and recommended that all the enlisted technicians be women.⁵⁵

At this juncture, the Director of the Women's Army Corps, Col. Oveta C. Hobby, sensed an opportunity to revive schemes for the establishment of WAC table-of-organization units. Already disturbed by complaints that WAC technicians were being required to perform duties beneath their station, and reluctant to recruit more women unless their status could be guaranteed, Colonel Hobby took her case directly to Gen. George C. Marshall during the closing days of 1944. As a result of this conference, and a second, concerning competition with civilian nursing aides on 5 January 1945, General Marshall directed the Medical Department to cease recruiting civilian nurses' aides and to prepare tables of organization for Women's Army Corps hospital companies.

The tables of organization drafted by representatives of the Surgeon General's Office and the Women's Army Corps called for 100 enlisted women and one WAC officer per hospital company. Nineteen women were to be trained as medical clerks, and the balance as medical and surgical technicians. Since all were to be technicians or skilled clerks, the lowest rating was technician, fifth grade. Companies were to be allotted to named general hospitals in proportion to the number of beds, and hospitals desiring such companies could requisition them.

⁵⁵ (1) Medical Department, United States Army. *Personnel in World War II*. Washington: U.S. Government Printing Office, 1963. (2) See footnote 52, p. 236.

The training of WAC hospital companies was conducted without major difficulties. The Third WAC Training Center at Fort Oglethorpe, Ga., was turned over to recruits, and the basic training program was condensed so that medical training could be conducted at the same post. Since the directive establishing the program required trainees to report to their hospital assignment not more than 12 weeks after reporting for basic training, the training period for medical technicians was shortened to 6 weeks. The usual 4 weeks of on-the-job training was postponed until trainees reported to their duty station.

Instructors for the course were provided by the Fourth Service Command upon recommendation by The Surgeon General. The nucleus of the training staff came from the Medical Department Enlisted Technicians School, Lawson General Hospital, and the program was conducted under the command of Lt. Col. James M. Dunn, MC, former assistant commandant of the school at Lawson General Hospital. The staff of the medical and surgical section ultimately included 28 medical officers, three Medical Administrative Corps officers, 23 Army nurses, 32 enlisted men from Lawson General Hospital, and about 160 enlisted women. Most of the enlisted women were graduates of the Medical Department Enlisted Technicians School who had achieved grades of excellent or superior. Since many of the staff had never been involved in teaching, Colonel Dunn required the entire staff to attend an intensive instructor guidance course. The staff for the medical clerks' course was created by sending a WAC officer and several enlisted women to Camp Berkeley, Tex., for conferences with instructors in the medical clerks' course at the basic training center. Women graduating from this course at Fort Oglethorpe were placed on 4 weeks' probation at their duty station, instead of receiving 4 weeks' on-the-job training. By the end of the war, a total of 120 WAC hospital companies had been trained and attached to hospitals in the Zone of Interior (table 17).⁵⁶

EDUCATIONAL TECHNIQUES AND PROBLEMS

Instructors for Medical Department Enlisted Technicians Schools were secured from a variety of sources, and each school was responsible for developing its own teaching staff. When the first Medical Department Enlisted Technicians Schools were established in 1941, the commanding officers of the hospitals to which the schools were attached became the commandants of the new schools. The assistant commandant, and, in some instances, other key officials, were selected by The Surgeon General from among Regular Army and Reserve Corps officers. In most instances, a large proportion of the school's initial staff was formed by transferring personnel from the hospital to which the school was attached. Instructors for schools established after 1941 were usually selected from among newly commissioned officers. Occasionally, new schools were able to secure instructors from schools already in operation, but such sources were the exception.⁵⁷ Instructors

⁵⁶ See footnotes 19(2), p. 219; and 55(1), p. 239.

⁵⁷ Annual Report, Medical Department Enlisted Technicians School, O'Reilly General Hospital, Springfield, Mo., fiscal year 1943.

TABLE 17.—Enlisted women trained in Medical Department Enlisted Technicians Schools, 1 July 1944 to 30 June 1945

Installation or source	X-ray technician (SSN 264)	Medical technician (SSN 409)	Dental technician (SSN 855)	Laboratory technician (SSN 858)	Surgical technician (SSN 861)	Hospital orderlies	Occupational therapy assistants	Special combined medical and surgical technicians course	Physical therapy technicians	Total
Fitzsimons General Hospital.....	83	108	20	92	77					380
William Beaumont General Hospital.....	42	503	50	46	387					1,028
Brooke Hospital Center.....		209			80					289
Wakeman Hospital Center.....	189	866	257	330	636					2,278
Army and Navy General Hospital.....		84	17	39	76					216
Fort Huachuca.....	2	18	3	2	14					39
Mayo General Hospital.....						74				74
Nichols General Hospital.....						66				66
Halloran General Hospital.....							181			181
Northington General Hospital.....								55		55
Foster General Hospital.....								50		50
Physical therapy technicians.....									245	245
Total.....	316	1,788	347	509	1,270	140	181	105	245	4,901

Source: Annual Report of the Training Division, Operations Service, Office of The Surgeon General, fiscal year 1945.

were sometimes ordered to another school for a brief period of indoctrination and training before assuming duties at a new installation.

Although enlisted instructors were secured from a variety of sources, the initial cadre was usually selected from the adjacent hospital or another school. At all schools, replacements for instructors were selected from among groups of unassigned graduates. This method of replacing instructors proved highly satisfactory, for it allowed careful evaluation of the student before assignment and assured his complete familiarity with the school and the course. Inexperienced staff members were usually oriented by the school section to which they were assigned, and the amount of orientation and training they received varied from school to school. New instructors were usually required to become familiar with Army field manuals on instruction as well as to observe experienced teachers in the classroom. As a general rule, inexperienced teachers were also required to study instructors guides and lesson plans on file at the schools, to prepare practice lesson plans of their own, and to deliver brief lectures before faculty committees.

During the last 2 years of the war, the demand for experienced personnel in the theaters made heavy inroads into school staffs, and instructor replacement became an acute problem. On occasion, schools reported having to replace more than 50 percent of their instructors in a single month. To combat the loss of experienced teachers, several schools established formal training programs for new instructors. The Medical Department Enlisted Technicians School at Billings General Hospital, for example, conducted a weeklong course of lectures and demonstrations on training techniques, and the school at Lawson General Hospital conducted a course that varied in length from 13 to 39 hours.⁵⁸

SELECTION, QUALITY, AND DISPOSITION OF TRAINEES

Medical Department Enlisted Technicians Schools received trainees from three major sources: Medical Replacement Training Centers, fixed hospitals and numbered units under the control of Army Service Forces, and hospitals and units under the control of the Air and Ground Forces. With two exceptions, trainees were required to have completed high school or an equivalent technical program. Those who had completed 4 weeks of basic military training and achieved an AGCT score of more than 100 were qualified, even though they did not meet the educational requirements for training as sanitary technicians or veterinary technicians.⁵⁹ In theory, students were selected according to their adaptability, intelligence, and previous educational attainments. In practice, many students were poorly or carelessly selected.

During the year preceding the establishment of enlisted technicians schools, students enrolled in technical courses at the Army Medical Center experienced few

⁵⁸ See footnote 33, p. 225.

⁵⁹ (1) Letter, The Adjutant General, War Department, to The Surgeon General, 7 Jan. 1942, subject: Selection of Soldiers for Specialists Schools. (2) Letter, The Surgeon General to The Adjutant General [War Department], 16 Jan. 1942, subject: Selection of Soldiers for Specialists Schools.

difficulties. Of the 188 students enrolled in the technical program, only 11 failed to graduate. Schools established in 1941, however, frequently complained about the presence of large numbers of unqualified trainees in their classes. In July 1941, only 3 months after an enlisted technicians school was established at the Army and Navy General Hospital, the commandant complained to the Director of Training, Office of The Surgeon General, that:⁶⁰

One of the worst troubles of the selectee school is the poor mental equipment of many of the men sent in for instruction * * *. The schools would undoubtedly be much more efficient if the officers making the selection of candidates could be induced to send only well educated men of proper type and character. Some few men we receive are obviously drunks, derelicts, or un-dependable, and many others of insufficient mental education to be capable of absorbing advanced training.

The assistant commandant of the school was equally disturbed and expressed concern over the time lost in attempting to bring poorly qualified men up to a minimum grade. Of the students enrolled in the school at the Army and Navy General Hospital through July 1941, 27 percent had less than an eighth grade education, and officials reported that the situation did not improve during the next 10 months.⁶¹ Reports from the Army Medical Center were equally critical; approximately one-third of the trainees assigned there were not educationally qualified, and many complained that they had never been asked if they desired to become technicians. In his annual report, the commandant observed that: "A certain proportion of these men assigned to the laboratory are incapable of getting beyond scrubbing the floors."⁶²

Beginning in May 1942, both schools reported an improvement in the quality of students being sent for training. During the next 12 months, schools were generally satisfied with the quality of trainees. The only students identified as being consistently below standard were those sent by the Army Air Forces between December 1942 and June 1943. The Army Medical Center complained that:⁶³

As a whole these men have been the poorest sent here, relatively ill-prepared, and in many instances did not desire to take this type of instruction. The trainees in some instances were mechanics with little or no interest in the medical specialties. They were therefore unsatisfactory students and required considerable additional special instruction which interfered to some extent with the instruction of the better qualified personnel.

During a conference in January 1943 on the problems of training AAF personnel, the Director of Training, ASF, informed representatives of the Medical Department that enlisted technicians schools were required to continue training men sent by the Army Air Forces, even if they were regarded as untrainable. In

⁶⁰ Letter, Col. Ralph H. Goldthwaite, MC, Commanding Officer, Army and Navy General Hospital, Hot Springs, Ark., to Maj. Frank B. Wakeman, MC, Plans and Training Section, Office of The Surgeon General, 8 July 1941.

⁶¹ (1) Letter, Lt. Col. Charles K. Holmes, MC, Assistant Commandant and Director of Training, Army and Navy General Hospital, Hot Springs, Ark., to Commanding Officer, Army and Navy General Hospital, 7 July 1941, subject: Qualifications of July Class. (2) Annual Report, Army and Navy General Hospital, Medical Technicians School, fiscal year 1942.

⁶² Annual Report of Technical Activities, Medical Department Professional Service Schools, Army Medical Center, Washington, D.C., fiscal year 1942. Section V: Annual Report of Technical Activities of the School for Medical Department Technicians.

⁶³ See footnotes 47, p. 234; and 61(2).

setting quotas, the Medical Department was allowed to include a 10-percent attrition factor so that the least qualified 10th of the trainees received from the Air Forces could be eliminated. The remaining 90 percent had to be either graduated or permitted to finish the course without graduating. Schools were directed to retain AAF trainees despite scholastic failure and to require periods of supervised study. Those who could not qualify as technicians were required to gain maximum benefit from attending. Academic standards were protected by allowing schools to refuse to certify those who could not qualify for graduation.⁶⁴

The Medical Department had little choice but to accept the mass assignment of low-caliber AAF trainees. As The Surgeon General's Deputy Director of Training lamented to one center official:⁶⁵

This office is not unappreciative of the tremendous problem and burden placed upon * * * training facilities in attempting to qualify personnel who were not basically fitted for the absorption of technical instruction. However, the rate of procurement of Air Force personnel and the high ratio of technicians required necessitates a rather small ratio of selection. For my own amusement I determined the number of Air Force personnel being assigned monthly to medical service with the Air Force. The problem involved is astounding when it is considered that approximately one out of every four men assigned to medical service with the Air Force must be a technician of some kind. (You are probably familiar with Air Force T/O's). * * * The Air Corps does not have adequate numbers from which to select technical personnel. This is why the Director of Training, S.O.S., makes the unqualified statement that [the] job will be done despite handicaps and imposition on schools, the presumption being that a man who had completed eight weeks of training in a special service school is a better man than when he entered the school even though he was not successful in graduating.

When the Army Air Forces withdrew from the program in June 1943, its decision was accepted without comment.

Variations in quality continued after June 1943, but without any apparent pattern. After its conversion into a training center for enlisted women, the school at the Army and Navy General Hospital reported that women being sent for training were generally highly qualified.⁶⁶ The school at Lawson General Hospital found itself neither pleased nor vexed by the trainees it received, and reported that quality tended to vary between classes. The Army Medical Center experienced increasing difficulty with students sent from Medical Replacement Training Centers, enrolling one class in which five members had jail or guardhouse records.⁶⁷ Despite minor variations, however, students enrolled during the last 2 years of the war appear to have been better qualified than those who attended between 1941 and 1943. By mid-1944, trainee quality had improved to the point that the rate of attrition for all candidates between July 1941 and 30 June 1944 had been reduced to 8.5 percent.

⁶⁴ Memorandum, Maj. Gen. John C. Magee, The Surgeon General, for the Commandant, Medical Department Enlisted Technicians School, Army and Navy General Hospital, Hot Springs, Ark., 14 Jan. 1943, subject: Training of Enlisted Technicians, Army Air Forces.

⁶⁵ Letter, Lt. Col. D. J. Sheehan, MC, Deputy Director, Training Division, Office of The Surgeon General, to Col. Robert E. Peyton, MC, Director of Training, Services of Supply, Headquarters, Medical Replacement Training Center, Camp Joseph T. Robinson, Ark., 17 Feb. 1943.

⁶⁶ See footnote 53, p. 236.

⁶⁷ See footnote 33, p. 225.

Other studies conducted by the Medical Department indicate that scholastic deficiencies were the immediate cause for relieving approximately 70 percent of the trainees who failed to graduate from enlisted technicians schools. Predictably, there was a strong correlation between the length of formal civilian education and success in technical training. Trainees with education beyond high school were almost certain to graduate, while those with less than a grammar school education seemed destined to fail. Each year of formal education beyond grammar school significantly increased the trainee's chances of success. Not all scholastic failures, however, were attributable to civilian educational achievement; disinterest also contributed to academic failure. Lack of interest was most frequently noticed in trainees who had been transferred from other arms or services. The Army Air Forces, in particular, seemed to have a penchant for assigning men who had no interest in becoming medical technicians. On occasion, authorities also noticed a resistance to training. Such resistance was noted during 1941 among draftees who were under the impression that they would be retained in the service if they excelled. The same tendency was reported late in 1944 for substantially the same reasons. Disciplinary dismissals, transfers, and recall for overseas movements accounted for those students who failed to complete the courses for nonacademic reasons.

Trainees were sent to Medical Department Enlisted Technicians Schools from a variety of units and installations under the control of the Army Air, Army Ground, and Army Service Forces, but a few remained permanently under the control of the Medical Department. Trainees sent to enlisted technicians schools by units and installations were returned to their parent organization whether they failed or completed the course.⁶⁸

Unassigned trainees sent to schools from replacement training centers were assigned to medical units and installations upon completion of their training. Until April 1944, The Surgeon General had the authority to make recommendations on the allocation of unassigned graduate technicians from all commands except the Army Air Forces. Schools were required to submit reports on the availability of unassigned technicians through the Office of The Surgeon General, which forwarded them to The Adjutant General with recommendations for allocation. The Surgeon General could recommend assignment to any medical activity in the Army, including those controlled by the Army Air Forces. Only unassigned personnel sent to school by the Army Air Forces were exempt. Technicians were assigned according to The Surgeon General's recommendations, unless they were required as loss replacements.⁶⁹ Unassigned trainees from AAF training centers who successfully completed their technical training were returned to the Air Surgeon for allocation to AAF medical organization.

⁶⁸ (1) Circular Letter No. 49, Office of The Surgeon General, 3 July 1940, subject: Selection of Enlisted Men, Medical Department, for Attendance at Special Service Schools. (2) Letter, The Adjutant General, War Department, to Commanding Generals, All Armies, Corps Areas, and Medical Replacement Training Centers, Chiefs of Armored Force and Army Air Force, 15 Jan. 1942, subject: Trainees Selected to Attend Medical Department Enlisted Technicians Schools.

⁶⁹ (1) Letter, The Adjutant General, U.S. Army, to Commanding Generals, Army Ground Forces and Services of Supply, 27 May 1942, subject: Enlisted Men From Replacement Training Centers to Attend Special Service Schools, and Their Assignment Upon Completion of Such Courses. (2) Letter, The Adjutant General, U.S. Army, to Arms and Services (except Air Corps), 31 Dec. 1941, subject: Trainees Selected to Attend Special Service Schools.

When the system of preactivation training was established on 15 April 1944, The Surgeon General was relieved of his responsibility for making direct recommendations on the allocation of unassigned trainees.⁷⁰ Under the preactivation program, technicians who had been sent to school from replacement training centers were returned to those centers for 3 weeks of basic team training. After completing team training, they were designated as fillers or replacements and assigned to appropriate units.

⁷⁰ (1) War Department Memorandum No. W615-70-42, 17 Dec. 1942. (2) Army Service Forces Circular No. 104, 15 Apr. 1944.

CHAPTER VIII

Medical Department Field Units¹

In the summer of 1939, the Medical Department had only five active field organizations. Of these, four were at peace strength, and one was "skeletonized."² During the first year of the limited emergency, the field strength of the Medical Department was modestly expanded, and by 30 June 1940, four medical battalions, a medical regiment, and the medical detachments of four Regular Army combat divisions were in training.³ All, including those activated early in 1940, were designed to provide organic support for combat divisions.

The first nonorganic medical units were activated following the onset of limited mobilization. By July 1941, The Surgeon General reported that 76 nondivisional medical field units had been activated, including numbered general and station hospitals, evacuation and surgical hospitals, medical supply depots and laboratories, a numbered general dispensary, a veterinary evacuation hospital, and a veterinary general hospital.⁴ Many of these units, described as "professional" units by The Surgeon General, were types that would later be trained by the Army Service Forces.

COMMAND AND STAFF RESPONSIBILITY FOR TRAINING MEDICAL DEPARTMENT UNITS

From the beginning of limited mobilization until the reorganization of March 1942, responsibility for training nondivisional medical units was vested in the offices of the field army surgeons through the field armies and General Headquarters. In November 1940, for example, the 2d Medical Laboratory, Fort Sam Houston, Tex., which was the only active nondivisional unit then in operation, was placed under the control of the Third U.S. Army. A month later, before any other nondivisional units were activated, the War Department directed that 60 nondivisional units whose activation was being planned be attached to the First, Second, and Third U.S. Armies. This group included 20 station hospitals, 17 general hospitals, 12 evacuation hospitals, six surgical hospitals, a medical laboratory, a general dispensary, a veterinary evacuation hospital, and two medical supply depots. From the standpoint of training responsibility, such attachments were considered equivalent to assignments. Corps Areas usually controlled the technical training

¹ Unless otherwise indicated, this chapter is based on Goodman, Samuel M.: History of Medical Department Training U.S. Army World War II. Volume VI: A Report on the Training of ASF-Type Medical Department Units, 1 July 1941-30 June 1945. [Official record.]

² Annual Report of The Surgeon General, U.S. Army. Washington: U.S. Government Printing Office, 1940.

³ Annual Report of The Surgeon General, U.S. Army. Washington: U.S. Government Printing Office, 1941.

⁴ See footnote 3.

of units when they were in garrison, but when the unit moved to the field, training became an army responsibility.⁵ Responsibility for training divisional medical units was vested in the division commander.

The Surgeon General participated in the training of medical units in his capacity as staff adviser to War Department General Staff, G-3, Operations and Training, on matters related to medical service.⁶ The Office of The Surgeon General, for example, developed the tables of organization, the training programs, the instructors' guides, and the field and technical manuals used not only by non-divisional medical units but also by divisional units.⁷ Commanding officers of non-divisional units, such as general hospitals and evacuation hospitals, called upon The Surgeon General for guidance, and he assumed responsibility for explaining to them their relationship to the armies and for listing the training programs and instructional materials available for training.⁸ Representatives of The Surgeon General also conducted technical inspections of both divisional and non-divisional units.⁹

The Reorganization of 1942

The War Department reorganization of March 1942 altered both the system of command responsibility for medical units and The Surgeon General's relationship to their training. War Department Circular No. 59, dated 2 March 1942, which authorized the division of the Army into three separate commands, also provided general guidelines for the unit training responsibilities of each command. Under the new system, AGF (Army Ground Forces) and AAF (Army Air Forces)

⁵ (1) Letter, The Adjutant General, War Department, to Commanding Generals of All Armies, Army Corps, Divisions, Corps Areas, and Departments; Commanding General, General Headquarters, Air Force; Chief of Staff, General Headquarters; Chiefs of Arms and Services; Chief of the Armored Force; Commanding Officers of Exempted Stations, 14 Jan. 1941, subject: Organization, Training, and Administration of Medical Units. (2) Letter, The Adjutant General, War Department, to Chiefs of Arms and Services; Commanding Generals of All Armies, Army Corps, Divisions, Corps Areas, and Departments; Commanding Officers of Exempted Stations; and the Chief of Staff, General Headquarters, 3 Oct. 1940, subject: Organization, Training, and Administration of the Army. (3) Medical Department, United States Army. *Organization and Administration in World War II*. Washington: U.S. Government Printing Office, 1963.

⁶ Letter, The Adjutant General, War Department, to All Army Commanders; All Corps Area and Department Commanders; All Chiefs of Arms and Services; Chief of the National Guard Bureau; Assistant Chiefs of Staff, War Department General Staff; Commanding General, General Headquarters, Air Force; Commandants, General and Special Service Schools; and Commanding Officers of Exempted Stations, 14 Mar. 1938, subject: The Protective Mobilization Plan. (The Initial Military Program.)

⁷ (1) Letter, The Adjutant General, War Department, to The Surgeon General, 10 Feb. 1939, subject: Tables of Organization, and inclosure thereto. (2) Letter, The Surgeon General, U.S. Army, to The Adjutant General, U.S. Army, 14 Aug. 1940, subject: Medical Department Mobilization Training Program 8-1. (3) Letter, Capt. T. J. Hartford, MC, Assistant to Chief, Training Subdivision, Plans and Training Division, Office of The Surgeon General, to Capt. J. F. Morehead, MC, Headquarters, 28th Surgical Hospital, Fort George G. Meade, Md., 3 Mar. 1941. (4) See footnote 4, p. 247.

⁸ (1) Letter, Capt. T. J. Hartford, MC, Assistant to Chief, Training Subdivision, Plans and Training Division, Office of The Surgeon General, to Capt. Jordan A. Kelling, MC, Surgeon, 148th General Hospital, Camp Shelby, Miss., 21 Feb. 1941. (2) Letter, Capt. T. J. Hartford, MC, Assistant to Chief, Training Subdivision, Plans and Training Division, Office of The Surgeon General, to Capt. Paul O. Wells, MC, Commanding Officer, 56th General Hospital, Fort Jackson, S.C., 4 Mar. 1941.

⁹ Letter, Lt. Col. G. C. Dunham, MC, Observer, to The Surgeon General, U.S. Army, 27 Aug. 1940, subject: Report of Observations Made During the Third U.S. Army Maneuvers, August 1940.

were responsible for training their own combat units, and ASF (Army Service Forces) was responsible for training the units necessary for its functioning. Responsibility for training nondivisional service units, however, was not clearly delineated.¹⁰ Each of the three major commands was charged with training units assigned to it, but the ultimate use of a service unit could not always be clearly forecast, and many service units were common to all commands. In April 1942, and again in May, Army Ground Forces requested clarification.¹¹

On 30 May 1942, the War Department issued a more specific statement on training responsibility, announcing that: "In general, the using command will train a unit."¹² Through this policy, the Commanding General, AAF, became responsible for training all Air Force units, including arms and services with the Army Air Forces. The Commanding General, ASF, was responsible for training units organized to operate installations and activities controlled by him and those units organized in the United States solely for Services of Supply installations and activities in overseas garrisons, bases, and theaters. The Commanding General, AGF, was responsible for training all units not falling into one of the other categories. By mutual agreement, the commanding generals of AGF, AAF, and ASF could transfer responsibility for training certain units to each other. Such transfers were encouraged when one command controlled the bulk of the training facilities available for a particular type of unit, or when a training program would create a duplication of existing facilities. The War Department also directed that: "Facilities such as exist at general and station hospitals and certain specialized replacement training centers and schools are required for the proper training of certain units and are under control of the Commanding General, Services of Supply [ASF]. The Commanding General, Services of Supply [ASF], by arrangement with [the] Commanding General, Army Ground Forces or Army Air Forces, should take over the responsibility for unit training which requires the use of these facilities."¹³ While this statement provided limited guidance, it still left doubt about the responsibility for units, such as veterinary evacuation hospitals, field hospitals, and small surgical teams, that might be used in either combat or communications zones, and, hence, might be considered either AGF or ASF units. The responsibility for training AAF units, however, was clearly defined.

In an effort to further define the responsibilities of the Army Service Forces and the Army Ground Forces, the War Department asked each command, in June 1942,

¹⁰ (1) Millett, John D.: *United States Army in World War II. The Army Service Forces. The Organization and Role of the Army Service Forces.* Washington: U.S. Government Printing Office, 1954. (2) Palmer, Robert R., Wiley, Bell I., and Keast, William R.: *United States Army in World War II. The Army Ground Forces. The Procurement and Training of Ground Combat Troops.* Washington: U.S. Government Printing Office, 1948.

¹¹ (1) Memorandum, Brig. Gen. Mark W. Clark, Chief of Staff, Army Ground Forces, for Assistant Chief of Staff, War Department General Staff, G-3, 9 Apr. 1942, subject: Agency or Agencies to Activate Units. (2) Memorandum, Commanding General, Army Ground Forces, for the Assistant Chief of Staff, War Department General Staff, G-3, 9 May 1942, subject: Responsibility for Training.

¹² Memorandum, Brig. Gen. I. H. Edwards, Assistant Chief of Staff, War Department General Staff, G-3, Operations and Training for the Commanding General, Army Ground Forces; Commanding General, Army Air Forces; and Commanding General, Services of Supply, 30 May 1942, subject: Responsibility for Training.

¹³ See footnote 12.

to provide a list of the units that it thought it should train. The lists submitted by the two commands suggest that each desired to control the training of all units except those which were clearly organic to the mission of the other.¹⁴ The first list delineating responsibilities for training specific units was issued by the War Department on 20 June 1942, but the compromise was not satisfactory to either headquarters.¹⁵ During the next several months, these lists were repeatedly altered in an attempt to arrive at a more satisfactory solution. In October 1942, the War Department expanded the responsibilities of the Army Ground Forces by authorizing that command to prepare the tables of organization, equipment, and basic allowances for units that served ground elements.

By January 1943, the division of responsibility had reached a state of relative stability, and the Army Ground Forces was responsible for training and writing the tables of organization, equipment, and basic allowances for the following units: Medical battalions, including those for such specialized divisions as the motorized, armored, and mountain divisions; medical squadrons for cavalry divisions; medical regiments; medical companies to serve the airborne divisions; ambulance battalions; animal-drawn companies; veterinary companies; evacuation hospitals, including the motorized type; and medical supply depots. The Army Service Forces was responsible for training units including general, station, and convalescent hospitals (human and veterinary); veterinary evacuation hospitals; field hospitals; hospital centers; headquarters of Medical Department concentration centers; general dispensaries; general laboratories and laboratories of the army or communications zone; surgical hospitals; sanitary companies; medical gas treatment battalions; hospital trains; three types of units concerned with evacuation by sea—hospital ship platoons, hospital ship companies, and ambulance ship companies; auxiliary surgical groups; detachments for museum and medical arts services; and the medical sections for the headquarters of a communications zone.

This division of responsibilities was by no means final. Many units were altered in name, size, or organization, and some types were abolished or superseded by units developed to meet special needs. Except for minor readjustments, however, the allocation of responsibilities between the two commands for developing, activating, and training Medical Department units continued to rest upon the basis of the zone of the overseas theater within which they were to be employed. The Army Air Forces trained only a few medical units designated to meet the special needs of air troops—chiefly a medical supply, an evacuation, and a dispensary unit.¹⁶

¹⁴ (1) Memorandum, Col. Walter L. Weible, GSC, Deputy Director of Training, Services of Supply, for The Surgeon General, 8 June 1942, subject: Responsibility for Training. (2) Memorandum, Col. John A. Rogers, MC, Executive Officer, Office of The Surgeon General, to Director of Training, Services of Supply, 10 June 1942, subject: Responsibility for Training. (3) Memorandum, Col. F. L. Parks, GSC, Deputy Chief of Staff, AG, for Assistant Chief of Staff, War Department General Staff, G-3, 11 June 1942, subject: Responsibility for the Activation of Units, and inclosures thereto.

¹⁵ (1) Memorandum, Brig. Gen. I. H. Edwards, Assistant Chief of Staff, War Department General Staff, G-3, Operations and Training, for the Commanding Generals, Army Ground Forces, Army Air Forces, Services of Supply, 20 June 1942, subject: Responsibility for the Activation of Service Units. (2) See footnote 10 (2), p. 249.

¹⁶ See footnote 5 (3), p. 248.

The Surgeon General's Responsibility for Training Under the Army Service Forces

The reorganization of 1942 did little to alter The Surgeon General's relationship to medical units trained by Army Service Forces. As The Surgeon General, and the special adviser to the Commanding General, ASF, on matters related to medical service, he continued to prepare the tables of organization, mobilization training programs, medical field and technical manuals, and training aids used by all ASF medical units.¹⁷ Representatives of the Surgeon General's Office were also entitled to conduct technical inspections of all medical units under the jurisdiction of the Army Service Forces.¹⁸ In sum, The Surgeon General's powers within the Army Service Forces were identical to those he had exercised throughout the Army before the War Department was reorganized.

The Surgeon General's relationship to medical units assigned to the Army Ground Forces or the Army Air Forces for activation and training, however, was more remote. Since the commanding generals of ASF, AGF, and AAF stood on a par in their relationship to the War Department, The Surgeon General, the Air Surgeon, and the Ground Surgeon were equals when they functioned as the chief surgeons for their respective commands. In their capacity as command surgeons, the Air Surgeon and the Ground Surgeon were responsible for inspecting AAF and AGF medical units, just as The Surgeon General was responsible for inspecting ASF units. In October 1942, authority to prepare tables of organization, equipment, and basic allowances was also dispersed among the command surgeons. With these exceptions, however, The Surgeon General remained the ultimate authority on medical training doctrine, just as he continued to be responsible for doctrine on matters relating to the health of the entire Army. In his capacity as the chief of a technical service, The Surgeon General continued to prepare technical manuals, field manuals, and mobilization training programs, or in the phrase commonly used, to promulgate doctrine, for all medical units of the Army.¹⁹

THE ARMY SERVICE FORCES UNIT ACTIVATION AND TRAINING SYSTEMS

The Cadre System

Between September 1939 and April 1944, Medical Department theater-of-operations units were activated and trained by a method generally referred to as the cadre system. Under this system, a new medical unit was built upon a nucleus of

¹⁷ (1) Letter, Brig. Gen. C. R. Huebner, Director of Training, Services of Supply, to Chief of Chemical Warfare Service; Chief of Engineers; Chief of Ordnance; Chief Signal Officer; Quartermaster General; Surgeon General; Chief of Administrative Services; Commandant, Command and General Staff School; Superintendent, United States Military Academy, 23 May 1942, subject: Training Publications and Visual Aids, Services of Supply. (2) Army Service Forces Manual M 301, 15 Aug. 1944.

¹⁸ Army Service Forces Manual M 4, April 1945.

¹⁹ See footnote 5 (3), p. 248.

presumably trained personnel supplied by another unit. Depending on the unit being trained, the source of the nucleus, or cadre, might be a Zone of Interior medical installation, such as a fixed general or station hospital, or another theater-of-operations unit or divisional medical unit undergoing training in the Zone of Interior.²⁰

The War Department letter activating a new unit routinely specified the size of the cadre, the installation or unit that would supply the cadre, and the date at which the cadre would report for duty. The same letter also included a schedule for the arrival of the commanding officer and other officer and enlisted personnel, and specified the sources of personnel other than cadre. The Surgeon General routinely supplied, other than cadre, officers and nurses, for all units except those of the Army Air Forces. The Adjutant General supplied a given number of technicians without requisition. Other fillers were requisitioned from The Adjutant General by the activating command as needed. Unit personnel were usually scheduled to arrive in three increments. The commanding officer was to arrive alone on the day of activation, followed in a few days by the other officers and cadre, and finally, by the unit's enlisted complement.

In theory, the cadre system was designed to provide the commanding officer of a new unit with a nucleus of trained officers and enlisted men capable of administering the unit and training other personnel. It was also assumed that all personnel would report to the unit within approximately a week after its activation. The commanding officer and his cadre were scheduled to arrive at their new post just far enough in advance of other personnel to put administrative and house-keeping affairs in order.

In practice, the cadre system frequently deviated from the theoretical model. In some instances, the designated commanding officer of a unit arrived days, or even several weeks, after other personnel had reported for duty. At times, the highest ranking soldiers who arrived were privates. More often, however, a lieutenant arriving with the cadre became the temporary commanding officer and was responsible for securing quarters, establishing the unit administratively, and initiating a training program. Activation under a temporary commanding officer did not necessarily work to the disadvantage of a unit, since such officers frequently managed to have training well underway by the time the designated commanding officer arrived. In some instances, however, the training program had to be postponed.

By the same token, unit fillers were supposed to arrive in a group shortly after the commander and his staff. In practice, however, few units received an appreciable portion of their fillers immediately after activation. Usually, fillers arrived at irregular intervals over a period varying from a few weeks to many months, and those who were sent varied in their background and training. One group might contain fillers trained by a replacement training center, and the next to arrive could consist entirely of recruits sent directly from reception centers. Still other groups might be of veterans of a combat theater or men trained by one of the combat arms

²⁰ (1) Annual Report, Headquarters, 37th General Hospital, 1943. (2) Annual Report, Headquarters, Fifth Auxiliary Surgical Group, 1943.

or technical services. Each group had to be trained according to its background and experience, and as a result, a large unit, such as a general hospital, might have to provide several groups of men with different levels of basic military and technical training at any given time. Because of these problems, it was not unusual for unit commanders to require 6 months or a year to complete the basic training of all the men in their organization.²¹

Training under the cadre system was further complicated by the uncertain quality of fillers and cadre assigned to the unit. For the cadre system to function efficiently, parent organizations had to release at least some of their best men to newly activated units. In practice, however, many units used the cadre system to slough their less efficient personnel.²² Since such men were frequently given ratings before they were released from the parent organization, the unit commander who received them was faced not only with the problem of administering and training a unit with substandard cadre but also with arranging for the transfer of over-rated, noncommissioned officers so that he could replace them with qualified men in the same grades.²³

Many units also complained of being assigned a high proportion of limited-service personnel.²⁴ Theater-of-operations units were supposed to receive only men qualified for service overseas, but some units reported that as many as four-fifths of their fillers were limited-service personnel whose presence made it difficult or impossible to conduct marches, calisthenics, or field exercises requiring strenuous physical activity.²⁵ The mental inadequacy of many limited-service personnel also made it difficult for commanders to achieve training objectives.²⁶

Unit commanders who were dissatisfied with their cadre or fillers usually attempted to improve their organizations by arranging transfers. This process of transferring and replacing undesirable personnel perpetuated many of the evils of the cadre system, and added to the inconvenience caused by the irregular arrival of fillers. Some organizations required many months to attain or approximate their table-of-organization strength and to become sufficiently stabilized to make meaningful unit training a possibility.²⁷

The procedure for training medical technicians and common specialists under the cadre system only added to the problems of unit commanders. When a new unit was activated, The Adjutant General automatically provided it with a limited number of technicians who were graduates of the Medical Field Service School, Carlisle Barracks, Pa., the Medical Supply Services School, the Army School of Roentgenology, Memphis, Tenn., and the Medical Department Enlisted Technicians Schools. A limited number of common specialists, such as cooks, bakers,

²¹ Memorandum, Lt. Col. Tyron E. Huber, MC, for The Historian, Training Division, Surgeon General's Office, 4 June 1945, subject: Unit Training, Army Service Forces, World War II, and inclosure thereto.

²² (1) Annual Report, Headquarters, 216th General Hospital, Camp Forrest, Tenn., 1943. (2) Annual Report, Fourth Auxiliary Surgical Group, Lawson General Hospital, Atlanta, Ga., 1943.

²³ (1) Annual Report, Fifth Auxiliary Surgical Group, Fort Sam Houston, Tex., 1943. (2) Annual Report, Fifth Station Hospital, Camp Stewart, Ga., 1941.

²⁴ (1) Annual Report, Headquarters, 11th General Hospital, Camp Livingston, La., 1942. (2) Annual Report, Headquarters, 216th General Hospital, Camp Forrest, Tenn., 1942.

²⁵ See footnotes 22 (1) and 24 (1).

²⁶ Annual Report, 41st Station Hospital, Camp Barkeley, Tex., 1942.

²⁷ See footnote 22 (2).

truckdrivers, and clerks, could be obtained from Medical Replacement Training Centers by requisition through The Adjutant General. Specialists and technicians needed in excess of those supplied by The Adjutant General, however, had to be trained by the unit commander. In training common specialists, the unit commander had a choice of options. If there were common specialists schools at the post at which the unit was located, he could enroll selected members of his organization.²⁸ If there were no such schools, he had to train his own cooks, truckdrivers, and clerks. Often, it was possible to simplify the task by searching for related civilian skills among personnel sent as fillers. When such men were not available, the commander had to provide special training programs within the unit.

The training of technicians posed a more serious problem. Commanders had their choice of two alternatives: One, they could send selected members of their unit to the post or station hospital for parallel training; or two, they could send them to Medical Department Enlisted Technicians Schools. Without close supervision from higher authorities, the training which hospital units received depended primarily upon the attitudes of local surgeons and unit commanders. In some instances, well-planned, on-the-job training programs were established in named hospitals and were coordinated with unit field training. In others, the commanders of named hospitals assigned men from numbered units to vacant jobs regardless of their training value. In such assignments, technical training suffered because many men did only menial work, and controversies developed between hospital commanders responsible for postmedical care and unit commanders responsible for technical and field training of their men.²⁹ The preferred alternative, therefore, was to send men to Medical Department Enlisted Technicians Schools.

Field units, however, were not always successful in obtaining authorization to send their men to Medical Department Enlisted Technicians School. The Surgeon General had to allot quotas for these schools indirectly through the Service Commands, Defense Commands, and the headquarters of Army Ground and Army Air Forces, which, in turn, subdivided quotas among subordinate units. Within Army Service Forces, quotas were subdivided a second time among posts under ASF jurisdiction. These suballotments were then utilized by the post for training both technicians from the station hospital and students from units being activated at the post. Because of this conflict of interest, it was reported that: "It was unusual for any unit to be able to send away from the unit over one-third of the * * * technicians that should have received training in Medical Department Enlisted Technicians Schools."³⁰

Unit commanders frequently added to the problem by using the schools to train specialists for unrated positions in their tables of organization. Numbered general hospitals, for example, were authorized 84 medical technicians: 35 who were rated graduates of enlisted technicians schools, and 49 who were unrated graduates of schools at medical replacement training centers. Often, a unit commander would

²⁸ Annual Report, Headquarters, 10th Hospital Center, Camp Rucker, Ala., 1942.

²⁹ (1) See footnote 21, p. 253. (2) Smith, Clarence McKittrick: *The Medical Department: Hospitalization and Evacuation, Zone of Interior. United States Army in World War II. The Technical Services.* Washington: U.S. Government Printing Office, 1956.

³⁰ See footnote 21, p. 253.

attempt to fill all of these vacancies with rated graduates of Medical Department Enlisted Technicians Schools, thereby creating a spurious shortage of technicians which made it difficult for other commanders to fill rated vacancies in their units.³¹

Whether technicians were qualified for ratings through Medical Department Enlisted Technicians Schools or on-the-job training at post hospitals, their training increased the administrative problems of the unit commander. Many of his future technicians had to be excused from unit training for all or part of the training day while acquiring skills at the post hospital, while others were enrolled at distant schools for periods of 3 or 4 months. Moreover, since schools and post hospitals were capable of enrolling only a relatively small number of trainees from any given unit at one time, instability frequently continued over a protracted period.³² Such instability was further increased when the unit, in its turn, was called on to provide cadre for another newly activated unit.

Despite its inherent drawbacks, most units trained during World War II were activated under the cadre system. In mid-1942, Army Service Forces began to move toward centralizing the activation and training of nondivisional service units. On 31 July 1942, representatives of the Surgeon General's Office and other technical services met at a conference called by the Unit Training Branch of the Training Division, ASF, to discuss the advisability of establishing a unit training center for ASF units. The Surgeon General's Office was reluctant to accept this recommendation, however, since there were already 12 large Medical Department unit training centers in Army Ground Forces housing adjacent to large fixed hospitals, and similar facilities were under construction at 22 fixed general hospitals and 34 station hospitals. The Surgeon General believed it would be preferable to continue training medical units at a large number of sites adjacent to an active fixed hospital if Army Ground Forces would provide assurance that these facilities would remain available. If not, he requested that the Medical Department be allotted a proportionate share of the facilities at the proposed unit training center.³³

In November 1942, a Medical Training Section was established at the newly activated Services of Supply Unit Training Center (later designated Camp Plauche), New Orleans Staging Area, New Orleans, La., "with the primary mission of controlling all training for medical units" at the center.³⁴ During the next 12 months, the Medical Training Section at Camp Plauche was responsible for training approximately 120 units, including seven general hospitals, 15 sanitary companies, 38 station hospitals, 56 hospital platoons, three portable surgical hospitals, and one hospital ship complement. In November 1943, the Medical Training Section's primary mission was changed to providing unit technical training for malaria survey

³¹ Memorandum, Col. John A. Rogers, MC, Executive Officer, Office of The Surgeon General, for the Director of Training, Services of Supply, 28 Aug. 1942, subject: Dissipation of Trained Enlisted Personnel.

³² See footnote 21, p. 253.

³³ Memorandum, Col. John A. Rogers, MC, Executive Officer, Office of The Surgeon General, to Training Division, Services of Supply (attention: Unit Training Branch), 1 Aug. 1942, subject: Unit Training Center.

³⁴ (1) Letter, Lt. Col. B. L. Steger, MC, Director of Medical Training, Headquarters, Services of Supply Unit Training Center, New Orleans, La., to Maj. John W. Middleton, MC, Training Division, Surgeon General's Office, 9 Dec. 1942. (2) Memorandum, Lt. Col. Donald J. Wolfram, MC, Chief, Readiness and Requirements Branch, Training Division, Surgeon General's Office, to The Historian, Training Division, Surgeon General's Office, 3 July 1945, subject: History of Unit Training Center, Camp Plauche, La., and attachment thereto.

and malaria control units which had been activated and received their basic training at other centers. Between August 1943 and November 1945, 141 malaria control units and 76 malaria survey units, comprising almost all the malaria units activated in the Zone of Interior, were sent to Camp Plauche for technical training.³⁵

After overcoming a series of initial problems, the medical section at Camp Plauche was able to provide a number of services that facilitated the activation and training of medical field units. When the officer designated as director of medical training for the medical section at Camp Plauche, Lt. Col. (later Col.) Byron L. Steger, MC, arrived at the center in November 1942, he encountered conditions prevalent, on a lesser scale, at posts and camps throughout the United States. At first, authorities at the camp refused to believe that there was such a position as Director of Medical Training, and assigned him duties as a medical instructor. After several conferences, Colonel Steger persuaded the local commander to assign him the position he had been sent to fill. Two officers sent to assist him arrived shortly afterward, but the administrative personnel for his section did not arrive for another 6 weeks.

Shortly after the medical section was activated, it was discovered that a number of medical units had already been activated, including 28 general and station hospitals, and 15 sanitary companies. No control was exercised over any of these units, and they had no place to turn for advice when problems arose. Each hospital sought to train as many men from their organization at the local station hospital as possible; as a result, the general hospital with the senior colonel was getting reasonably good training for his unit, and the remaining units had to fend for themselves.³⁶ The newly established medical section, however, was gradually able to bring these problems under control by arranging for an equitable allocation of the training facilities available at the post hospital and by securing additional quotas at Medical Department Enlisted Technicians Schools from the the Surgeon General's Office. Center-level courses were set up for common specialists and a 4-week refresher course for officers was inaugurated. The medical section also organized its own training aid section and provided central facilities for producing and distributing lecture and conference material.

A second ASF Unit Training Center with facilities for training Medical Department theater-of-operations units was activated at Camp Ellis, Ill., on 1 February 1943. At first, the center attempted to operate under a common headquarters, but within a short time, it was realized that the special training requirements of each of the technical services made this structure too cumbersome. After several reorganizations, the medical section was established as a separate entity early in May 1943. Between May 1943 and January 1945, when the center was deactivated, 266 medical units of all types were activated at Camp Ellis.³⁷

³⁵ Letter, Maj. Joseph E. Schenthal, MC, Director, Medical Training Section, Third Regiment, Army Service Forces Training Center, Camp Plauche, New Orleans, La., to the Surgeon, New Orleans Port of Embarkation, New Orleans, La., 5 Nov. 1945, subject: Summary of Activities, Medical Training Section, Army Service Forces Training Center, Camp Plauche, New Orleans, La.

³⁶ See footnote 34 (2), p. 255.

³⁷ (1) Annual Report, Unit Training Center, 1644th Service Unit, Camp Ellis, Ill., 1943. (2) "The Story of Camp Ellis." [Official record.]

The medical section at Camp Ellis played a similar role in the training of medical units. It operated a school for cooks, bakers, truckdrivers, and other common specialists, and, in addition, conducted courses for unrated medical, surgical, X-ray, dental, and pharmacy technicians. A weeklong orientation course was provided for the unit commander, his adjutant, executive officer, and supply officer, to acquaint them with the problems of unit activation. The medical section also assisted the various units at Camp Ellis to secure training aids and provided them with general, station, and field hospital equipment sets for use on field problems.³⁸

The Preactivation System

Despite the inherent advantages of unit training centers, the Army Service Forces did not achieve a complete centralization of its training facilities until the preactivation system was adopted in April 1944, well after the pace of unit activations within Army Service Forces was past its peak. During the final year of the war, facilities for training medical units were available at three Army Service Forces Training Centers: Camp Ellis, Camp Barkeley, Tex., and Fort Lewis, Wash. Camp Grant, Ill., also served briefly as a center for unit training under the preactivation system, until its facilities were transferred to Fort Lewis in the summer of 1944. Camp Plauche, which by this time was being used exclusively to provide field training for malaria control and survey teams activated at other centers, was never reorganized to include preactivation training.

Under the preactivation system, ASF Training Centers served as pools from which a unit could draw a full complement of trained enlisted personnel at the moment of activation. Responsibility for training personnel before it was assembled as a unit was vested entirely in the training center. When a new unit was scheduled for activation, the center received orders for its "preactivation" or, in effect, was informed that it was required to earmark a given number of enlisted men at the center for assignment to the unit as fillers. Such men then received basic military and technical training at the center, and those selected to become technicians were sent to an appropriate enlisted technicians school. Late in the war, the system also served as a device for channeling "spare parts" or men from overstrength or deactivated Zone of Interior units into field units scheduled for shipment overseas.

The ASF preactivation system had several intrinsic advantages over the system that it replaced. It relieved the commander of responsibility for providing his men with basic military and technical training and simultaneously eliminated the problems that developed when men were received in increments over several months and had to be provided with separate training programs. It also relieved the unit commander of responsibility for finding ways to train the technicians needed to fill his table of organization. Unit training at ASF Training Centers could thus begin at the end of the 14th week of the basic training cycle, instead of being delayed for weeks, or even months, while fillers in the unit were being brought to a common level of training. In sum, the new system provided the commander with

³⁸ (1) See footnote 21, p. 253. (2) Annual Report, Headquarters, Medical Group, 1644th Service Unit, Army Service Forces Training Center, Camp Ellis, Ill., 1944.

all the components necessary for his unit and allowed him to focus his attention on molding these components into a smoothly functioning team.³⁹

In addition to the intrinsic advantages of the preactivation system, units activated after 15 April 1944 had several other factors working in their favor. War Department policies requiring Zone of Interior installations to release general service personnel for service overseas, for example, provided ASF Training Centers with an adequate supply of noncommissioned officers and experienced enlisted men who could be assigned to newly activated units.⁴⁰ Thus, units activated under the new system were more frequently provided with the training nucleus of enlisted personnel that should have been provided under the cadre system, and less frequently subjected to debilitating cadre levies. Units activated after April 1944 also had the advantage of receiving at least the first 3 weeks of their team training at ASF Training Centers, which provided guidance and assistance to the unit commander that formerly had been available only to organizations activated as ASF Unit Training Centers. As a result, units found it easier to obtain training aids and equipment, and the facilities of the post were at their disposal.

In June 1942, a Unit Training Branch was organized in the Training Division, Surgeon General's Office, to discharge the newly assigned responsibility for preparing Medical Department nondivisional units trained by the Army Service Forces for functional deployment in the theaters of operations. In addition to maintaining liaison with other elements of the Surgeon General's Office and divisions of the Army Service Forces and the War Department in matters relating to the activation and training of numbered units at class I and class IV installations of the Army Service Forces, the Unit Training Branch was also responsible for inspecting their technical training and submitting appropriate recommendations to the Director of Military Training, ASF. The Unit Training Branch reached its peak strength in December 1942, when the staff consisted of two officers and an enlisted clerk. Because of its limited staff, and the constantly growing number of medical units scattered throughout the Zone of Interior, the Unit Training Branch found it impossible to conduct frequent and periodic inspections. Control was maintained by requiring units to file bimonthly Unit Training Status Reports, developed in the summer of 1942, that provided the Surgeon General's Office with information on the strength, training programs, equipment, and status of each medical unit being trained by Army Service Forces.⁴¹ The Unit Training Branch then confined itself to inspecting units that were being prepared for shipment overseas. Whenever inspection of a numbered ASF medical unit was required, members of the Unit Training Branch also inspected all other medical units at the same post. No record was kept of the number of units inspected before mid-1943, but between June 1943 and June 1944, the Unit Training Branch conducted 751 inspections and be-

³⁹ (1) See footnote 21, p. 253. (2) Memorandum, Lt. Col. Donald J. Wolfram, MC, Chief, Readiness and Requirements Branch, Training Division, Surgeon General's Office, to the Historian, Training Division, Surgeon General's Office, 3 July 1945, subject: History of Unit Training Center, Camp Plauche, La., and attachment thereto.

⁴⁰ (1) Army Service Forces Circular No. 26, 24 Jan. 1944. (2) Army Service Forces Circular No. 100, 21 Mar. 1945.

⁴¹ Annual Report, Training Division, Operations Service, Office of The Surgeon General, U.S. Army, fiscal year 1943.

tween June 1944 and June 1945, it inspected all of the 319 units activated by Army Service Forces.

Until April 1945, inspections conducted by representatives of the Surgeon General's Office encompassed all aspects of training and preparation for overseas movement, including any discrepancy that might result in a unit's being declared unsatisfactory by the Inspector General.⁴² As a result, 104 of the 115 ASF medical units inspected by the Inspector General in the 9 months preceding June 1944 were declared qualified to perform their primary mission. Of the remaining 11, four reported only minor deficiencies and four had not been allowed enough time for re-fitting and refresher training after returning from overseas service. Only two were rejected for serious deficiencies. The following year was equally successful.⁴³

In May 1944, the Unit Training Branch was redesignated as the Readiness and Requirements Branch, to symbolize the transition to the preactivation system. After this system was established, representatives of the Surgeon General's Office inspected all nondivisional medical units during their first 3 weeks of unit training at ASF Training Centers. In September 1944, the Surgeon General's Office also prepared a series of training tests consisting of questions and a field problem that was designed to prepare such units for inspection.⁴⁴ In April 1945, the responsibilities of the subordinate agencies of the Army Service Forces were redefined, and the chiefs of the technical services were directed to confine themselves to purely technical inspections. Thereafter, representatives of The Surgeon General coordinated their inspections with those of the service commands, and representatives of the service commands inspected units in matters involving administration, supply, and military training.⁴⁵

ARMY AIR FORCES SYSTEMS

The Army Air Forces trained less than half a dozen types of medical units designed to fit the special needs of air troops—primarily a medical supply, an evacuation, and a dispensary unit. Because such units were small and required only limited housing facilities, the Army Air Forces was able to bring these units together at selected locations and provide special schools for their training.

The Army Air Forces facilities for training tactical medical units were decentralized until the spring of 1942 when a new medical detachment at Warner Robins Air Depot in Georgia was called on to furnish Medical Department officers for

⁴² Memorandum, Capt. Harold D. Brennand, MAC, Regular Training Branch, Training Division, Office of The Surgeon General, to the Historian, Training Division, Surgeon General's Office, 5 July 1945, subject: Policy and Procedure Governing Inspection of ASF-Type Medical Department Units by Surgeon General's Office.

⁴³ (1) Report, Readiness and Requirements Branch, fiscal year 1944. *In* Annual Report, Training Division, Operations Service, Office of The Surgeon General, U.S. Army, fiscal year 1944. (2) Report, Readiness and Requirements Branch, fiscal year 1945. *In* Annual Report, Training Division, Operations Service, Office of The Surgeon General, U.S. Army, fiscal year 1945.

⁴⁴ Memorandum, Col. Floyd L. Wergeland, MC, Director, Training Division, Office of The Surgeon General, for the Director of Military Training, Army Service Forces, 8 Sept. 1944, subject: Test for Training Inspection, Numbered ASF Medical Units, and inclosures thereto.

⁴⁵ See footnotes 18, p. 251; and 43 (2).



FIGURE 40.—School of Aviation Medicine building, Randolph Field, Tex.

tactical units under the Air Service Command. The station surgeon, Maj. (later Lt. Col.) Richard R. Cameron, MC, asked permission to establish a school for this type of training. In the fall, the Medical Training Section at Warner Robins Air Depot began training men for a newly created type of unit, the medical supply platoon (aviation). This unit, consisting of two Medical Administrative Corps officers and 19 enlisted men, was designed to supply medical equipment to rapidly moving combat air squadrons in forward areas where Services of Supply did not maintain depots. In such areas, AAF general depots were furnished with the medical supply platoons (aviation) necessary to supply combat units. The Medical Training Section at Warner Robins Air Depot eventually developed into the Medical Service Training School which was established late in 1943 with Colonel Cameron as commandant.⁴⁶ By this time, the school had been assigned the additional mission of training medical dispensary detachments (aviation), a unit consisting of four officers and 24 enlisted men with enough equipment to set up a 36-bed field dispensary in areas where hospital facilities were not available. It also provided facilities for training command and administrative specialists.⁴⁷

Air evacuation of sick and wounded troops was a major responsibility of the Air Transport Command, which was established in June 1942 as a successor to the former Air Corps Ferrying Command. Responsibility for organizing and training

⁴⁶ See footnote 5 (3), p. 248.

⁴⁷ History, Army Air Forces, Medical Service Training School, Robins Field, Ga., 1942, vol. I. [Official record.]

troop carrier units, together with personnel for replacements, was delegated to the I Troop Carrier Command, activated in June 1942 with headquarters at Stout Field, Indianapolis, Ind. In addition to carrying out the typical responsibilities of the surgeon of any large command, the Staff Surgeon, Col. Wood S. Woolford, MC, was responsible for the development and training of units for evacuating casualties by air. In 1942, the Air Surgeon and Colonel Woolford developed plans for a standard unit. In the latter half of 1942, the 349th Air Evacuation Group was established at Bowman Field, Louisville, Ky., as a training command for personnel assigned to units accompanying patients during air evacuation flights. In June 1943, the 349th Air Evacuation Group was established as the Army Air Forces School of Air Evacuation, and in October 1944, it was absorbed into the School of Aviation Medicine, Randolph Field, Tex. (fig. 40).⁴⁸

ARMY GROUND FORCES SYSTEMS

Medical units attached or organic to AGF organizations were universally activated and trained under the cadre system. Nondivisional medical units under the jurisdiction of Army Ground Forces were activated and trained at a wide variety of posts and camps throughout the Zone of Interior, in approximately the same manner as those activated by Army Service Forces. Organic units were activated and trained in conjunction with their division.

When Army Ground Forces inherited responsibility for the creation and training of combat divisions from General Headquarters on 9 March 1942, it adopted unit activation procedures that were already well developed. In common with ASF units, AGF divisions were established by a letter of activation under the cadre system. The commander, assistant commander, and artillery commander were selected by the War Department from a list that Lt. Gen. Lesley J. McNair, Commanding General of the Army Ground Forces, submitted for their consideration. General McNair was also responsible for selecting and designating the heads of the general staff of the new division and other key officers for which Army Ground Forces was responsible. The selection of special staff heads and other key service officers was coordinated with the appropriate chiefs of the technical services in Army Service Forces.

Each division was assigned a parent unit responsible for furnishing it with trained cadre. The G-3 section of Army Ground Forces then formulated plans for the division's assignment and issued a letter officially ordering activation of the unit and instructing all agencies in their respective duties. This letter provided for delivery by the service commands, without requisition, of enlisted fillers from reception centers and replacement training centers on a schedule worked out by the division and the service command. In addition, War Department General Staff, G-1, Personnel, prepared a memorandum providing instructions for the selection, schooling, and assignment of commissioned personnel for the division.

Early in 1942, these procedures were expanded to provide special training for

⁴⁸ (1) See footnote 5 (3), p. 248. (2) Link, Mae Mills, and Coleman, Hubert A.: *Medical Support of the Army Air Forces in World War II*. Washington: U.S. Government Printing Office, 1954.



FIGURE 41.—Medical Department officers attend courses at the Command and General Staff College, Fort Leavenworth, Kans., where extensive use was made of training aids, including demonstrations. Here instructors demonstrate staff work at an infantry division headquarters for the benefit of a class at the college.

division cadre officers. Thereafter, when a new division was activated, the commander, assistant commander, and division artillery commander were designated by the War Department not later than 78 days before activation and assigned to General Headquarters, or after March 1942, to Army Ground Forces, for a week of orientation. The division commander then spent a month in special training at the Command and General Staff School, Fort Leavenworth, Kans. (fig. 41), the assistant division commander took a special course at the Infantry School, Fort Benning, Ga., and the division artillery commander was sent to the Field Artillery School, Fort Sill, Okla. Officers assigned to the division's general and special staffs, including the division surgeon, joined the division commander for the monthlong course at the Command and General Staff School. The remaining members of the officer cadre were sent to special cadre courses conducted at branch schools under the jurisdiction of the chief of their arm or service. All Medical Department cadre officers, except the division surgeon, attended the Special Cadre Course for Divisional Officers at the Medical Field Service School.

After completing their special training, the commander and his staff arrived at the division camp 37 days before activation. A week later, they were joined by the rest of the cadre, and a few days after that, by a complement of 452 officers provided by the War Department from graduates of officer candidate schools, service schools, and officer replacement pools. The unit was formally activated on D-day; during the next 15 days, the unit received its quota of fillers (approximately 13,000 in the case of the infantry division). After the last installment of fillers arrived, the division was ready to begin training.

Between March 1942 and August 1943, when the last of the divisions of World War II was activated, Army Ground Forces made several refinements in the procedures for division activation. None of these changes, however, had a significant effect on the activation of medical components of the division, and from the standpoint of the Medical Department, procedures remained unchanged after the establishment of the division cadre course.

When the War Department was reorganized in March 1942, Army Ground Forces inherited a schedule for training newly activated divisions that had only recently been put into effect by General Headquarters. Before 1942, training programs were designed to fill and train Regular Army and National Guard Divisions under peacetime conditions. The previous program had provided neither a specific date for the attainment of combat readiness nor a clear differentiation between individual and unit training. Once a unit had completed its initial 13 to 16 weeks of training under the mobilization training programs, its training was governed by a series of annual and special training directives that prescribed additional unit training and exercises designed to prepare the unit for the next series of maneuvers. Such directives were couched in the broadest terms and governed not only the training of divisions and their organic medical support but also the training of all other field units, including those later controlled by Army Service Forces.

On 16 February 1942, General Headquarters issued a training directive designed to bring divisions to a state of combat readiness 44 weeks after the date of activation.⁴⁹ This period was divided into three definite phases—individual training, unit training, and combined-arms training—and a training guide was set up for each period. During the individual training period, commanders were required to use War Department mobilization training programs as their guides. Although the mobilization training programs were drawn up on a 13-week period, General Headquarters allowed an extra 4 weeks to compensate for delays in the arrival of fillers and equipment and to permit testing by higher commands. During the 13-week unit training period, specific guides were available only for infantry, field artillery, engineer, and quartermaster organizations; commanders of other service organizations were expected to rely on guidance provided by the division and to tailor their programs to combine elements of their technical specialty with divisional training requirements. The directive of 16 February provided the only guidance for the 14-week period of combined training.⁵⁰ Nondivisional units of the Army Ground Forces trained on the same schedule but were provided with only

⁴⁹ See footnote 10 (2), p. 249.

⁵⁰ Wiley, Bell I.: *The Army Ground Forces. Training in the Ground Army 1942-1945. Study No. XI. Historical Section—Army Ground Forces, 1948, p. 4.* [Official record.]

limited guidance beyond their branch mobilization training programs. During 1942, control over the training of nondivisional units, including medical units, was vested principally in the armies; it was not unusual for such units to go for months without being subjected to the tests and inspections that were provided for the guidance of divisional units at each stage of their training.

The General Headquarters training directive of February 1942 was superseded on 19 October 1942 by an AGF directive designed to guide all existing and future units through the training cycle. The new schedule shortened the training period for divisions from 44 to 35 weeks, and time was allotted among training phases in the following pattern: Individual or basic training, 13 weeks; unit training, 11 weeks; and combined training, 11 weeks. Reduction of the basic phase from 17 to 13 weeks seemed possible because of the accelerated pace of inductions, making it possible to fill the division and begin training immediately upon activation. Shortening of the entire training cycle was considered necessary because of the likelihood in 1943 of heavy requirements for overseas operations. In addition, the directive added two new training tests to the program: a physical training test required for all units, and an infantry battalion combat-firing test.

By late 1942, when the new directive was issued, the training of divisions assumed a pattern which was basically stable throughout the remainder of the war. The 13-week individual training period, based on War Department mobilization training programs, was devoted to individual and small unit training up to the battalion level. As at replacement training centers, the first few weeks focused on basic military subjects such as military courtesy, drill, and map reading designed to transform the individual into a soldier before he began training as a specialist. After the first month, emphasis shifted to technical subjects, and soldiers were oriented to the basic elements of their unit's specialty. During the last 4 weeks of the individual training period, training focused on tactical subjects and was increasingly conducted in the field. The last few days of the basic period were devoted to preparing for the mobilization training program tests given by corps or army commanders to units on the platoon level.

At the end of the individual training period, the division began 11 weeks of progressive unit training that began with the squad and culminated in regimental exercises, with the goal of developing each unit into a team capable of taking its place in the division and carrying out its special mission in combat. While combat arms concentrated on tactical training, support elements were given practical training in their specialist roles and taught to work together in platoons and companies. Medical technicians, for example, practiced skills required in first and second echelon medical service; and medical companies moved to the field to engage in exercises requiring them to evacuate casualties across rivers, set up battalion aid stations, and move casualties from collecting stations to clearing stations. Units were also required to complete a series of tests, such as the AGF platoon combat-firing proficiency tests for infantry components and the AGF battery tests for the field artillery. Because of their highly specialized mission, however, medical units were required only to complete the AGF special battle courses and physical fitness tests.

Unit training was followed by 11 weeks of combined-arms training designed to weld the elements of the division into a division team. After October 1942, this phase consisted of three series of problems: One, regimental combat team exercises, culminating in field maneuvers; two, division exercises and maneuvers; and three, command post exercises. The combined training period began with regimental combat team exercises, and ended with maneuvers by one division against another. Exercises were conducted both by day and at night, in all types of terrain. All exercises were followed by a critique. During such exercises, medical units and other service elements were expected to function in a supporting role.⁵¹

The training received by medical elements of the 89th Infantry Division was typical of the experience of most divisions during World War II. Orders for the creation of the new division were issued on 1 April 1942, and approximately a month later, members of the division cadre reported to Army schools for special training. The division surgeon, Maj. (later Col.) Clifford G. Blicht, MC, arrived at Camp Carson, Colo., the home of the new division, on 1 June 1942, after completing the monthlong cadre course at the Command and General Staff School along with the commanding general and his general and special staff officers. Medical officers who had completed the special cadre course at the Medical Field Service School reported to the division on 13 June, followed between 3 and 12 July by the unit's remaining Medical Department officer fillers. The latter consisted of 37 Medical Corps, 12 Dental Corps, and five Medical Administrative Corps officers. The 72-man medical enlisted cadre arrived at Camp Carson on 8 June 1942, after completing a cadre course at Fort Leonard Wood, Mo. On 15 July 1942, the 89th Infantry Division was officially activated.

For several months following its activation, the division was engaged in providing basic training for fillers who had been assigned directly from reception centers. Such training, conducted under programs written by the chiefs of the arms and services, was nearly identical with that provided at replacement training centers. By January 1943, medical units of the division were in their final stage of basic training, and during the first week of February, an VIII Corps testing team administered individual training tests to all units of the division. As a result of these tests, the division received a rating of "very satisfactory" despite the fact that, during January, it suffered heavy losses from cadre levies. In mid-January, medical elements of the division sent 12 officers to the Medical Field Service School to be trained as cadre for the 66th Infantry Division, and shortly thereafter, seven more officers were transferred to the 76th Infantry Division. On 31 January, Colonel Blicht was transferred to the 99th Evacuation Hospital, and Maj. (later Lt. Col.) Sydney L. Stevens, MC, regimental surgeon of the 354th Infantry Regiment, was assigned to replace him.

From 8 February through 24 April 1943, the division and its medical elements were enrolled in the unit phase of training. Emphasis at all levels was placed upon realism and battlefield leadership, with the objective of developing each team into a unit capable of taking its place in the division. All such training was conducted

⁵¹ See footnote 10 (2), p. 249.

under simulated tactical conditions. Training began with the smallest unit and progressed to the largest, culminating on 24 April with a demonstration given by the division for President Roosevelt in which the medical battalion played a part in evacuating casualties on a litter raft constructed from the tarp of a weapons carrier. During the individual and unit training phases, a number of enlisted men were also detached to attached special schools, including 50 men who were sent to Medical Department Enlisted Technicians Schools for training as medical and surgical technicians, and 36 men who received a month of special training at the Camp Carson station hospital. Between 12 and 17 April, medical personnel participated in physical training tests given by the VIII Corps testing team.

The division's combined arms training began on 10 May, and lasted until 19 June. Three collecting companies, each assigned to a regimental combat team, took part in exercises which were conducted in the Camp Carson and Lake George areas of Colorado. Company D, the division clearing company, moved to Lake George to establish a clearing station and to set up a base camp for the division. During these exercises, all units were able to gain experience in handling both actual and simulated casualties, including 376 men who became sick or were injured in the course of training. When not engaged in exercises, the medical battalion practiced evacuation of casualties over water obstacles, using facilities provided at Camp Carson lake. Units were also required to conduct two training sessions on an infiltration course, one by day and one at night, and to train their men to climb cargo nets in full field equipment. Combined arms training was completed on 19 June 1943 following a critique by the division commander.

On 28 June, the division moved south of the Camp Carson area to an area near Pueblo, Colo., to hold a series of maneuvers under the direction of the VIII Corps. Again, the three collecting companies were employed under combat team control, while the clearing company remained under the division. In the course of the maneuvers, medical units evacuated a total of 347 sick and injured, as well as a number of simulated casualties. These maneuvers had originally been planned to extend to the beginning of August, but on 14 July, they were cut short to make time for the division's reorganization.

On 1 August 1943, the 89th Infantry Division was reorganized and redesignated as the 89th Light Division. After the reorganization, the officer strength of medical elements was reduced from 51 Medical Corps, 12 Dental Corps, and 12 Medical Administrative Corps to 38 Medical Corps, eight Dental Corps, and nine Medical Administrative Corps, respectively, while enlisted strength was reduced from 896 to 582. The medical battalion was placed under a new table of organization, and its allotment of vehicles was reduced to eight jeeps and four trailers. During the period from 1 August to 15 November, the unit spent its time in maneuvers designed to test the capabilities of the 89th Light Division. On 15 November, the 89th Light Division completed its training at Camp Carson and moved to the Louisiana Maneuver Area for corps and army maneuvers, and eventual shipment overseas.⁵²

The growth of training systems for nondivisional units of the Army Ground

⁵² Medical History and Progress of the 89th Infantry Division for the Calendar Year 1943.

Forces during 1943 and 1944 paralleled the development of unit training systems in Army Service Forces. In mid-1942, the Army Ground Forces began to experiment with the use of group headquarters to control the 700-odd units that were then being trained under corps and army jurisdiction. In the summer and fall of 1943, after group headquarters proved effective in controlling the training of tactical units, group organization was extended to service units. By 31 December 1943, 12 group headquarters had been organized to control the training of nondivisional medical units.⁵³ Late in 1942, the Army Ground Forces also adopted a systemized activation procedure for nondivisional units. The system was followed closely for approximately 6 months, but after mid-1943, the dwindling manpower supply made rigid application nearly impossible.⁵⁴

Throughout 1942, the basic training of AGF nondivisional units was guided by mobilization training programs prepared during the General Headquarters period by chiefs of the appropriate arms or services. Since most mobilization training programs did not extend beyond the basic training phase, units in advanced stages of training did not have detailed programs to follow, and training was conducted under weekly schedules drawn up by the unit commander in accordance with the very general guidelines provided in directives issued by higher headquarters. No effort was made to revise these programs until late 1942; then, deficiencies observed in combined training exercises and in the theater focused attention sharply on the fact that many mobilization training programs were obsolete, and that unit training programs had never been prepared for the guidance of service units. Early in 1943, the special staff sections of Army Ground Forces were instructed to revise mobilization training programs covering the individual training period and to prepare unit training programs covering the unit training period. By the autumn of 1943, all of the staff except the Ground Surgeon had submitted revised mobilization training programs. In January 1944, the medical section submitted a unit training schedule, and shortly afterward, the mobilization training program for AGF medical units was published.

Before the end of 1944, Army Ground Forces also adopted a series of MOS (Military Occupational Specialty) tests designed to test individuals in their proficiency as specialists. Most of these tests were already in use by subordinate commands, or modified versions of tests prepared by the chiefs of the services were used. Usually, MOS tests were divided into two parts: One, theoretical questions involving the duties and skills required in a particular specialty, and, two, practical exercise requiring the application of specialized techniques. Tests for personnel in quartermaster and medical units were supplemented by exercises designed to check the ability of the units to perform their primary mission. The test for members of a medical collecting company, for example, required the unit to collect and transport casualties under tactical conditions. Because such tests were already in use by many subordinate commands, the tests published by Army Ground Forces were not mandatory.⁵⁵

⁵³ See footnote 10 (2), p. 249.

⁵⁴ Wiley, Bell I.: *The Army Ground Forces. Problems of Nondivisional Training in the Army Ground Forces.* Study No. 14. Historical Section—Army Ground Forces, 1946. [Official record.]

⁵⁵ See footnote 10 (2), p. 249.

On 14 April 1944, approximately 2 months after Army Service Forces adopted the preactivation system, the Army Ground Forces also published an accelerated training schedule for nondivisional units. Under the new system, training schedules varied according to the source of the unit's fillers and, because of the diverse duties assigned AGF nondivisional units, according to the unit's mission, branch, or service. In medical units, only the period of individual or basic training varied: Units that received the bulk of their fillers directly from reception centers were required to complete a 14-week program of individual training; those whose fillers were sent from units of replacement training centers of another branch were required to provide 5 weeks of individual training; and units whose fillers were provided by a medical unit or Medical Replacement Training Center were required only to complete a 1-week refresher course. Following this phase, all medical units were required to complete 9 weeks of unit training and 3 weeks of combined training. Thus, depending on the unit's source of fillers, the training period for medical units ranged from 13 to 26 weeks. By comparison, the training time required for other technical service units ranged from 13 to 42 weeks.⁵⁶

The final year of the war produced a marked decline in AGF training activity. Efforts focused on converting unneeded organizations and excess Zone of Interior personnel into units required for support in the theater of operations. The accelerated system made it possible to tailor the training of each unit according to its needs. The most serious problem created by the program involved the training of technical personnel. Most nondivisional technical service units, including medical units, contained a large number of men whose duties required qualification as technicians or specialists. Getting these men to school without disrupting the training program and impairing the integrity of the unit had been a serious problem even under the former system. Under the accelerated program, the problem became increasingly acute. Schooling was accomplished in many instances at the cost of having a majority of the unit's personnel absent after the completion of basic training. Despite this problem, however, the system remained in effect through the end of the war.⁵⁷

PROGRAM GUIDES AND TRAINING LITERATURE

The Medical Department's prototype for World War II mobilization training programs was created in 1935 when The Surgeon General directed the staff at the Medical Field Service School to prepare a 16-week training program for the mobilization of medical regiments. This program, issued by the War Department on 1 August 1935, served as a model for mobilization training programs throughout the war. Under this program, instruction was roughly divided into three phases: The first phase included both military and technical subjects, with emphasis on military subjects such as drill and military courtesy; the second, emphasized technical subjects, such as first aid, nursing, ward management, litter drill, and the organization and functions of the Medical Department; and the third, was devoted primarily to

⁵⁶ See footnote 54, p. 267.

⁵⁷ See footnote 10 (2), p. 249.

field activities and a review of basic military training. The program also contained special annexes outlining the training of common specialists, such as cooks, clerks, cobblers, horseshoers, wheelwrights, and motor mechanics, and, in addition, prescribed the training for medical, surgical, and veterinary technicians.⁵⁸ Programs utilized during World War II differed widely from the 1935 prototype in details but did not radically alter its form.

The program of 1935 was superseded, on 9 September 1940, by a 13-week program bearing the designation Mobilization Training Program No. 8-1, entitled "Medical Department Mobilization Training Program for Medical Department Units at Unit Training Centers and Medical Department Replacements at Enlisted Replacement Centers." In contrast to its predecessor, which was designed to train specialized units within the medical regiment, the new mobilization training program was a general program written to guide the training of specialists within the unit, regardless of the unit's ultimate mission. As in the previous program, the new schedule was divided into three phases, which, for the first time, were broken up into three distinct chronological periods. At the end of the first 2 weeks of training, or the basic period, the soldier was expected to be able to care for his uniform and equipment, to march and pitch shelter tents, and to understand the fundamentals of technical subjects prescribed by the program.

The technical period, which lasted from the third through the 10th week of the cycle, focused on providing the individual with technical skills that would enable him to fill a specialized position in his unit. During this period, members of the unit received the same amount of training and attended a number of common classes in basic military subjects. Those who were selected to become common specialists and technicians, however, spent the bulk of their time in specialized training, while the remaining members of the unit continued their basic military and basic technical training. At the end of this period, trainees were also expected to be familiar with basic tactics and logistics.

In the final month of the cycle, units turned their attention to tactical training. At the end of the 13th week of the cycle, medical units were expected to be able to march and execute tactical movements, to establish and operate stations, to collect and treat casualties in the field, to operate battalion or regimental stations, and to participate in field exercises with the combat arms under tactical conditions. Having trained his men as individuals, the unit commander was responsible at this stage for training them as a team through the employment of appropriate field exercises. Commanders were expected to adjust the program to the needs of their unit during all phases of training, and during the tactical phase, tailoring was particularly important. Indeed, commanders were notified that:⁵⁹

* * * The character of operations which will be required, the character and armament of the enemy, the probable theater of operations, including the geographical, topographical, sanitary, and climatic conditions therein and the results that may be expected should always be considered. The programs may, therefore, require modification to adapt them to the type of medical unit to

⁵⁸ Letter, Gen. Douglas MacArthur, Chief of Staff, 1 Aug. 1935, subject: Sixteen-week Training Schedule—Effective Upon Mobilization (Medical Regiment).

⁵⁹ Mobilization Training Program No. 8-1, 9 Sept. 1940.

be trained, to meet the status of the individual or unit, to shorten or lengthen the time of training in order to conform to the time available, to make the best use of existing facilities and of training expedients, and to conform to the climatic or other conditions of the training situation. Progressive and balanced training in subjects essential to accomplish the training mission, however, must be preserved at all times.

In addition to these general guidelines, special programs were provided for units organic to divisional medical service, including the collecting, clearing, and ambulance components of the medical regiment and medical battalion.

In January 1941, the Medical Department published a mimeographed "Instructors' Guide" that had been prepared by the staff at the Medical Field Service School to supplement Mobilization Training Program No. 8-1. By themselves, mobilization training programs were little more than outlines that presented course titles, time allocations, and text references in tabular form. The schedule for 13 weeks of unit training under the program of September 1940, for example, consisted of six pages and charts and explanatory notes. In contrast, the four-volume "Instructors' Guide" specified the location, references, and instructional aids for each hour of training, and provided the instructor with a detailed outline of the subject. Commanders were not required to use the guide, but they were assured that "if the outlines for the subjects scheduled for the various hours are followed, a satisfactory standard of proficiency will be attained."⁶⁰ Commanders were also urged to consult field manuals that would provide them with a detailed knowledge of the mission of their unit and the special training it required. As each new mobilization training program was issued during the course of World War II, it was followed by a comparable "Instructors' Guide," and as the war progressed, the guides became increasingly more detailed and complete.

With minor changes, the mobilization training program for medical units issued in September 1940 remained in effect until September 1943. On 18 February 1942, the original document was superseded by a revised version that eliminated schedules for programs at replacement training centers.⁶¹ Except for small refinements in the allocation of training time, and a modernization of references, however, the new unit training schedule remained identical with its predecessor.

Neither program provided guidance for units that had completed the 13-week basic training cycle, and there were no published guidelines for the advanced training of units that had completed Mobilization Training Program No. 8-1 until mid-1942. Before the War Department reorganization of 1942, the Office of The Surgeon General instructed unit commanders to look to the headquarters of the combat organizations to which they were attached for guidance after completing the basic training cycle. On 29 July 1942, however, after the reorganization placed many types of nondivisional medical units under the jurisdiction of Army Service Forces, the Medical Department prepared a mobilization training program for the advanced training of numbered hospital units containing personnel that had completed their basic training either under Mobilization Training Program No. 8-1 or at a Medical Replacement Training Center. Reflecting the technical orientation of

⁶⁰ Instructors' Guide for Medical Department Mobilization Training Program No. 8-1. Volume I. Basic Military Training, January 1941.

⁶¹ Mobilization Training Program No. 8-1, 18 Feb. 1942.

ASF units, the program provided 1 week of review and orientation for all personnel and 12 weeks of advanced training for officers, common specialists, and technicians. During this period, specialists and technicians were expected to participate in on-the-job programs in a hospital on the post to which the unit was attached, while officers attended classes in administration and sanitation. In October 1942, the program was amended to provide training for nurses, and the following March, a program for sanitary technicians was added.⁶²

The basic and advanced training programs remained the only unit training guides available until mid-1943, when the Medical Department prepared three special advanced programs for specific types of units. The first, Mobilization Training Program No. 8-21, a guide for training malaria survey and malaria control units, was published on 4 May 1943. Based on the assumption that all personnel would have at least 8 weeks of basic training in another unit, a Medical Replacement Training Center, or a Medical Department Enlisted Technicians School before assignment to a malaria unit, the new program outlined two 4-week programs, one for survey units, and one for malaria control units. Both programs contained similar introductions to malariology and entomology, but major emphasis in the program for survey units was placed on parasitology and the use of malaria survey equipment, while the program for control units stressed mosquito control methods and appliances.

The program for malaria units was followed on 21 May 1943 by a specialized guide, Mobilization Training Program No. 8-15, providing 13 weeks of advanced training for army and communications zone medical supply depots. Under this program, men selected to work in the headquarters, transportation, optical repair, or depot sections of medical supply depots were assigned to comparable sections of Zone of Interior depots for on-the-job training. During the final stage of training, all members of these units participated in an 85-hour field problem.

The third guide written for a specific unit was a mobilization training program for portable surgical hospitals, Mobilization Training Program No. 8-22, issued on 20 August 1943, approximately 2 months after the first of these units was activated. Assuming that personnel assigned to the unit had already received basic training, the program for portable surgical hospitals prescribed 4 weeks of intensive training designed to prepare the unit for jungle warfare. Included in the unit's program were military subjects such as scouting and patrolling; hasty entrenchment and camouflage defense against chemical, mechanized, and airborne attack; and heavy tent pitching, map reading, and litter carrying over difficult terrain. The medical portion of the program also focused on jungle warfare and included such topics as tropical disease, malaria, and field sanitation.

On 1 September 1943, the basic-unit training program, Mobilization Training Program No. 8-1 of February 1942, was superseded by a new guide designated Mobilization Training Program No. 8-101, "Mobilization Training Program for Medical Department Units of the Army Service Forces." In line with the increasing length of basic training cycles throughout the Army, the revised program extended

⁶² Mobilization Training Program No. 8-10, 29 July 1942, with changes 1 and 2, dated 21 Oct. 1942 and 13 Mar. 1943, respectively.

the period of basic training to 16 weeks. Renewed emphasis on military subjects was reflected by the use of the additional time to expand the basic military phase of the program from 2 to 6 weeks. By comparison, the technical training phase remained unchanged at 7 weeks, and the tactical training phase was reduced from 3 weeks to 2.

On 10 January 1944, this program was supplemented by a guide for units that had been assigned such numbers of limited service personnel that they were unable to sustain the normal pace of training.⁶³ This supplementary mobilization training program for substandard units could be utilized only after a unit had been in training for 6 weeks and had demonstrated that it was staffed by substandard personnel. With the approval of Army Service Forces, such units were placed on a decelerated schedule during their seventh week of training, and allowed an additional 19 weeks to complete the cycle. By this technique, substandard units were able to spend a total of 25 weeks in basic training.

The mobilization training program for substandard units was the last issued for unit training under the cadre system. After the cadre system was replaced by the preactivation system on 15 April 1944, all unit training programs had to be rewritten. Under the new system, which shifted the entire responsibility for basic training to the replacement training centers, all male recruits, regardless of their branch, assigned to Army Service Forces were provided with 6 weeks of basic military training under a common program written by Army Service Forces.⁶⁴ In their seventh week of training, those soldiers who were assigned to medical components of the Army Service Forces began an 8-week technical training phase, or its equivalent at an enlisted technicians school, under Medical Department Mobilization Training Program No. 8-1, "Mobilization Training Program for Medical Department Enlisted Personnel of the Army Service Forces," published on 1 June 1944. At the end of the 14th week of the cycle, men who had been selected for assignment as replacements were scheduled for 3 weeks of basic team training. Those who were earmarked for assignment as fillers were separated from the basic training program and transferred to newly activated units.

During the final year of the war, three mobilization training programs governed the training of all Medical Department units. The first, a new program published by the War Department on 1 July 1944, provided medical units established under the preactivation system at ASF Training Centers with 6 weeks of basic training before they entered the advanced training cycle. On 10 May 1945, the War Department issued a revised version of the same program that left training schedules virtually unchanged, but for the first time during the war provided a lengthy discussion of the scope, content, and purpose of the program.⁶⁵

Under this program, members of hospital units, general dispensaries, hospital trains, laboratories, and medical groups devoted their first week of training to classes in military and medical subjects and squad and platoon exercises. The second and third weeks were spent in field exercises designed to train the unit to perform

⁶³ Mobilization Training Program No. 8-101A, 10 Jan. 1944.

⁶⁴ Mobilization Training Program No. 21-3, 1 May 1944.

⁶⁵ (1) Mobilization Training Program No. 8-2, 1 July 1944. (2) Mobilization Training Program No. 8-2, 10 May 1945.

its mission under tactical conditions with a minimum of confusion and delay. In addition, units were also required to participate in 8 hours of night training each week. The last 3 weeks of the program were used to provide unit personnel with additional parallel or on-the-job training at fixed installations and hospitals and to prepare the unit for overseas movement. Malaria control units, malaria survey units, and sanitary companies, the latter consisting entirely of Negroes, were provided with separate schedules that substituted practical exercises in their technical specialty for parallel training at fixed installations. After completing the 6-week basic training program, units were expected to be prepared to move to the field or the theater of operations on short notice or, if time permitted, to complete an advanced unit training cycle.

The second program, a mobilization training program issued in 1943 to guide the advanced training of medical supply units, was the only program of that period to remain in effect under the preactivation system. The third and final program was published on 1 July 1944 as a revised version of Mobilization Training Program No. 8-10, the guide originally issued in 1942 to govern the advanced training of numbered hospitals and nondivisional units of the Army Service Forces. During the first 10 weeks of the program, specialists and technicians spent half of each day in on-the-job training at local hospitals and installations; the remaining time was divided between classes in military and technical subjects. After the technical phase was completed, the cycle concluded with 3 weeks of field exercises. Officers, including for the first time dietitians and physical therapists, were provided with 4 weeks of classes in military, technical, and administrative subjects. The final section of the program contained the schedules prepared by the Ground Surgeon in January 1944 for AGF divisional and nondivisional units during their advanced or unit phase of training.

PERSONNEL AND EQUIPMENT

During the early years of World War II, medical units were plagued by a chronic shortage of personnel and equipment. In part, these problems were the result of a nationwide shortage of the specialized men and materiel required by the Armed Forces and, in part, from confusion and controversy over the role to be played by numbered medical units in the Zone of Interior. Details of this controversy have been discussed at length in another volume in this series, but certain aspects need to be considered here.⁶⁶ To a great extent, this controversy developed because The Surgeon General contended that numbered medical units should be used primarily as schools for tactical training that would furnish cadres and fillers to affiliated hospitals and other medical units, while the War Department, and later the Hospitalization and Evacuation Branch, ASF, believed that such units should be used to operate hospitals in the Zone of Interior. At times, shortages and changes in military requirements forced each party to modify its position, but the basic controversy dominated training policies until early 1943.

When mobilization began in the fall of 1940, The Surgeon General planned to

⁶⁶ See footnote 29 (2), p. 254.

issue only field training equipment to numbered hospital units and to assign only the two to five officers required for tactical and administrative training. In principle, these policies were opposed by the General Staff, which published a statement on 3 January 1941 stating that hospitals should be immediately available to operate in either the United States or a theater of operations in an emergency.⁶⁷ Despite this policy, however, shortages of officers, men, and equipment forced the General Staff to adopt The Surgeon General's position. Units activated during 1941 were initially provided with a cadre of Regular Army enlisted men, between two and five officers each, and only enough selectees—from either reception centers or Medical Replacement Training Centers—to provide them with approximately half of their table-of-organization enlisted strength. The General Staff's position on issue of equipment also differed from The Surgeon General's. In December 1940,⁶⁸ the staff announced that all Army units could obtain complete issues of equipment, except for controlled items (those in short supply and issued only with War Department permission), by submitting requisitions to corps area headquarters. Two weeks later, it issued a special directive making this policy specifically applicable to Medical Department units.⁶⁹ When units were first activated in 1941, however, shortages of supplies and equipment again made it impossible for the Medical Department to comply with War Department policies.

Events during the first half of 1941 tended to reduce the areas of disagreement between The Surgeon General and the War Department on personnel policies. In May 1941, difficulties encountered by the Medical Department in drawing complements from named hospitals in the United States for newly established hospitals in overseas areas and units required by task forces being formed to protect the French West Indies, and the inherent threat of such levies to medical service in the Zone of Interior, persuaded The Surgeon General to ask the War Department to authorize full complements of officers, nurses, and enlisted men for the 17 hospitals activated earlier in the year. By this step, he hoped to simplify the problems of converting training units into functional organizations. At the same time, however, he requested authority to withhold all supplies and equipment from such units except training equipment, individual equipment, vehicles, and controlled items, until they were assigned missions involving medical care. In July, the War Department approved increases to bring 11 of these units to full table-of-organization enlisted strength, and their officer and nurse allotments to 50 and 75 percent, respectively. It also authorized withholding full issues of hospital equipment to these units, and, at least for these units, approved a practice already adopted by the Medical Department. A month later, however, the War Department refused to approve a request for authority to apply this policy to all units, and when the

⁶⁷ Letter, The Adjutant General to Chief of Staff and Commanding Generals, Armies and Corps Areas, 3 Jan. 1941, subject: Purpose and Training of Certain Medical Corps Units To Be Activated With Selective Service Men.

⁶⁸ Letter, The Adjutant General to Chief of Staff, General Headquarters; Commanding Generals, Armies, Corps Areas, and Departments; Chief of the Armored Force; Commanding General, General Headquarters, Air Force; Chiefs of Arms and Services; Chief of the National Guard Bureau; and Commanding Officers of Exempted Stations, 30 Dec. 1940, subject: Current Supply Policies and Procedure.

⁶⁹ Letter, The Adjutant General to Commanding Generals of all Armies, Army Corps, Divisions, Corps Areas, and Departments; Commanding General, General Headquarters, Air Force; Chief of Staff, General Headquarters; Chiefs of Arms and Services; Chief of the Armored Force; Commanding Officers of Exempted Stations, 14 Jan. 1941, subject: Organization, Training, and Administration of Medical Units.

number of medical units activated and earmarked for task forces was increased from 11 to 31 in August 1941, different supply procedures had to be applied to the two groups of units.

The controversy reached a critical point in the fall of 1941 when the War Department pressed The Surgeon General to provide hospitals with full assemblages and asked for his recommendations. In response, he pointed out that five hospital assemblages had been issued, and 20 others were ready. Pointing to slow deliveries by manufacturers, however, he again asked for authority to hold assemblages in depots until units were assigned missions requiring the actual care of patients. To support this recommendation, he argued that units in training did not require a full issue of equipment, that storage in the field was inadequate, that careless handling by unit members would result in breakage and deterioration, and that units were not trained to repack assemblages for overseas shipment. In response, the War Department refused to abandon its position, but recognized the possibility of storing scarce supplies, and, on 6 December 1941, directed The Surgeon General to earmark and hold all available equipment until it could complete a survey of warehousing facilities. Thus, by the time the United States entered the war, The Surgeon General and the War Department had arrived at a common policy of providing units with less than a full quota of officers and nurses, and at times, a reduced complement of enlisted personnel. They disagreed, however, on the question of providing units with full issues of supplies and equipment, and the dispute continued unabated during the first half of the war.

By 7 December 1941, the Medical Department had activated 22 general, 24 station, 17 evacuation, and eight surgical hospitals as training units. Of this group, three station hospitals had been sent overseas, and 12 general, nine station, four evacuation, and three surgical hospitals were included in task force pools and authorized almost 100 percent of their table-of-organization enlisted strength, and from 50 to 75 percent of their commissioned strength. The balance had half or less of their enlisted strength and from three to five officers each. In addition, the Medical Department had organized an unactivated reserve of affiliated units that included 41 general, 11 evacuation, and four surgical hospitals. Such units consisted primarily of a professional complement of doctors and nurses and, under prewar plans, were to be called to active duty immediately after the outbreak of war, supplied with equipment and enlisted personnel, and pressed into service without further training. Supplies for these units consisted of five assemblages that had already been issued, 20 being held in reserve, and 41 that were in various stages of packing.

Early in January 1942, The Surgeon General outlined his plans for full-scale mobilization.⁷⁰ Affiliated units were to be called to active duty and provided with half their enlisted strength from training units, and the balance from reception centers, Zone of Interior installations, and other medical units. Training units that transferred such personnel, in turn, were to retain a cadre to train additional fillers. Some training units, especially station hospitals, were to be brought to authorized

⁷⁰ Memorandum, Lt. Col. John A. Rogers, MC, Executive Officer, Office of The Surgeon General, to the Assistant Chief of Staff, G-3, 13 Jan. 1942, subject: Activation of Numbered Professional Medical Units, and inclosures thereto.

enlisted and commissioned strength, and sent overseas as needed. Every unit was to draw individual clothing, equipment, and vehicles at its home station. Hospital assemblages would be provided only to those being sent overseas, preferably at the port of embarkation.

Shortly after this system was proposed, The Surgeon General realized that it would have to be modified. The practice of activating training units at half strength, adopted in 1941, resulted in units being hurriedly assembled at ports of embarkation. Members of units going overseas frequently had little time to become acquainted with each other's capabilities before embarkation, and installations from which fillers were drawn were often drained of personnel. In February 1942, therefore, The Surgeon General recommended that all units be activated at full table-of-organization enlisted strength.⁷¹ In May 1942, after receiving both ASF and AGF support, the policy received War Department approval.⁷²

The Surgeon General, Maj. Gen. James C. Magee, received only partial support, however, for his stand on the issuance of assemblages. After lengthy discussion, he accepted a compromise whereby unit assemblages were declared controlled items and placed under War Department control, and the Medical Department was authorized to make fractional issues of training equipment.⁷³ Although The Surgeon General agreed to this compromise, he did not give up hope of being able to hold assemblages in medical depots until numbered hospitals were assigned operational missions. Once unit assemblages had been declared controlled items, he sought this control indirectly. On 6 February 1942,⁷⁴ he succeeded in persuading the War Department to include a paragraph in movement orders for units ordered overseas, directing The Surgeon General to ship appropriate assemblages to ports of embarkation or staging areas. Neither of these measures, however, settled the controversy over equipment.

Under the compromise reached in January and February 1942, units were to receive only field training equipment, individual equipment, and vehicles for use in field training. Technical training and experience with professional supplies and equipment were to be gained at Zone of Interior hospitals. As long as one or two units were activated at a particular post for training, this method seemed satisfactory, but delay in the construction of housing often caused units to be grouped wherever housing was available. Too often, this system produced overcrowding and inefficient training.

In March 1942, the entire system was challenged by the Hospitalization and Evacuation Branch of Army Service Forces, which took the stand that hospital units could best be prepared for overseas service by receiving complete assemblages

⁷¹ Memorandum, Brig. Gen. Larry B. McAfee, Acting The Surgeon General, for the Assistant Chief of Staff, G-3, 28 Feb. 1942, subject: Organization and Dispatch of Medical Department Theater of Operations Units.

⁷² Letter, The Adjutant General to the Commanding Generals, Army Ground Forces; Army Air Forces; Services of Supply; Armored Force; Armies; Army Corps; Corps Areas; Air Forces; Departments; Divisions; Base Commands; and Defense Commands; Exempted Station and Force Commanders, 6 May 1942, subject: Allotments of Grades and Ratings and Authorized Strengths to Tactical Units (less Air Corps and Services with Air Corps).

⁷³ Letter, The Adjutant General to The Surgeon General, 21 Jan. 1942, subject: Equipment for Medical Department Units.

⁷⁴ Disposition Form, Maj. Gen. Brehon Somervell, Assistant Chief of Staff, War Department General Staff, to The Adjutant General, 6 Feb. 1942, subject: Proposed Modification of Movement Orders, and inclosure thereto.

and being required to function as hospitals in the Zone of Interior. This stand strengthened when Army Ground Forces submitted a similar recommendation in May, believing that units should be trained in the storage, maintenance, and repair of hospital equipment, and that they should be capable of managing their own messes and administration. In the paper duel that followed, The Surgeon General reached the point by September 1942 of agreeing to issue housekeeping equipment, but he continued to insist that all other equipment be withheld until units were assigned operational missions.

At this point, controversy over the issuance of assemblages was absorbed by a larger and inconclusive dispute over the use of numbered hospitals to provide medical service in the United States that lasted until mid-1943. By late 1942, many units were becoming restless from long periods in training without an opportunity to function, and reports of doctors sitting idle in army camps were beginning to reach the public. Moreover, reports from the theater indicated the desirability of training units to pack their own equipment and to reduce its size and weight by eliminating unnecessary items. On 16 September, and again on 12 October, Army Service Forces directed the Medical Department to prepare a plan for employing numbered medical units in the Zone of Interior,⁷⁵ and on 17 September 1942, it requested The Surgeon General's comments on a draft of a policy requiring the issuance of complete assemblages to all hospital units.⁷⁶ In response, The Surgeon General repeated his earlier recommendations, and supported by almost every argument that had been used since 1940, to oppose the issuance of assemblages. As a result, Army Service Forces published a compromise policy in January 1943 by which assemblages would contain only Medical Department supplies and equipment, while items needed by hospitals but supplied by other services, such as the Quartermaster Corps, could be furnished to units upon requisition.⁷⁷ Although The Surgeon General was not satisfied with this compromise, the policy remained in effect until the end of the war. Debate continued until mid-1943, when rapid reductions in the troop strength in the Zone of Interior brought it to an inconclusive end.

In contrast to the hospital units trained by Army Service Forces, evacuation units trained by Army Ground Forces were charged with providing medical service during their training in the United States. To fill this dual role, they required both personnel and equipment and usually suffered from a shortage of both. In the absence of an adequate number of Medical Corps officers, Army Ground Forces was unable to assign full complements to units in training. The ratio of Medical Corps officers to table-of-organization authorizations varied from time to time and unit to unit, but often it was less than 50 percent. Shortages of medical officers continued through 1943 and 1944, and at times, units were brought to full table-of-organization strength only after being scheduled for shipment overseas. Whenever possible,

⁷⁵ (1) Memorandum, Brig. Gen. LeRoy Lutes, Assistant Chief of Staff for Operations, Services of Supply, for The Surgeon General, 16 Sept. 1942, subject: Assignment, Training, and Utilization of Theater of Operations Medical Units. (2) 1st Indorsement, Brig. Gen. LeRoy Lutes, Assistant Chief of Staff for Operations, Services of Supply, to The Surgeon General, 12 Oct. 1942.

⁷⁶ Memorandum, Brig. Gen. LeRoy Lutes, Assistant Chief of Staff for Operations, Services of Supply, for The Surgeon General, 17 Sept. 1942, subject: Medical Unit Assemblages, and inclosure thereto.

⁷⁷ War Department Memorandum No. W700-4-43, 18 Jan. 1943.

however, The Surgeon General agreed to provide AGF units with a full complement of professional personnel during the maneuver phase of training.⁷⁸

Shortages of equipment were most severe during 1942 and the first half of 1943. During that period, the Ground Surgeon repeatedly petitioned the Surgeon General's Office for more complete allowances of supplies and equipment, and it was repeatedly notified that production of medical supplies was sufficient only to meet the needs of units scheduled for shipment to the theaters of operations. In mid-1943, however, the situation began to improve, and by the end of the year, some units reported all of their equipment on hand. By early 1944, the Ground Surgeon was able to report that all medical units engaged in maneuvers in Louisiana had between 95 and 100 percent of their authorized equipment.

⁷⁸ Shambora, William E.: Army Ground Forces Medical Training During World War II. [Official record.]

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For explanation of abbreviations used, see AR 310-50.

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